A 10-Foot Rope for a 40-Foot Hole

Tax Credits for the Uninsured

2004 Update

A REPORT BY

Families USA

November 2004

A 10-Foot Rope for a 40-Foot Hole:
Tax Credits for the Uninsured – 2004 Update

Families USA Publication No. 04-106

Families USA
1334 G Street, NW
Washington, DC 20005
Phone: (202) 628-3030
Fax: (202) 347-2417
E-mail: info@familiesusa.org

This publication is available online at
www.familiesusa.org

Support for this report was generously provided by
The George Gund Foundation
The Nathan Cummings Foundation

INTRODUCTION

In response to mounting concern about the number of Americans without health insurance, several policy makers have proposed the enactment of tax credits to help the uninsured purchase coverage. These proposals generally provide a credit against federal income taxes to defray all or part of the cost of purchasing coverage in the private, individual health insurance market. One such proposal, developed by President Bush, would provide a tax credit of up to $1,000 for a low-income individual or up to $3,000 for a low-income family. This tax credit would be available only to those who do not have insurance coverage through their employers and who are not eligible for Medicaid.

To find out what such a tax credit would mean for the target population—uninsured, low-income people—Families USA gathered and analyzed information about insurance plans offered in 50 states and the District of Columbia.

The study used three hypothetical applicants: a 55-year-old woman, a 40-year-old woman, and a 25-year-old woman. All three of these hypothetical applicants were *healthy non-smokers* and, as such, were favorable prospects for coverage. Information was sought for two different types of health plans for these three hypothetical applicants. The first type was plans that cost approximately $1,000, the maximum amount of the tax credit for an individual. The second type, which we called a "standard plan," was modeled after the most popular plan offered under the 2003 Federal Employees Health Benefits Program (2003 FEHBP). However, our standard plan did not have to match all, or even most, of the benefits offered in the FEHBP plan.

Standard plans are meant to reflect the bare minimum of adequate coverage coupled with reasonable cost-sharing. Notably, this study allowed standard plans to have coinsurance rates that were twice as high as those of the FEHBP plan, despite the barrier to obtaining health care that these out-of-pocket costs pose for the targeted low-income population. For our study, a standard plan was comparable to the health insurance coverage provided by the majority of mid- to large-sized employers in the United States (based on a comparison of prescription drug coverage, out-of-pocket annual limits on benefits, deductibles, copayments for doctors' visits, and coinsurance rates for other services).[1]

Analyzing the data gathered for this study allowed us to answer two questions: First, what kind of coverage can be purchased in the individual insurance market with a $1,000 tax credit? Second, how much extra money does a consumer have to pay in order to purchase an adequate health care plan in the individual market?

Our analysis found that, in many cases, $1,000 plans were simply not available. When they were available, the $1,000 plans generally provided substandard coverage, had high deductibles, and required high coinsurance or copayments. Standard plans would be too costly for most low-income people to afford, even with the $1,000 tax credit.

Definition of a Standard Plan

For this study, a standard health insurance plan was defined as a plan that enables a consumer to receive adequate health care with a reasonable level of cost-sharing. The 2003 Federal Employees Health Benefits Program Blue Cross/Blue Shield Standard Preferred Provider Organization plan (2003 FEHBP BC/BS PPO) was used as a model for a standard plan. However, a standard plan did not have to meet every aspect of coverage that the model plan offered. Notably, the study allowed standard plans to have coinsurance rates that were twice as high as those of the FEHBP plan. To be fair in selecting a standard plan that was also reasonably available, only some of the model plan's benefits had to be matched. Standard plans had three requirements. First, a plan could not have a deductible higher than the $250 deductible in the 2003 FEHBP BC/BS PPO. Second, standard plans had to have a coinsurance rate for inpatient and outpatient services that was no higher than 20 percent (by contrast, the FEHBP plan has a lower coinsurance rate of 10 percent). In addition, a standard plan had to meet at least one of the following three criteria:

1) copayments for doctors' office visits of $15 or less;
2) prescription drug coverage with coinsurance no higher than 25 percent or flat copayments no higher than $10 for generics and $20 for brand-name drugs (using a "preferred pharmacy" if necessary); or
3) an annual out-of-pocket limit of $4,000 or less.

(For more information, see the Appendix.)

KEY FINDINGS

$1,000 Health Plans Are Not Available or Are Substandard

- **$1,000 health plans are rarely available for healthy, non-smoking, 55-year-old women.** Of the 50 states and the District of Columbia, only two states had plans available for a healthy, non-smoking, 55-year-old woman. Those states were Maryland and Ohio (see Table 1).
- **When available, $1,000 plans for healthy, non-smoking, 55-year-old women are substandard.** In the two states that had $1,000 plans for healthy, non-smoking, 55-year-old women, the coverage offered was substandard.
  - *The deductibles were very high.* The annual deductible was $10,000 in Maryland and $2,500 in Ohio.
  - *Other out-of-pocket costs were high.* For example, in both states, the co-insurance rate was 20 percent, and the annual limit on out-of-pocket spending was $10,000 in Maryland and $4,500 in Ohio.
  - *The coverage offered by these plans was very limited* (see Table 5):
    - Doctors' office visits: Deficient in Maryland; not covered in Ohio.
    - Annual health exam: Covered in Maryland; deficient in Ohio.
    - Prescription drugs: Deficient in Maryland; not covered in Ohio.
    - Emergency services: Deficient in both states.
    - Inpatient hospital services: Deficient in both states.
    - Mental health care: Deficient in Maryland; not covered in Ohio.
    - Lifetime limit on benefits: Deficient in both states.
- **$1,000 health plans are not widely available for healthy, non-smoking, 40-year-old women.** In 23 states and the District of Columbia, no $1,000 plan was available for a healthy, non-smoking, 40-year-old woman.
- **When available, $1,000 plans for healthy, non-smoking, 40-year-old women are substandard.** In the 27 states that had $1,000 plans available for healthy, non-smoking, 40-year-old women, the coverage offered was substandard in every case.
  - *The deductibles were very high.* No state had an annual deductible as low as $250. In 21 of the 27 states that offered plans, the annual deductible was at least $2,500. In nine states, the annual deductible was at least $5,000.

- *Other out-of-pocket costs were high.* For example, the coinsurance rate was 20 percent in 25 of the 27 states, and the annual limit on out-of-pocket spending was more than $4,000 in 20 of the 27 states.
- *The coverage offered by these plans was very limited* (see Table 4):
  - Doctors' office visits: Covered in two states; deficient in seven states; not covered in 18 states.
  - Annual health exam: Covered in one state; deficient in 22 states; not covered in four states.
  - Prescription drugs: Covered in two states; deficient in two states; not covered in 23 states.
  - Emergency services: Deficient in all 27 states.
  - Inpatient hospital services: Covered in one state; deficient in 26 states.
  - Mental health care: Deficient in six states; not covered in 21 states.
  - Lifetime limit on benefits: Deficient in all 27 states.

