A 10-Foot Rope for a 40-Foot Hole

Tax Credits for the Uninsured

2002 Update

A REPORT BY

Families USA

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A 10-Foot Rope for a 40-Foot Hole:
Tax Credits for the Uninsured – 2002 Update

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INTRODUCTION

In response to mounting concern about the number of Americans without health insurance, several policymakers have proposed the enactment of tax credits to help the uninsured purchase coverage. These proposals generally allow a credit against federal income tax liability 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 in 2001 about insurance plans offered in 25 states and the District of Columbia. This 2002 update is based on data gathered for 50 states and the District of Columbia.

The study used two hypothetical applicants—a 55-year-old woman and a 25-year-old woman. Both 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 two 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 based on the most popular plan offered under the 2001 Federal Employees Health Benefits Program (2001 FEHBP). A standard plan is comparable to the health insurance coverage provided by the majority of mid- to large-size 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]

The data gathered by 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 standard coverage in the individual market similar to that provided by many employers?

Our analysis found that, in many cases, $1,000 plans were simply not available. When they were available, the $1,000 plans generally provided incomplete coverage, had high deductibles, and required high coinsurance or copayments. Standard plans, by contrast, were more widely available, but they were also considerably more expensive than the amount of the proposed tax credit and would consume a significant portion of annual income for the low-income people eligible for the tax credit.

These findings apply to plans available to the healthiest applicants. Applicants who have health conditions would be even less likely to find any plan available. Moreover, plans offered to such applicants would restrict coverage for services related to their health conditions and/or charge significantly higher premiums.

Definition of a Standard Plan

For this study, a "standard" health insurance plan was defined as a plan that is comparable to the 2001 Federal Employees Health Benefits Program Blue Cross/Blue Shield Standard Preferred Provider Organization plan (2001 FEHBP BC/BS PPO). To be designated standard, a plan could not have a deductible higher than the $250 deductible in the 2001 FEHBP BC/BS PPO. In addition, the plan had to be equivalent to the FEHBP plan in at least two of the following four measures:

1) copayments for doctors' office visits of $15 or less;
2) coinsurance for inpatient and outpatient services no higher than 20 percent (by contrast, the FEHBP plan has a lower coinsurance rate of 10 percent);
3) 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
4) an annual out-of-pocket limit of $3,000 or less.

(For more information, see 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 three states had plans available for a healthy, non-smoking, 55-year-old woman. Those states were Connecticut, Maryland, and Ohio. (See Table 1.)
- **When available, $1,000 plans for healthy, non-smoking 55-year-olds are substandard.** In the three states that had $1,000 plans available for a healthy, non-smoking, 55-year-old woman, the coverage offered was substandard.
  - *The deductibles were very high.* In all three states, the annual deductible was $5,000. (See Table 1.)
  - *Other out-of-pocket costs were very high.* For example, in all three states, the coinsurance rate was higher than the 10 percent coinsurance in the 2001 FEHBP BC/BS PPO plan, and the annual limit on out-of-pocket spending was higher than $3,000 ($7,000 in Connecticut and Ohio; $6,000 in Maryland). (See Table 3.)
  - *The coverage offered by these plans was very limited (see Table 3):*
    - ≠ Doctor's office visits: Not covered in two states; deficient* in one (20 percent coinsurance after the high plan deductible).
    - ≠ Annual health exam: Not covered in one; deficient in one (20 percent coinsurance after the high plan deductible).
    - ≠ Prescription drugs: Not covered in two states; deficient in one ($500 annual limit).
    - ≠ Emergency services: Not covered in one state; deficient in two.
    - ≠ Inpatient hospital services: Deficient in all three states (20 percent coinsurance after the high plan deductibles).
    - ≠ Mental health care: Not covered in one state; deficient in two.
    - ≠ Lifetime limit on benefits: Deficient in all three plans ($1,000,000 in one plan; $3,000,000 in two plans).

* Coverage is "deficient" if it is less extensive than the coverage in the 2001 FEHBP PPO (see page 31).