- **$1,000 health plans are not always available for healthy, non-smoking, 25-year-old women.** In 12 states, no $1,000 plan was available for a healthy, non-smoking, 25-year-old woman.
- **When available, $1,000 plans for healthy, non-smoking, 25-year-old women are substandard.** In the District of Columbia and the 38 states that had $1,000 plans available for healthy, non-smoking, 25-year-old women, the coverage offered was substandard in every case.
  - *The deductibles were very high.* No state had an annual deductible as low as $250. In 29 of the 38 states plus the District of Columbia that offered plans, the annual deductible was at least $1,000. In 12 states and the District of Columbia, the annual deductible was at least $2,500.
  - *Other out-of-pocket costs were high.* For example, the coinsurance rate was 20 percent in the District of Columbia and 28 of the 38 states, and the annual limit on out-of-pocket spending was more than $4,000 in seven states and the District of Columbia.
  - *The coverage offered by these plans was very limited* (see Table 3).
    - Doctors' office visits: Covered in five states and the District of Columbia; deficient in 19 states; not covered in 14 states.

- Annual health exam: Covered in four states; deficient in 24 states; not covered in 10 states and the District of Columbia.
- Prescription drugs: Covered in seven states; deficient in 11 states; not covered in 20 states and the District of Columbia.
- Emergency services: Deficient in all 38 states and the District of Columbia.
- Inpatient hospital services: Covered in three states; deficient in 35 states and the District of Columbia.
- Mental health care: Deficient in 16 states and the District of Columbia; not covered in 22 states.
- Lifetime limit on benefits: Covered in one state; deficient in 37 states and the District of Columbia.

Standard Health Insurance Plans Are Very Costly

- **When available, standard plans for healthy, non-smoking, 55-year-old women have premiums that are significantly higher than $1,000.**
  - The average annual premium for a healthy, non-smoking, 55-year-old woman was $5,780. (See Table 2.)
  - In 25 states, premiums for a healthy, non-smoking, 55-year-old woman were higher than $5,000. The highest premiums were $10,284 in Louisiana, $9,615 in Georgia, and $8,964 in Alabama.
- **When available, standard plans for healthy, non-smoking, 40-year-old women have premiums that are significantly higher than $1,000.**
  - The average annual premium for a healthy, non-smoking, 40-year-old woman was $3,536. (See Table 2.)
  - In 28 states, premiums for a healthy, non-smoking, 40-year-old woman were higher than $3,000. The highest premiums were $6,799 in Maine, $6,510 in New Jersey, and $6,204 in Texas.
- **When available, standard plans for healthy, non-smoking, 25-year-old women have premiums that are significantly higher than $1,000.**
  - The average annual premium for a healthy, non-smoking, 25-year-old woman was $2,403. (See Table 2.)
  - In 11 states, premiums for a healthy, non-smoking, 25-year-old woman were above $2,500. The highest premiums were $6,510 in New Jersey, $5,439 in Maine, and $4,824 in Georgia.

Table 1

Deductibles for $1,000 Plans* (Healthy, Non-Smoking Women)

STATE	Deductible for:			STATE	Deductible for:		
	25-year-old	40-year-old	55-year-old		25-year-old	40-year-old	55-year-old
Alabama	X	X	X	Montana	$5,000	X	X
Alaska	$5,000	X	X	Nebraska	$500	$1,000	X
Arizona	$500	$5,000	X	Nevada	$2,000	X	X
Arkansas	$500	$1,000	X	New Hampshire	$4,950	X	X
California	$500	$1,500	X	New Jersey	X	X	X
Colorado	$1,700	$2,500	X	New Mexico	$1,000	$5,000	X
Connecticut	$1,500	$2,500	X	New York	X	X	X
Delaware	X	X	X	North Carolina	$5,000	X	X
D. C.	$5,000	X	X	North Dakota	$2,500	X	X
Florida	$2,600	$5,000	X	Ohio	$500	$500	$2,500
Georgia	$1,000	$5,000	X	Oklahoma	$1,000	$5,000	X
Hawaii	X	X	X	Oregon	$2,500	$7,500	X
Idaho	$500	X	X	Pennsylvania	$1,000	$2,500	X
Illinois	$2,500	X	X	Rhode Island	X	X	X
Indiana	$1,000	$5,000	X	South Carolina	$1,000	$2,500	X
Iowa	$500	$1,000	X	South Dakota	$5,000	X	X
Kansas	$2,500	X	X	Tennessee	$1,000	$2,500	X
Kentucky	$500	$2,500	X	Texas	$2,000	X	X
Louisiana	X	X	X	Utah	$2,500	$5,000	X
Maine	X	X	X	Vermont	X	X	X
Maryland	$1,000	$2,500	$10,000	Virginia	$300	$2,500	X
Massachusetts	X	X	X	Washington	$1,500	$1,500	X
Michigan	$1,000	$2,500	X	West Virginia	$1,000	$5,000	X
Minnesota	$1,000	$3,000	X	Wisconsin	$1,000	$2,500	X
Mississippi	X	X	X	Wyoming	X	X	X
Missouri	$1,000	$2,500	X	Average	$1,822	$3,130	$6,250

X = No $1,000 plan available.

* See the Appendix for an explanation of the selection of $1,000 plans.

Table 2

Premiums for Standard Plans* (Healthy, Non-Smoking Women)

STATE	Premium for:		
	25-year-old	40-year-old	55-year-old
Alabama	$2,892	$4,812	$8,964
Alaska	$2,592	$3,564	$5,976
Arizona	$2,388	$2,340	$4,032
Arkansas	$2,172	$3,612	$6,732
California	$1,236	$2,340	$4,776
Colorado	$2,736	$4,548	$8,472
Connecticut	$1,796	$2,278	$4,460
Delaware	$2,532	$4,200	$7,824
D. C.	$1,776	$2,400	$4,716
Florida	X	X	X
Georgia	$4,824	$6,059	$9,615
Hawaii	X	X	X
Idaho	X	X	X
Illinois	$2,276	$3,339	$5,114
Indiana	$2,106	$3,704	$5,448
Iowa	$1,752	$2,916	$5,424
Kansas	$1,859	$3,092	$5,238
Kentucky	$1,384	$2,434	$3,865
Louisiana	$3,312	$5,520	$10,284
Maine	$5,439	$6,799	$8,158
Maryland	$1,788	$2,400	$4,728
Massachusetts	X	X	X
Michigan	$2,268	$3,768	$7,020
Minnesota	$2,221	$2,779	$6,319
Mississippi	$2,989	$4,997	$8,223
Missouri	$2,280	$2,616	$3,960
Montana	$2,376	$3,312	$6,288
Nebraska	$2,016	$3,348	$6,240
Nevada	$1,308	$1,500	$2,376
New Hampshire	X	X	X
New Jersey	$6,510	$6,510	$6,510
New Mexico	$1,376	$2,281	$2,851
New York	$3,411	$3,411	$3,411
North Carolina	$1,928	$3,204	$4,812
North Dakota	X	X	X
Ohio	$1,608	$2,676	$4,980
Oklahoma	$2,484	$4,140	$7,716
Oregon	$1,608	$2,772	$4,812
Pennsylvania	$1,908	$2,136	$2,940
Rhode Island	$2,248	$3,610	$4,970
South Carolina	$2,016	$3,984	$5,405
South Dakota	$1,956	$3,252	$6,072
Tennessee	$2,097	$3,036	$4,137
Texas	$3,732	$6,204	$8,556
Utah	$1,308	$1,500	$2,376
Vermont	X	X	X
Virginia	$2,016	$3,300	$4,656
Washington	X	X	X
West Virginia	$2,452	$4,082	$7,603
Wisconsin	$2,024	$3,372	$5,218
Wyoming	$2,340	$3,900	$7,272
Average	$2,403	$3,536	$5,780

X = No standard plans available.

* See the Appendix for an explanation of the selection of standard plans.

Table 3

$1,000 Plans for 25-Year-Old, Healthy, Non-Smoking Women, Compared to 2003 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

State	Deductible	Doctors' Office Visits	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Emergency Services	Annual Health Exam	Mental Health	Maternity	Ob-Gyn Exam
	$250	$15[a]	$4,000	None	25%[b]	$100/ 20%	Covered[c]	$15[d]	$5/$100 20%[e]	Covered[f]	$15[g]
Alabama	*No plan available*										
Alaska	$5,000										
Arizona	$500										
Arkansas	$500										
California	$500										
Colorado	$1,700										
Connecticut	$1,500										
Delaware	*No plan available*										
D. C.	$5,000										
Florida	$2,600										
Georgia	$1,000										
Hawaii	*No plan available*										
Idaho	$500										
Illinois	$2,500										
Indiana	$1,000										
Iowa	$500										
Kansas	$2,500										
Kentucky	$500										
Louisiana	*No plan available*										
Maine	*No plan available*										
Maryland	$1,000										
Massachusetts	*No plan available*										
Michigan	$1,000										
Minnesota	$1,000										
Mississippi	*No plan available*										
Missouri	$1,000										

KEY:
- As good as Federal Employees Health Benefits Program (FEHBP)
- Covered, but coverage is substandard
- Not covered

Table 3 continued

$1,000 Plans for 25-Year-Old, Healthy, Non-Smoking Women, Compared to 2003 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

State	Deductible	Doctors' Office Visits	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Emergency Services	Annual Health Exam	Mental Health	Maternity	Ob-Gyn Exam
	$250	$15[a]	$4,000	None	25%[b]	$100/ 20%	Covered[c]	$15[d]	$5/$100 20%[e]	Covered[f]	$15[g]
Montana	$5,000										
Nebraska	$500										
Nevada	$2,000										
New Hampshire	$4,950										
New Jersey	*No plan available*										
New Mexico	$1,000										
New York	*No plan available*										
North Carolina	$5,000										
North Dakota	$2,500										
Ohio	$500										
Oklahoma	$1,000										
Oregon	$2,500										
Pennsylvania	$1,000										
Rhode Island	*No plan available*										
South Carolina	$1,000										
South Dakota	$5,000										
Tennessee	$1,000										
Texas	$2,000										
Utah	$2,500										
Vermont	*No plan available*										
Virginia	$300										
Washington	$1,500										
West Virginia	$1,000										
Wisconsin	$1,000										
Wyoming	*No plan available*										

KEY:
- As good as Federal Employees Health Benefits Program (FEHBP)
- Covered, but coverage is substandard
- Not covered

Table 4

$1,000 Plans for 40-Year-Old, Healthy, Non-Smoking Women, Compared to 2003 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

State	Deductible	Doctors' Office Visits	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Emergency Services	Annual Health Exam	Mental Health	Maternity	Ob-Gyn Exam
	$250	$15[a]	$4,000	None	25%[b]	$100/ 20%	Covered[c]	$15[d]	$5/$100 20%[e]	Covered[f]	$15[g]
Alabama	*No plan available*										
Alaska	*No plan available*										
Arizona	$5,000										
Arkansas	$1,000										
California	$1,500										
Colorado	$2,500										
Connecticut	$2,500										
Delaware	*No plan available*										
D. C.	*No plan available*										
Florida	$5,000										
Georgia	$5,000										
Hawaii	*No plan available*										
Idaho	*No plan available*										
Illinois	*No plan available*										
Indiana	$5,000										
Iowa	$1,000										
Kansas	*No plan available*										
Kentucky	$2,500										
Louisiana	*No plan available*										
Maine	*No plan available*										
Maryland	$2,500										
Massachusetts	*No plan available*										
Michigan	$2,500										
Minnesota	$3,000										
Mississippi	*No plan available*										
Missouri	$2,500										

KEY:
- As good as Federal Employees Health Benefits Program (FEHBP)
- Covered, but coverage is substandard
- Not covered

Table 4 continued

$1,000 Plans for 40-Year-Old, Healthy, Non-Smoking Women, Compared to 2003 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

State	Deductible	Doctors' Office Visits	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Emergency Services	Annual Health Exam	Mental Health	Maternity	Ob-Gyn Exam
	$250	$15[a]	$4,000	None	25%[b]	$100/ 20%	Covered[c]	$15[d]	$5/$100 20%[e]	Covered[f]	$15[g]
Montana	*No plan available*										
Nebraska	$1,000										
Nevada	*No plan available*										
New Hampshire	*No plan available*										
New Jersey	*No plan available*										
New Mexico	$5,000										
New York	*No plan available*										
North Carolina	*No plan available*										
North Dakota	*No plan available*										
Ohio	$500										
Oklahoma	$5,000										
Oregon	$7,500										
Pennsylvania	$2,500										
Rhode Island	*No plan available*										
South Carolina	$2,500										
South Dakota	*No plan available*										
Tennessee	$2,500										
Texas	*No plan available*										
Utah	$5,000										
Vermont	*No plan available*										
Virginia	$2,500										
Washington	$1,500										
West Virginia	$5,000										
Wisconsin	$2,500										
Wyoming	*No plan available*										

KEY:
- As good as Federal Employees Health Benefits Program (FEHBP)
- Covered, but coverage is substandard
- Not covered

Table 5

$1,000 Plans for 55-Year-Old, Healthy, Non-Smoking Women, Compared to 2003 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