- **$1,000 plans are not always available for healthy, non-smoking, 25-year-old women.** In 19 states, no plans were available for a healthy, non-smoking, 25-year-old woman. Those states were Alabama, Hawaii, Idaho, Kansas, Louisiana, Maine, Massachusetts, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Rhode Island, South Dakota, Vermont, West Virginia, Wisconsin, and Wyoming. (See Table 1.)
- **When available, $1,000 plans for healthy, non-smoking 25-year-olds are substandard.** Although $1,000 plans were available for a healthy, non-smoking, 25-year-old woman in 31 states plus the District of Columbia, the coverage offered by those plans was substandard in every case.
  - *The deductibles charged for these plans were high.* Only one state had a $1,000 plan with an annual deductible as low as $250. In 15 of the other 31 states, the deductibles were at least $750: The deductible was $750 in one state, $1,000 in seven states, $2,500 in three states plus the District of Columbia, and $5,000 in three states. (See Table 1.)
  - *Other out-of-pocket costs were very high.* For example, the coinsurance rate was higher than the 10 percent coinsurance in the 2001 FEHBP BC/BS PPO plan in the District of Columbia and in 30 of the 31 states. The annual out-of-pocket limit was higher than $3,000 in nine of the states; in six of those nine states, the limit was $5,000 or higher. (See Table 4.)
  - *The coverage offered by these plans was very limited (see Table 4):*
    - ≠ Doctor's office visits: Not covered in 18 states; deficient in 10 states plus the District of Columbia.
    - ≠ Prescription drugs: Not covered in 19 states; deficient in 11 states plus the District of Columbia.
    - ≠ Emergency services: Not covered in two states; deficient in the remaining 29 states plus the District of Columbia.
    - ≠ Inpatient hospital services: Deficient in 30 states plus the District of Columbia.
    - ≠ Maternity care: Not covered in 28 states plus the District of Columbia; deficient in three states.
    - ≠ Mental health care: Not covered in 22 states; deficient in the remaining nine states plus the District of Columbia.

Standard Health Insurance Plans Are Very Costly

- **Standard health insurance plans are not always available for healthy, non-smoking, 55-year-old women.** In 11 states (Hawaii, Idaho, Kansas, Kentucky, Maine, New Hampshire, North Dakota, Utah, Vermont, Washington, and West Virginia), there was no standard plan available at any price for a healthy, non-smoking, 55-year-old woman. (See Table 2.)
- **When available, standard plans for healthy, non-smoking 55-year-olds have premiums that are significantly higher than $1,000.**
  - The average annual premium for a healthy, non-smoking, 55-year-old woman was $4,934. (See Table 2.)
  - In 18 of the states, premiums for a healthy, non-smoking, 55-year-old woman were higher than $5,000. The highest premiums were $7,620 in Colorado, $7,399 in Nevada, and $7,392 in Louisiana.
- **Standard health insurance plans are not always available for healthy, non-smoking, 25-year-old women.** In 11 states (Hawaii, Idaho, Kansas, Kentucky, Maine, New Hampshire, North Dakota, Utah, Vermont, Washington, and West Virginia), there was no standard policy available for a healthy, non-smoking, 25-year-old woman. (See Table 2.)
- **When available, standard plans for healthy, non-smoking 25-year-olds have premiums that are significantly higher than $1,000.**
  - The average premium for a healthy, non-smoking, 25-year-old woman was $2,459. (See Table 2.)
  - In 11 states, the premiums for a healthy, non-smoking, 25-year-old woman were above $3,000. The highest premiums were $5,593 in New Jersey and $5,532 in Michigan.

Table 1

Deductibles for $1,000 Plans*

State	Deductible for healthy, non-smoking:		State	Deductible for healthy, non-smoking:	
	55-year-old	25-year-old		55-year-old	25-year-old
Alabama	X	X	Montana	X	X
Alaska	X	$2,500	Nebraska	X	$500
Arizona	X	$1,000	Nevada	X	X
Arkansas	X	$500	New Hampshire	X	X
California	X	$500	New Jersey	X	X
Colorado	X	$1,000	New Mexico	X	$5,000
Connecticut	$5,000	$500	New York	X	X
Delaware	X	$500	North Carolina	X	$1,000
D. C.	X	$2,500	North Dakota	X	X
Florida	X	$5,000	Ohio	5,000	$500
Georgia	X	$500	Oklahoma	X	$1,000
Hawaii	X	X	Oregon	X	$2,500
Idaho	X	X	Pennsylvania	X	$500
Illinois	X	$2,500	Rhode Island	X	X
Indiana	X	$500	South Carolina	X	$250
Iowa	X	$500	South Dakota	X	X
Kansas	X	X	Tennessee	X	$500
Kentucky	X	$1,000	Texas	X	$5,000
Louisiana	X	X	Utah	X	$750
Maine	X	X	Vermont	X	X
Maryland	$5,000	$500	Virginia	X	$500
Massachusetts	X	X	Washington	X	$500
Michigan	X	$500	West Virginia	X	X
Minnesota	X	$1,000	Wisconsin	X	X
Mississippi	X	$1,000	Wyoming	X	X
Missouri	X	$500			

X = No $1,000 plan available.