	Deductible	Doctors' Office Visits	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Emergency Services	Annual Health Exam	Mental Health	Maternity	Ob-Gyn Exam
	$250	$15[a]	$4,000	None	25%[b]	$100/ 20%	Covered[c]	$15[d]	$5/$100 20%[e]	Covered[f]	$15[g]
State											
Alabama	*No plan available*										
Alaska	*No plan available*										
Arizona	*No plan available*										
Arkansas	*No plan available*										
California	*No plan available*										
Colorado	*No plan available*										
Connecticut	*No plan available*										
Delaware	*No plan available*										
D. C.	*No plan available*										
Florida	*No plan available*										
Georgia	*No plan available*										
Hawaii	*No plan available*										
Idaho	*No plan available*										
Illinois	*No plan available*										
Indiana	*No plan available*										
Iowa	*No plan available*										
Kansas	*No plan available*										
Kentucky	*No plan available*										
Louisiana	*No plan available*										
Maine	*No plan available*										
Maryland	$10,000										
Massachusetts	*No plan available*										
Michigan	*No plan available*										
Minnesota	*No plan available*										
Mississippi	*No plan available*										
Missouri	*No plan available*										

KEY:
- As good as Federal Employees Health Benefits Program (FEHBP)
- Covered, but coverage is substandard
- Not covered

Table 5 continued

$1,000 Plans for 55-Year-Old, Healthy, Non-Smoking Women, Compared to 2003 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

State	Deductible	Doctors' Office Visits	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Emergency Services	Annual Health Exam	Mental Health	Maternity	Ob-Gyn Exam
	$250	$15[a]	$4,000	None	25%[b]	$100/ 20%	Covered[c]	$15[d]	$5/$100 20%[e]	Covered[f]	$15[g]
Montana	*No plan available*										
Nebraska	*No plan available*										
Nevada	*No plan available*										
New Hampshire	*No plan available*										
New Jersey	*No plan available*										
New Mexico	*No plan available*										
New York	*No plan available*										
North Carolina	*No plan available*										
North Dakota	*No plan available*										
Ohio	$2,500										
Oklahoma	*No plan available*										
Oregon	*No plan available*										
Pennsylvania	*No plan available*										
Rhode Island	*No plan available*										
South Carolina	*No plan available*										
South Dakota	*No plan available*										
Tennessee	*No plan available*										
Texas	*No plan available*										
Utah	*No plan available*										
Vermont	*No plan available*										
Virginia	*No plan available*										
Washington	*No plan available*										
West Virginia	*No plan available*										
Wisconsin	*No plan available*										
Wyoming	*No plan available*										

KEY:
- As good as Federal Employees Health Benefits Program (FEHBP)
- Covered, but coverage is substandard
- Not covered

Notes to Tables 3, 4, and 5

[a] *Office visit to a preferred provider:* The insured person pays $15 for each visit, and the deductible is waived.

[b] If prescription drugs are purchased through a mail-order pharmacy service, the insured pays $12 per generic drug and $20 per brand-name drug for a 90-day supply. If prescription drugs are purchased at a retail pharmacy, the insured pays 25 percent of the cost of the prescription (with no limits on the number of prescriptions).

[c] No charge for emergency room services from a preferred provider, and insured pays 10 percent of the cost of the ambulance.

[d] *Annual health exams from a preferred provider*: Covered every three years; insured pays $15. The cost of preventive screening and diagnostic tests is covered in full.

[e] *Mental health care from a preferred provider*: Insured pays a $15 copayment for each office visit (with the deductible waived and no limits on the number of visits). A $100 deductible is applied for inpatient hospital services; the insured pays 20 percent for other services.

[f] *Maternity care from a preferred provider*: No charge to the insured.

[g] *Obstetrical-gynecological care from a preferred provider*: The insured pays $15 per office visit (with no limit on the number of visits and deductible waived). Pap smears and mammograms are covered in full, and the insured pays a $15 copayment for other services.

Underwriting Primer

The premiums, benefits, and availability of the plans referenced in the key findings are not available to all health care consumers. In fact, these plans represent what is available in the best-case scenario—a person who is not just in perfect health now, but who has always been in perfect health. For many Americans, these plans would either cost far more than the listed premium, lack key benefits, or not be offered at all.

Availability of Plans

Very few states require what is called "guaranteed issue," which ensures that insurance companies cannot deny a plan to an applicant because of the applicant's health. In 45 states, providers are free to reject applicants because of medical problems, whether minor or serious.

Cost Containment

In most states, insurance companies can drastically increase prices for their plans based on an applicant's medical conditions, age, gender, occupation, geographic location, and other attributes. Only three states offer consumers full protection against these cost hikes.

Coverage Exclusion

Insurance companies attempt to minimize risk by excluding coverage for preexisting conditions. They do this by eliminating specific benefits, either temporarily or permanently, that are related to the applicant's preexisting medical condition. In some states, insurance companies can label a condition as preexisting even if the applicant never received care for it, as long as the insurance company believes that most people would have sought care in a similar situation. In 37 states, insurance companies are allowed to permanently strip consumers of coverage for their pre-existing health conditions. In 15 states, providers can look back at least five years into an applicant's medical history to find preexisting conditions.

METHODOLOGY

For this study, Families USA identified the health insurance plans available in the individual market for healthy, non-smoking, 55-year-old women; healthy, non-smoking, 40-year-old women; and healthy, non-smoking, 25-year-old women in the largest city in each state and in the District of Columbia. The study used eHealthInsurance.com to identify plans in 43 states and the District of Columbia. In the seven states where information was not available through eHealthInsurance.com, Families USA contacted health insurance companies that offered individual market coverage directly. These states were Hawaii, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, and West Virginia.

The study had two components. First, we identified plans available for a premium of no more than $90 per month ($1,080 annually). When more than one plan was available in this price range, we chose the best plan by applying the following criteria, in descending order of importance:

1) having the lowest deductible;
2) having the best coinsurance rate for inpatient and outpatient services (with no more than 20 percent paid by the insured individual); and
3) offering some coverage of doctors' office visits.

Second, we looked at the annual premiums for a standard health insurance plan. For purposes of this study, Families USA defined adequate plans as plans *comparable* to the Blue Cross/Blue Shield Standard Preferred Provider Organization (BC/BS PPO) plan offered by the 2003 Federal Employees Health Benefits Program (2003 FEHBP). Plans were deemed comparable if they had a $250 deductible, a 20 percent or less coinsurance rate, and provided decent coverage for at least one of three critical health services. (See the Appendix for more details.)

Limitations of This Study: The health insurance premium quotes gathered were for healthy, non-smoking women in each age group. The premiums were the *absolute lowest available* for the given policies at the time of the study. The premiums do not necessarily reflect the actual prices that an individual might have to pay based on the detailed information she would provide in the application process. Women with any significant health risk factors would pay much more for coverage, if coverage were available at all.

DISCUSSION

Tax Credits to Help the Low-Income Uninsured

President Bush has proposed a federal income tax credit to help people purchase health insurance. Individuals with annual incomes under $15,000 would receive a tax credit of 90 percent of the cost of purchasing a policy, up to a limit of $1,000. Families with incomes under $25,000 would receive a tax credit of 90 percent of the cost up to $3,000 ($1,000 per adult and $500 per child, up to a total of $3,000). The tax credit would phase out for individuals with incomes of $30,000 or higher and for families with incomes of $60,000 or higher. Although details vary, a number of bills containing proposals similar to the Administration's proposal have been introduced in Congress.

In the President's latest proposal, the tax credits have been made "refundable," meaning that low-income people who could not otherwise benefit from a tax credit because they owe no federal taxes would be eligible to receive up to $1,000 for individuals ($3,000 for families). Further, because low-income people do not have extra cash to spend out of pocket, the proposed tax credit is "forward funded." This means a refund is available to pay for insurance at the beginning of the tax year.

Nearly all children in families with incomes below 200 percent of the federal poverty level ($31,340 for a family of three in 2004) are eligible for health insurance coverage through the State Children's Health Insurance Program (SCHIP). Therefore, the real targets of the proposed tax credit are uninsured, low-income adults—both parents and non-parents. President Bush, in a January 2004 speech about his policies for increasing access to health care, stated, "Congress needs to pass refundable tax credits to help the working uninsured."[2]

Unfortunately, the proposed tax credit would do little to help the uninsured and would instead force many people out of existing employer-based coverage. According to a study by the Kaiser Family Foundation, only 30 percent of the people who would use the proposed tax credit are currently uninsured.[3] The vast majority of Americans who would use the proposed tax credit are already insured. So, while the tax credit may offer a tax break for

some people who are already purchasing insurance on their own, it will do little to reduce the numbers of uninsured Americans.

Additionally, the shift of workers from employer-based plans to the private market would cause many employers to drop health care coverage for their remaining employees. As younger, healthier employees leave employer-based plans for the private market, older and less healthy employees will be left behind. Employers will then be faced with higher costs for health care for these employees, and many will drop their plans altogether. A study by the Kaiser Family Foundation estimates that 1.32 million Americans that currently receive health insurance from their employer will become uninsured if the proposed tax credits are enacted.[4]

As ineffective as tax credits would be in helping the uninsured in 2005, they would become even less useful in subsequent years. The President's proposal calls for the size of the tax credits to increase at the rate of inflation. Health care costs, however, have been increasing at a rate much higher than inflation and are likely to continue doing so.[5] The relative impact of the credits will therefore decrease in future years.

Even with tax credits, low-income people are forced to choose between being underinsured with a $1,000 plan and spending beyond their budget on a standard health plan. To purchase a standard plan, which would minimize the risk of incurring high deductibles and copayments if they get sick, these people will be forced to forgo other necessities, such as housing and food, to pay high premiums. The other option is to purchase a cheaper plan and pay very high deductibles, high copayments or coinsurance, and the full cost of services that are not covered by their plan. Either way, they will have to pay far more than most low-income people can afford.

■ Option 1: Pay a High Premium Now

As stated previously, the average annual premium for a standard health insurance policy that is comparable to the 2003 FEHBP Blue Cross/Blue Shield Standard Preferred Provider Organization plan is $5,780 for a healthy 55-year-old woman, $3,536 for a healthy 40-year-old woman, and $2,403 for a healthy 25-year-old woman. Table 2 lists the premiums for the least expensive plans in each state that were comparable to the FEHBP plan.

These health insurance premium costs—combined with a $250 deductible—would leave adequate health insurance coverage well beyond the economic reach of most low-income people. Based on the average premium cost of a standard plan, and taking the $1,000 tax credit into account, a healthy 55-year-old woman living at the federal poverty level ($9,310 in annual income[6]) would have to spend—after the tax credit—more than half (54 percent) of her annual income before she would gain any health insurance benefit. A healthy 40-year-old woman living at the federal poverty level would have to spend—after the tax credit—30 percent of her income before she would gain any health insurance benefit. A healthy 25-year-old woman living at the poverty level would have to spend—after the tax credit—18 percent of her income before she would gain any health insurance benefit. In addition, if any of these women then used any health services, they would have to pay *additional* charges out of pocket.

These figures may not seem extreme at first glance, but for a low-income individual, they are devastating. According to a study by the Urban Institute, nearly one-quarter (23 percent) of low-income adults spend more than half of their income on housing.[7] Other necessities—such as food, clothing, and transportation—comprise such a large portion of a low-income individual's income that there is little left to pay for health insurance.

Research has shown that, for low-income people, the decision to enroll in health care programs or to take up insurance is strongly influenced by premium costs. In the State Children's Health Insurance Program (SCHIP), federal law requires that premiums be capped at 5 percent of family income. This is much less than the premium contribution necessary to buy the 80 standard health insurance plans identified in this study. Yet a recent survey of families who left or lost SCHIP coverage in seven states found that nearly four out of 10 (38 percent) of these families had experienced difficulty paying their premiums for SCHIP coverage.[8] State records from the California SCHIP program (Healthy Families) showed that, even with premiums at less than 5 percent of income, nonpayment of premiums was the reason 35 percent of families dropped out of the program from June 1998 to February 2002.[9]

In 2002, North Carolina reported that failure to pay the $50 annual enrollment fee was the leading cause of SCHIP denials, even though only 30 percent of families were subject to the fee. A healthy, 25-year-old woman in North Carolina would have to pay at least $1,178—after accounting for the tax credit—to receive a standard health care plan. A healthy, 40-year-old woman in North Carolina would have to pay at least $2,454, while a healthy, 55-year-old woman would have to pay at least $4,062—both after accounting for the tax credit—to receive a standard health care plan. Those steep costs, for an individual living at the federal poverty level, amount to 13 percent of income for a healthy, 25-year-old woman; 26 percent of income for a healthy, 40-year-old woman; and 44 percent of income for a healthy, 55-year-old woman.

Other research illustrates the strong inverse relationship between premium levels and participation in public programs.[10] Analyses of data from Hawaii, Minnesota, Tennessee, and Washington found that 57 percent of the uninsured would participate when premiums were 1 percent of income, but *if premiums rose to 5 percent of income, only 18 percent would participate*.[11] For a 25-year-old woman living at the federal poverty level in Minnesota, the least expensive premium for a standard plan—after accounting for the tax credit—would comprise 13 percent of her income.