* See appended Methodology for explanation of the selection of $1,000 plans.

Table 2

Premiums for Standard Plans*

State	Premium for healthy, non-smoking:	
	55-year-old	25-year-old
Alabama	$7,032	$3,144
Alaska	$7,368	$2,580
Arizona	$3,444	$2,700
Arkansas	$4,680	$2,088
California	$4,296	$1,541
Colorado	$7,620	$3,408
Connecticut	$5,280	$2,352
Delaware	$5,304	$2,664
D.C.	$4,260	$1,608
Florida	$2,736	$2,112
Georgia	$2,424	$1,104
Hawaii	X	X
Idaho	X	X
Illinois	$5,088	$2,196
Indiana	$3,828	$1,656
Iowa	$4,152	$2,088
Kansas	X	X
Kentucky	X	X
Louisiana	$7,392	$3,300
Maine	X	X
Maryland	$3,101	$1,591
Massachusetts	$6,836	$3,529
Michigan	$6,060	$5,532
Minnesota	$4,366	$1,595
Mississippi	$7,104	$3,168
Missouri	$4,207	$2,428
Montana	$6,120	$2,412
Nebraska	$4,212	$1,896
Nevada	$7,399	$3,727
New Hampshire	X	X
New Jersey	$5,593	$5,593
New Mexico	$4,248	$1,932
New York	$3,078	$3,078
North Carolina	$3,192	$1,428
North Dakota	X	X
Ohio	$3,116	$1,662
Oklahoma	$5,784	$2,592
Oregon	$2,964	$1,356
Pennsylvania	$5,520	$2,472
Rhode Island	$6,264	$3,156
South Carolina	$3,109	$1,352
South Dakota	$4,548	$2,040
Tennessee	$4,740	$2,112
Texas	$6,768	$3,408
Utah	X	X
Vermont	X	X
Virginia	$3,468	$1,500
Washington	X	X
West Virginia	X	X
Wisconsin	$5,796	$2,100
Wyoming	$4,848	$2,172.00
Average Premium	**$4,934**	**$2,459**

X = No Standard plan available.

* See appended Methodology for explanation of the selection of Standard plans.

Table 3

$1,000 Plans for 55-Year-Old, Healthy, Non-Smoking Women, Compared to 2001 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

	Deductible	Doctor's Office Visits	Coinsurance	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Outpatient Hospital Services	Emergency Services	Annual Health Exam	Dental	Mental Health	Maternity	Ob-Gyn Exam
FEHBP Plan	$250	$15 [1]	10% [2]	$3,000	None	25% [3]	$100/ 10% [2]	10%	Covered [4]	$15 [5]	Accident only [6]	$15/ $100/ 10% [7]	Covered [8]	10% [9]
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	$5,000													
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	$5,000													
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

(See Notes to Tables 3 and 4 on page 12)

Table 3 cont'd

$1,000 Plans for 55-Year-Old, Healthy, Non-Smoking Women, Compared to 2001 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

	Deductible	Doctor's Office Visits	Coinsurance	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Outpatient Hospital Services	Emergency Services	Annual Health Exam	Dental	Mental Health	Maternity	Ob-Gyn Exam
FEHBP Plan	$250	$15 [1]	10% [2]	$3,000	None	25% [3]	$100/ 10% [2]	10%	Covered [4]	$15 [5]	Accident only [6]	$15/ $100/ 10% [7]	Covered [8]	10% [9]
State														
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	$5,000													
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

(See Notes to Tables 3 and 4 on page 12)

Table 4

$1,000 Plans for 25-Year-Old, Healthy, Non-Smoking Women, Compared to 2001 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