A study conducted by the Lewin Group found that, when premium contributions in Washington State's health insurance program for the uninsured were 7 percent of income, only 10 percent of eligible people bought the plan. Another Lewin Group study, which used a health benefits simulation model, estimated that participation in subsidized health insurance programs would drop from 70 to 45 percent when premium costs reached 5 percent of income.[12]

■ Option 2: Pay High Out-of-Pocket Costs Later

For the majority of low-income individuals, the standard health plans referenced in the above section are not realistic options. The alternative these individuals face is to buy a less expensive plan that puts them at a much greater risk of paying higher out-of-pocket costs if they get sick. When available, the $1,000 plans provided very limited benefits and required the insured individual

to meet a high deductible and pay other high out-of-pocket costs. Table 1 lists the deductibles for the $1,000 plans. Tables 3, 4, and 5 compare the coverage of the $1,000 plans to a standard plan's coverage.

Even more disturbing is the fact that these substandard plans are not available in many states—after taking the tax credit into account—at a premium cost that low-income individuals can afford. In 48 states and the District of Columbia, a healthy, non-smoking, 55-year-old woman could not buy a health insurance policy with a $1,000 annual premium; in 23 states and the District of Columbia, a healthy, non-smoking, 40-year-old woman could not buy a $1,000 plan; and in 12 states, a healthy, non-smoking, 25-year-old woman could not buy a $1,000 plan.

Researchers refer to deductibles, copayments, and coinsurance collectively as "cost-sharing." Research shows that cost-sharing discourages the use of health services. This is true even when cost-sharing is significantly lower than that required by the $1,000 plans and even when it is *lower than this study's standard health insurance plan*.

The most rigorous research on cost-sharing is the RAND Health Insurance Experiment (HIE).[13] This longitudinal study randomly assigned families to one of 14 health plans, which covered identical services but varied by level of cost-sharing. The RAND findings demonstrate that, *even with cost-sharing limited to the lesser of 5 percent of income or $1,000*, there is a significant negative impact on use of necessary acute and preventive care. Among adults with incomes under 200 percent of poverty (currently $18,620 for an individual), those subject to this limited cost-sharing were 59 percent as likely as those with no cost-sharing requirements to seek timely and effective health care and 65 percent as likely as those who were not subject to cost-sharing to seek care for their children.[14] Further, adults with any copayments were less likely to purchase prescription drugs.[15]

The RAND study findings have been confirmed by subsequent research. A 1994 review of the literature on cost-sharing found five other studies confirming that even limited cost-sharing reduces health care utilization among low-income populations.[16] A 1996 survey of TennCare (Tennessee's Medicaid program)

documented the negative impact of copayments on visits to doctors and use of prescription drugs on beneficiaries with incomes *above 100 percent of poverty*:

- 20 percent of beneficiaries said they had not been able to pay a required copayment at the time of an office visit;
- 11 percent of beneficiaries said they could not make copayments if they had to go to the doctor today; another 39 percent said they could afford only $3 to $5; and
- 22 percent were unable to make a copayment for medication, and nearly two-thirds of these (62 percent) had gone without their prescription because of inability to pay.[17]

The numbers above are frightening considering the coverage offered by the available $1,000 plans. In the District of Columbia and 20 of the 38 states that offer $1,000 plans for healthy, 25-year-old women, the $1,000 plan offers *no coverage for prescription drugs.* Other services, such as routine doctors' office visits and annual health exams, also were not covered in several states' $1,000 plans.

Another study that looked at the impact of copayments on the use of services by Washington State employees and their dependents enrolled in Group Health Cooperative of Puget Sound found that a $5 copayment resulted in an 11 percent decline in primary care visits and a 14 percent decline in physical examinations, with a 20 to 25 percent decline in physical examinations for children.[18] A $1.50 prescription drug copayment resulted in an 11 percent decline in use of prescription drugs.[19] In the best $1,000 plan available in Washington for a healthy, 25-year-old woman, doctors' office visits require a $15 copayment, and prescription drugs are not covered at all.

The research on cost-sharing demonstrates that the high deductibles, copayments, and coinsurance rates required by $1,000 health insurance plans would be a significant barrier to care for low-income people. In addition to these cost-sharing obstacles, a large number of $1,000 plans offer no coverage at all for common services such as maternity care, office visits, prescription drugs, and OB/GYN care.

What about People Who Are Not Perfectly Healthy?

The numbers referenced in this study for standard and $1,000 plans are not reflective of the prices most low-income individuals can expect to pay for the plans. These figures are "best case scenarios," treating every woman as if she is in—and always has been in—perfect health. Laws vary from state to state, but in most states, insurers are able to drastically change the cost and coverage of plans. These laws allow insurance companies to significantly increase the plan's cost, reduce the plan's coverage, or even completely deny the applicant any coverage.

■ Denial of Coverage

A select few states have what is called "guaranteed issue," which requires that insurance companies offer all of their plans to all applicants. Those five states are as follows: Maine, Massachusetts, New Jersey, New York, and Vermont. In the other 45 states and in the District of Columbia, insurance companies can—and do—reject applicants based on their medical conditions, past and present.

A recent study by the Kaiser Family Foundation examined the availability of health insurance coverage in the individual market. For this study, hypothetical consumers applied for coverage in diverse health insurance markets.[20] *The applicants were rejected for coverage 37 percent of the time,* and only 10 percent of the remaining offers of health insurance were "clean"—that is, at the standard premium with no limitations on covered benefits. This study shows that when a person has any health conditions—even relatively minor problems—the availability, cost, and terms of coverage of health insurance decline significantly. One hypothetical applicant with only a mild case of hay fever (a condition experienced by 36 million Americans) was rejected for coverage 8 percent of the time. And a hypothetical applicant who was an overweight smoker with high blood pressure was rejected 55 percent of the time.

The Maryland Insurance Administration has reported health insurance applicant rejection rates comparable to those found in the Kaiser study. The Maryland Blue Cross/Blue Shield plan, CareFirst of Maryland, rejected 32 percent of the 18,000 people who applied for individual coverage in 1998.[21]

This percentage does not take into account the people who never formally submitted an application after they were discouraged from doing so because they had a health condition. Nor does it include the people who are offered coverage—but with a high premium and with limitations on covered benefits.

Increased Cost

If an insurance company chooses to offer an applicant coverage, it can still increase the cost of the policy depending on the applicant's medical condition, age, gender, occupation, geographic location, and other habits and attributes. Only three states—New Jersey, New York, and Vermont—offer consumers full protection from these types of adjustments. Four other states—Maine, Massachusetts, Oregon, and Washington—limit the magnitude of the cost increases insurance companies can impose on consumers. Eight other states limit the cost increases insurers can impose for medical conditions. This leaves 35 states, plus the District of Columbia, that offer consumers no protection from insurance companies drastically changing the advertised costs of their plans.

Limited Coverage

Insurance companies can also rescind specific benefits of their plans to avoid covering preexisting conditions. In the aforementioned Kaiser Family Foundation study, when health insurance coverage was available to the hypothetical applicants in this study, the plans often included limitations on benefit coverage (usually related to the health conditions of the particular applicant) and/or the premiums were higher than the standard premium. For example, the hypothetical applicant who was an overweight smoker with high blood pressure was offered coverage at an average premium of $9,936 a year. Three of the offers to this hypothetical consumer excluded coverage of his entire circulatory system. The exclusion of benefits can be temporary or permanent, depending on the state. In 37 states, insurance companies are allowed to permanently exclude coverage for preexisting medical conditions.

When applying for coverage, applicants are generally asked about their preexisting medical conditions. However, insurance companies are also allowed to "look back" into an applicant's medical history for conditions. Fifteen states al-

low insurance companies to look back at least five years into an applicant's past to find preexisting conditions.

What about People Who Don't *Stay* Perfectly Healthy?

What happens to people who are young and healthy and find an acceptable plan in the individual market—and *then* become sick and need to use that coverage? It is not safe to assume that health insurance companies evaluate medical history only when a person first applies for coverage. More and more companies today want to reevaluate a person's medical status at the end of each year of coverage when the person tries to renew the policy. If a person has developed a serious or chronic condition, or even just filed more than a few claims over the past year, then the insurance company may try to find a way to raise premiums, increase deductibles and other out-of-pocket costs, and restrict coverage.

In the past, both contract provisions and some state insurance laws restricted a health insurer's ability to raise a person's premiums after the policy was initially sold. But insurance companies in the individual market who want to avoid this limit have been able to circumvent state laws by, for example, basing their operations in states without these laws or by taking plans off the market and forcing everyone who had the plan to apply for a new plan.

CONCLUSION

Will a tax credit such as the one proposed by President Bush really help low-income people buy health insurance coverage in the private, non-group market?

Tax credit proponents answer this question in two contradictory ways. They assert that $1,000 alone will buy a health insurance plan with reasonable benefit coverage and out-of-pocket costs. At the same time, they assert that uninsured people are expected to supplement the purchasing power of the tax credit's value to pay the premiums for better coverage.

This study demonstrates that the proponents of tax credits are wrong on both counts. Even for the healthiest individuals, $1,000 does not buy adequate coverage. Further, the $1,000 plans often exclude important primary and

preventive services and require the insured person to pay high additional out-of-pocket costs. These costs are unaffordable for low-income people and erect a barrier between low-income people and the health services they may need. The alternative—supplementing the value of the tax credit to purchase standard coverage—would require a substantial investment that would, in many cases, consume a large share of the total income of people who, by definition, have little to spare.

Enacting a $1,000 tax credit for the purchase of health insurance is like extending a 10-foot rope to a person at the bottom of a 40-foot hole—it leaves a gap that can't be closed. It is no help at all.

ENDNOTES

[1] Gary Claxton, Isadora Gil, Ben Finder, Erin Holve, Jon Gabel, Jeremy Pickreign, Heidi Whitmore, Samantha Hawkins, and Cheryl Fahlman, *Employer Health Benefits: 2004 Annual Survey* (Menlo Park, CA: Kaiser Family Foundation and the Health Research and Educational Trust, September 2004).

[2] Bush, George W., *President Bush Discusses Quality, Affordable Health Care* (Washington, DC: White House Press Release, January 28, 2004), available online at http://www.whitehouse.gov/news/releases/2004/01/print/20040128-2.html. Downloaded on June 17, 2004.

[3] Jonathan Gruber, *Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals* (Washington: Henry J. Kaiser Family Foundation, March 2004), Table 1.

[4] Jonathan Gruber, op. cit., Table 2.

[5] Iris Lav, *Tax Credits for Individuals to Buy Health Insurance Won't Help Many Uninsured Families* (Washington: Center on Budget and Policy Priorities, February 15, 2001).

[6] 69 Fed. Reg. 7336 (February 13, 2004).

[7] Sharon Long, *Hardship among the Uninsured: Choosing among Food, Housing, and Health Insurance* (Washington: Urban Institute, May 21, 2003).

[8] Trish Riley, Cynthia Pernice, Michael Perry, and Susan Kannel, *Why Eligible Children Lose or Leave SCHIP: Findings From a Comprehensive Study of Retention and Disenrollment* (Portland, ME: National Academy of State Health Policy, February 2002).

[9] Healthy Families Program Children Disenrollment Statistics, Healthy Families Program Monthly Enrollment Report, available online at http://www.mrmib.ca.gov/HFP/HFPRpt.9.pdf. Downloaded on April 15, 2002.

[10] Judith Feder and Larry Levitt, *Choices Under the New State Child Health Insurance Program: What Factors Shape Cost and Coverage?* Policy Brief #2140 (Menlo Park, CA: Henry J. Kaiser Family Foundation, January 1998).

[11] Leighton Ku and Teresa Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington: The Urban Institute, March 1997), available online at http://www.urban.org/entitlement/premium.htm. Downloaded on April 15, 2002.

[12] Lewin-VHI, Inc, *Options and Recommendations Paper: Cost-Sharing for Low-Income Populations: Task Order B-21*, Prepared for State of Washington, Health Services Commission, August 22, 1994.

[13] Key findings of the RAND Health Insurance Experiment Study (HIE) are described in Geri Dallek, *A Guide to Cost-Sharing and Low-Income People* (Washington: Families USA, October 1997).

[14] Kathleen Lohr, et al., "Use of Medical Care in the RAND Health Insurance Experiment Study: Diagnosis-and-Service-Specific Analyzes," *Medical Care* 24, no. 9 (September 1986): Supplement, S1-S80.

[15] Arleen Leibowitz, Willard Manning Jr., and Joseph Newhouse, *The Demand for Prescription Drugs as a Function of Cost-Sharing*. Prepared for the U.S. Department of Health and Human Services (Santa Monica, CA: RAND, October 1985).

[16] Thomas Rice and Kathleen Morrison, "Patient Cost-Sharing for Medical Services: A Review of the Literature and Implications for Health Care Reform," *Medical Care Review* 51 (Fall 1994): 235-287.

[17] Kathleen Lohr et al., op. cit.

[18] Brian Harris, Andy Stergachis, and L. Douglas Ried, "The Effect of Drug Co-Payments on Utilization and Cost of Pharmaceuticals in a Health Maintenance Organization," *Medical Care* 28, no. 10 (October 1990): 907-917.

[19] Thomas Rice and Kathleen Morrison, op. cit.

[20] Karen Pollitz, Richard Sorian, and Kathy Thomas, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington: The Henry J. Kaiser Family Foundation, June 2001).

[21] Testimony of Steven B. Larsen, Insurance Commissioner, State of Maryland, before the Subcommittee on Health of the House Committee on Ways and Means, April 4, 2001.