	Deductible	Doctor's Office Visits	Coinsurance	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Outpatient Hospital Services	Emergency Services	Annual Health Exam	Dental	Mental Health	Maternity	Ob-Gyn Exam
FEHBP Plan	$250	$15 [1]	10% [2]	$3,000	None	25% [3]	$100/ 10% [2]	10%	Covered [4]	$15 [5]	Accident only [6]	$15/ $100/ 10% [7]	Covered [8]	10% [9]
State														
Alabama	No plan available													
Alaska	$2,500													
Arizona	$1,000													
Arkansas	$500													
California	$500													
Colorado	$1,000													
Connecticut	$500													
Delaware	$500													
D. C.	$2,500													
Florida	$5,000													
Georgia	$500													
Hawaii	No plan available													
Idaho	No plan available													
Illinois	$2,500													
Indiana	$500													
Iowa	$500													
Kansas	No plan available													
Kentucky	$1,000													
Louisiana	No plan available													
Maine	No plan available													
Maryland	$500													
Massachusetts	No plan available													
Michigan	$500													
Minnesota	$1,000													
Mississippi	$1,000													
Missouri	$500													

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

(See Notes to Tables 3 and 4 on page 12)

Table 4 cont'd

$1,000 Plans for 25-Year-Old, Healthy, Non-Smoking Women, Compared to 2001 FEHBP Blue Cross/Blue Shield Preferred Provider Organization (PPO)

	Deductible	Doctor's Office Visits	Coinsurance	Out-of-Pocket Limit	Lifetime Limit on Benefits	Rx Drugs	Inpatient Hospital Services	Outpatient Hospital Services	Emergency Services	Annual Health Exam	Dental	Mental Health	Maternity	Ob-Gyn Exam
FEHBP Plan	$250	$15 [1]	10% [2]	$3,000	None	25% [3]	$100/ 10% [2]	10%	Covered [4]	$15 [5]	Accident only [6]	$15/ $100/ 10% [7]	Covered [8]	10% [9]
State														
Montana	No plan available													
Nebraska	$500													
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	$1,000													
North Dakota	No plan available													
Ohio	$500													
Oklahoma	$1,000													
Oregon	$2,500													
Pennsylvania	$500													
Rhode Island	No plan available													
South Carolina	$250													
South Dakota	No plan available													
Tennessee	$500													
Texas	$5,000													
Utah	$750													
Vermont	No plan available													
Virginia	$500													
Washington	$500													
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

(See Notes to Tables 3 and 4 on page 12)

Notes to Tables 3 and 4

[1] *Office visit to a preferred provider:* The insured person pays $15 for each visit (the deductible is waived, and there are no limits on the number of visits). *Office visit to a non-preferred provider:* The plan pays 75 percent of the plan allowance for visits, and the insured may have to pay the difference between the physician's charge and the plan allowance.

[2] The coinsurance rate for inpatient and outpatient hospital services is generally 10 percent from the insured/90 percent from the plan for services from a preferred provider hospital. (*Preferred provider hospital:* Insured pays $100 for unlimited days of room, board, and general nursing care and pays 10 percent for other services—including inpatient surgical services, inpatient physician and pharmacotherapy services, other inpatient services, and outpatient consultations. *Non-preferred provider hospital:* Insured pays 25-30 percent of the plan allowance plus the difference between the actual charge and the plan allowance.)

[3] If prescription drugs are purchased through a mail pharmacy service, the insured pays $12 for generic and $20 for brand name 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).

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

[5] *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.

[6] *Dental care from a preferred provider*: For any accidental injury, the insured pays 10 percent. For other care, the insured pays a defined contribution (for example, any cost over $8-$14 for office visits).

[7] *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 10 percent for other services.

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

[9] *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 10 percent for other services.

METHODOLOGY

For this study, Families USA identified the health insurance plans available in the individual market for healthy, non-smoking, 55-year-old women and for 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 45 states and the District of Columbia. For three states where information was not available through eHealthInsurance.com, the study used QuoteSmith.com (Kansas, Massachusetts, and West Virginia). In Hawaii and Vermont, Families USA contacted health insurance companies offering individual market coverage directly.

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 "standard" plans as plans *comparable* to the Blue Cross/Blue Shield Standard Preferred Provider Organization (BC/BS PPO) plan offered by the 2001 Federal Employees Health Benefits Program (2001 FEHBP). Plans were deemed "comparable" if they had a $250 deductible and provided coverage equivalent to the 2001 FEHBP BC/BS PPO plan for at least two of four critical health services. (See 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.