APPENDIX:

METHODOLOGY

METHODOLOGY

For this study, Families USA looked at the availability of health insurance coverage for individuals in the private, non-group market in 50 states and the District of Columbia. In each state, we identified: 1) the best plan available for a $1,000 annual premium and 2) the price of a health insurance plan with a standard package of covered health care services and with reasonable deductibles. The study used plans available in the primary zip code (as identified by the U. S. Postal Service) for the largest city in each state.

Because the State Children's Health Insurance Program (SCHIP) reaches many previously uninsured *children* in families with incomes up to 200 percent of the federal poverty level, being low-income and uninsured is more likely to be a problem for *adults*. In fact, only 18 percent of uninsured Americans are children; the rest are adults. For this reason, the study looked at the health insurance plans available to *individuals* seeking to purchase coverage on their own, not at family coverage. The study examined health insurance coverage available in each of the 50 states and the District of Columbia for healthy, non-smoking 55-year-old, 40-year-old, and 25-year-old women. We chose these three groups to reflect the age spectrum of the majority of the uninsured and to demonstrate how the cost of premiums increases and the quality of coverage diminishes for individuals as they grow older. Young adults aged 19 to 34 have the highest rate of uninsurance—approximately 27 percent. The uninsurance rate for adults aged 35 to 64 averages approximately 15 percent. However, at age 55, an individual faces greater obstacles to getting and/or affording health insurance in the private, non-group market. Older adults have an increased likelihood of experiencing a limiting or disabling condition and generally use more health care. As a result, older individuals typically pay more than younger people for health insurance: 55- to 64-year-olds pay the highest insurance premiums of any non-elderly age group. They are also more likely to be denied coverage entirely because of their greater need for health care services. (For a full discussion of these issues, see Amanda McCloskey and Rachel Klein, *Too Few Options: The Insurance Status of Widowed or Divorced Older Women*, prepared by Families USA for The W.K. Kellogg Foundation, Battle Creek, MI, March 2001).

Sources of Health Insurance Plan Information

To identify available health insurance plans, we used eHealthInsurance.com when available (43 states plus the District of Columbia). All annual premium rates, deductibles, copayments, coninsurance, covered benefits, and other terms of coverage were based on the plans listed as available for each state on eHealthInsurance.com between June 1 and June 30, 2004.

For these 43 states and the District of Columbia, the individual carriers were not contacted to determine if other plans or terms than those listed on the Web site were available.

For Hawaii, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, and West Virginia, plans were not available from eHealthInsurance.com. Therefore, we contacted health insurance companies directly between June 1 and June 30, 2004.

Selection of Benchmark Plan

To select benchmark plans, we used a set of criteria that would provide consumers with adequate coverage at decent cost-sharing rates. We used the Blue Cross/Blue Shield Standard Preferred Provider Organization (BC/BS PPO) plan offered under the 2003 Federal Employees Health Benefits Program (FEHBP) as a model for what a standard plan should be. This plan was the most popular of the plans offered to federal employees and annuitants in 2003. It is one of three benchmark plans in the State Children's Health Insurance Program (SCHIP). Blue Cross/Blue Shield also offered a "High Option" Preferred Provider Organization plan in FEHBP; for this study, we deliberately avoided using this plan or any other that might be construed as providing a level of coverage beyond the public's perception of a basic, decent health insurance plan. Our benchmark plan does not have to match every benefit of the BCBS plan, only some of the most vital benefits. Notably, the study allowed standard plans to have coinsurance rates that were twice as high as those of the FEHBP plan.

The 2003 FEHBP BC/BS PPO is comparable to the health insurance coverage provided by the majority of mid- to large-sized employers in this country (based on a comparison of prescription drug coverage, out-of-pocket annual limits, deductibles, copayments for doctors' visits, and coinsurance rates for other services).[1]

Selection of $1,000 Annual Premium Health Insurance Plans

We selected the best plan available for the primary zip code with a premium no higher than $90 a month or $1,080 a year. To determine the best plan among those available at this price, we applied the following criteria, in descending order of importance:

- lowest deductible;
- best coinsurance rate for inpatient and outpatient services (with no more than 20 percent paid by the insured individual); and
- coverage of doctors' office visits.

To evaluate the coverage and cost-sharing terms of the $1,000 plans and determine when they were deficient, the study used the benchmark plan described above as the basis for comparison. We determined the terms of coverage of a

given health service in a $1,000 plan to be deficient or substandard if the number of times the insured person could use the service was more limited than the benchmark plan, if the cap on total spending by the plan for the service was lower than in the benchmark plan, or if the out-of-pocket costs associated with using the service were higher for the insured person than in the benchmark plan. Because there is great variation in the terms of coverage of plans, the evaluation of coverage of different services was done on a case-by-case basis within a set of basic rules. Inquiries about specific scoring may be directed to the authors at Families USA.

Selection of Standard Health Insurance Plans

To determine the price of a standard health insurance plan—a plan with a standard package of covered health care services with reasonable deductibles, copayments, and coinsurance, we again used the benchmark plan described earlier.

To determine if a plan was comparable to the benchmark plan and could be identified as a standard health insurance plan, we first required that the plan have a deductible of no more than $250. We required a $250 deductible because it is the deductible in the 2003 FEHBP BC/BS PPO and because a literature review of the research on cost-sharing indicated that a deductible that was any larger would be prohibitive to the tax credit's target low-income population.

Second, standard plans had to have a coinsurance rate for inpatient and outpatient services no higher than 20 percent (by contrast, the FEHBP plan has a lower coinsurance rate of 10 percent).

If a plan met these first two criteria, the plan was then required to meet at least one of the following three criteria:

- copayment for doctors' office visits of $15 or less;
- prescription drug coverage with no more than a 25 percent coinsurance rate or a flat charge of no more than $10 for generic and $20 for brand-name drugs (using a preferred pharmacy, if necessary); or
- annual out-of-pocket limit of $4,000 or less.

We did not require a plan to provide coverage of obstetrical-gynecological exams or services or of maternity, dental, or mental health services. Plans that offered limited short-term coverage were not considered. The study selected the cheapest plan that met the above criteria. Plans were selected from those available between June 1, 2004 and June 30, 2004.

[1] Gary Claxton, Isadora Gil, Ben Finder, Erin Holve, Jon Gabel, Jeremy Pickreign, Heidi Whitmore, Samantha Hawkins, and Cheryl Fahlman, *Employer Health Benefits: 2004 Annual Survey* (Menlo Park, CA: Kaiser Family Foundation and the Health Research and Educational Trust, September 2004).

CREDITS

This report was written by:

Daniel Tyre-Karp, Research Associate

Families USA

Kathleen Stoll, Director of Health Policy

Families USA

The following Families USA staff contributed to the preparation of this report:

Ron Pollack, Executive Director

Peggy Denker, Director of Publications

Ingrid VanTuinen, Writer-Editor

Nancy Magill, Design and Production Coordinator