Premium quotes were for individuals living in the primary zip code of the largest city in each state. Therefore, the data do not reflect urban/rural differences or other geographic variations in affordability and availability within states. Finally, insurance companies may also increase premiums above the quoted prices based on an individual's employment status and type of work, educational attainment, and many other factors.

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 incomes under $15,000 annually 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 maximum total of $3,000). The tax credit would phase out for individuals with incomes of $30,000 and for families with incomes of $60,000. Although details vary, a number of similar bills have been introduced in Congress.

Because almost all of the children in families with incomes below 200 percent of the federal poverty level ($30,040 for a family of three) are eligible for health insurance coverage through the State Children's Health Insurance Program (SCHIP), the real targets of the proposed tax credit are uninsured, low-income adults, both parents and non-parents.

The current tax credit proposals have been modified in response to criticisms of earlier versions. Recognizing that most low-income people owe little or no federal income tax, the tax credits have been made "refundable." Low-income people who could not otherwise benefit from a tax credit because they have no tax liability 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 tax credit in the current proposals is "forward funded," that is, a refund is available to pay for insurance at the beginning of the tax year.

Despite these improvements, uninsured, low-income people who wish to take advantage of the tax credit will have to choose between two unsatisfactory options. They can try to scrape together enough money to purchase a standard plan, thus minimizing the risk of incurring high deductibles and copayments if they get sick. Or they can 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 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 2001 FEHBP Blue Cross/Blue Shield Standard Preferred Provider Organization plan is $4,934 for a healthy 55-year-old woman and $2,459 for a healthy 25-year-old woman. Table 2 lists the premiums for 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 beyond the economic reach of low-income people. Based on the average premium cost, and taking the $1,000 tax credit into account, a healthy 55-year-old woman living at the federal poverty level ($8,860 annual income) would have to spend nearly half (47 percent) of her annual 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—19 percent of her income before she would gain any health insurance benefit. In addition, if either woman then used any health services, she would have to pay *additional* charges out of pocket.

Research has shown that, for low-income people, the decision to enroll in health care programs or to take up insurance is very sensitive to premium costs. Low-income people have very little disposable income available to spend on health care after paying for housing, utilities, food, and other necessities. 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 state records from the California SCHIP program (the Healthy Families Program) 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.[2] North Carolina reports that failure to pay the $50 annual enrollment fee is the leading cause of SCHIP denials, even though only 30 percent of families are subject to the fee.[3] 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.[4]

Other research illustrates the strong inverse relationship between premium levels and participation in public programs.[5] 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*.[6]

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.[7] Another Lewin Group study, using 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.[8]

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

In 47 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 19 states, a healthy, non-smoking, 25-year-old woman could not buy a $1,000 plan. 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 and 4 compare the coverage of the $1,000 plans to a standard plan's coverage.

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 was the RAND Health Insurance Experiment (HIE).[9] 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, 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.[10] Further, adults with any copayments were less likely to purchase prescription drugs.[11]

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.[12] 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.[13]

Another study looking 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.[14] A $1.50 prescription drug copayment resulted in an 11 percent decline in use of prescription drugs.[15]

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.

What about People Who Are Not Healthy?

These unpalatable options, "pay now or pay later," confront low-income people who are healthy and who are not smokers. In a sense, they are "best case" scenarios. Low-income people who have health problems or risk factors may find that insurers refuse to provide coverage altogether or, if they are willing to provide coverage, may charge significantly higher premiums and/or restrict coverage for the very conditions most likely to require treatment.

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.[16] *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 degenerate 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.

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 the circulatory system.

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.[17] 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.

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

What happens to people who are young and healthy and find an acceptable coverage 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 only evaluate medical history when a person first applies for coverage. More and more companies today want to re-evaluate 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. In fact, the American Academy of Actuaries plans to call on states to allow health insurance companies more flexibility to treat health insurance like automobile or home owner's insurance—with premium increases based on an individual's experience and use of the coverage.[18]

The eHealthInsurance Analysis of the Individual Market: Only Telling Part of the Story

In June 2001, the online company eHealthInsurance issued an analysis of proposals to provide a federal income tax credit for the purchase of health insurance. This analysis and subsequent testimony on the issue by Vip Patel, the chairman of eHealthInsurance, have received wide attention. The analysis concluded, "… modest health insurance tax credits for individuals and families may significantly reduce the number of uninsured." But is this conclusion justified by the facts presented in their analysis?

☑ eHealthInsurance Data Ignore Those Who Do Not or Cannot Purchase Coverage

The eHealthInsurance analysis was based on a sample of 20,000 *sold* policies. It is important to note that these policies were purchased without the inducement of a federal income tax credit. The findings of the analysis, therefore, may tell us something about people who were willing and able to purchase individual health insurance plans, but the data provide no basis for drawing conclusions about the needs or the preferences of the uninsured. As a result, this analysis completely misses the point: Will a modest tax credit enable low-income uninsured people to purchase individual health insurance? We know no more about this question now than we knew before eHealthInsurance released its analysis.

How many of the 20,000 purchasers have modest incomes? The eHealthInsurance analysis cannot tell us. How many people applied for coverage and were turned down by insurers for health reasons? Again, we do not know.

By looking only at policies sold, the analysis selectively captured the experience of the people who got the best deals in the individual market and decided to purchase coverage. It did not take into account the people who applied but declined to purchase a policy because the cost was prohibitive and/or the coverage was inadequate.

☑ The Majority of Policies Sold Cost Significantly More than the Tax Credit's Value

In the original June 21, 2001 analysis, eHealthInsurance found that *only half* of the individual and family policies actually sold had premiums within the proposed tax credit amounts ($1,000 for an individual and $2,500 for a family). In February 2002 testimony before the U.S. House Ways and Means Committee, Vip Patel presented data collected in January 2002. This new sample comprised 20,000 policies sold to individuals, not families. The average annual cost of these policies was $1,900. However, the average annual price for purchasers over the age of 35 was significantly higher ($2,178 for purchasers from 35 to 44 and $3,144 for purchasers from 45 to 64).

☑ eHealthInsurance Fails to Report Details on the Policies

Both the original analysis and the more recent testimony fail to tell the rest of the story: What benefits were covered or excluded, what was the size of the deductible, and what were the copayments and coinsurance levels in these plans? When Vip Patel testified before Congress in February, he stated that 56.5 percent of the policies sold to individuals had deductibles higher than $501 a year and 30.6 percent had deductibles higher than $1,000 a year. He did not, however, discuss the relationship between the size of the deductibles and the size of the premiums. Did plans with lower premiums have higher deductibles, more out-of-pocket costs (copayments and coinsurance), and less comprehensive coverage, as one would expect?

According to the analysis, most of the sold plans could be considered to be "comprehensive," that is, they "typically cover inpatient and outpatient hospital services as well as physician services, tests and laboratory services and in most cases pharmaceuticals." But no data are provided to support this claim. Do any of the plans limit physician services to two visits a year, or do they limit hospitalization to inpatient services and not cover any outpatient services? Does prescription drug coverage mean only a 15 percent discount card or require a $2,500 drug deductible? Families USA found these limits and others in its analysis of coverage offered through eHealthInsurance. Plans with such stringent limitations would not generally be viewed as comprehensive coverage. The authors acknowledge this limitation when they note that designating a plan as "comprehensive" does not imply the coverage is "complete" or "adequate." (A footnote in the study explains that the determination of comprehensiveness rested on assertions by insurers, representations by insurance agents, and eHealthInsurance's review of plan benefits.)

The Bottom Line

The eHealthInsurance analysis may tell us something about the preferences of people who are able to purchase private coverage in the individual market without a federal income tax credit, but it tells us nothing about the needs or preferences of uninsured people—particularly not about uninsured people with low incomes. Mr. Patel acknowledged this in his testimony, saying, "…I was surprised at the number of people below 100 percent of FPL [the federal poverty level], that aren't covered by Medicaid. Perhaps Medicaid ought to be available to all individuals under the FPL to guarantee health care coverage to the poorest of the poor."

Notes: "Analysis of National Sales Data of Individual and Family Health Insurance: Implications for Policymakers and the Effectiveness of Health Insurance Tax Credits," was widely distributed to Members of Congress and other policymakers but was never formally published. The name of the Chairman of eHealthInsurance, Vip Patel, appears on the cover, but no authors are identified, and the analysis did not state the time period during which the sample of 20,000 policies were sold. The analysis can be located at ehealthinsurance.com (by following these menu options, "About Us," then option, "Expert Center on the Uninsured," and then "Publications").

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.

Will the Tax Credit Help Uninsured Low-Income People Take Up Job-Based Group Health Insurance?

S. 590, the "Relief, Equity, Access, and Coverage for Health (REACH) Act," includes a provision to provide a federal tax credit of $400 for individuals and $1,000 for families to pay the premiums of health insurance provided through an employer. However, the potential of a tax credit to help currently uninsured people buy job-based group health insurance is very small.

Less than 30 percent of all uninsured workers have access to job-based coverage; only 55 percent of low-wage workers ($7.00 per hour or below) are offered health insurance benefits (compared to 95 percent of workers earning above $15 an hour). Without job-based coverage, workers are forced to buy health insurance in the non-group private health insurance market examined in this study.

Even for this small portion of currently uninsured people, the tax credit is not helpful. Three-fourths of the low-income uninsured workers who declined job-based coverage cited cost as the main reason. Low-wage workers and workers in small firms often pay a greater portion of the cost of job-based coverage—50 percent of the total cost is not unusual.[19] The average annual job-based health insurance premium for all workers in 2002 was $2,650 for individual coverage and $7,053 for family coverage. A tax credit of $400 or $1,000 would still leave a significant gap in meeting the premium cost. And the worker would still need to pay out of pocket to meet the deductible and any copayments and coinsurance charges.

Sources: Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs* 16 no. 6 (November/December 1997); Peter J. Cunningham, Elizabeth Schaefer, and Christopher Hogan, *Who Declines Employer-Sponsored Health Insurance and Is Uninsured?*, Issue Brief Number 22 (Washington: Center for Studying Health System Change, October 1999); Larry Levitt, Erin Holve, and Jain Wang, *Employer Health Benefits: 2001 Annual Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, September 2001), pp. 83-128.

ENDNOTES

[1] Larry Levitt, Erin Holve, and Jain Wang, *Employer Health Benefits: 2001 Annual Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, September 2001), pp. 83-128.

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

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[16] 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).

[17] 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.

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APPENDIX:

METHODOLOGY

APPENDIX: 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) from 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 poverty, the problem of the low-income uninsured is becoming a problem of 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 looked at health insurance coverage available in each of the 50 states and the District of Columbia for healthy, non-smoking 55-year-old and 25-year-old women. The study chose these two age 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 26 percent. The uninsurance rate for ages 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 persons 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 (45 states plus the District of Columbia) and QuoteSmith.com for three states (Kansas, Massachusetts, and West Virginia). 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 and QuoteSmith.com between April 2 and April 16, 2002. For these 48 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 Vermont and Hawaii, health insurance companies were contacted directly. In Vermont, the insurance companies were identified through the Vermont Division of Health Care Administration on the state Web site, "Guides to Shopping for Health Insurance in Vermont." The Web site (www.bishca.state.vt.us/consumpubs/hcatips&pubs/Shop_Indiv&SmallGroup/shop_ind&small_index.htm) was visited on April 11, 2002. The carriers were also contacted on April 11, 2002. In Hawaii, the Department of Insurance identified the two carriers providing health insurance in the individual market, and the carriers were contacted on April 15, 2002.

Selection of Benchmark Plan

We selected the Blue Cross/Blue Shield Standard Preferred Provider Organization (BC/BS PPO) offered under the 2001 Federal Employees Health Benefits Program (FEHBP) as the study's benchmark plan. This plan was the most popular of the plans offered to federal employees and annuitants in 2001. 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. The 2001 FEHBP BC/BS PPO is comparable to the health insurance coverage provided by the majority of mid- to large-size 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.

If only one plan was available that met the premium criteria, we selected it regardless of the deductible or other cost-sharing requirements or the scope of covered health benefits.

To evaluate the coverage and cost-sharing terms of the $1,000 plans and determine when they were deficient, the study used the 2001 FEHBP BC/BS PPO 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 2001 FEHBP BC/BS PPO plan, if the cap on total spending by the plan for the service was lower than in the 2001 FEHBP BC/BS PPO plan, or if the out-of-pocket costs associated with using the service were higher for the insured person than in the 2001 FEHBP BC/BS PPO 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 an adequate standard package of covered health care services with reasonable deductibles, copayments, and coinsurance—we again used the 2001 FEHBP BC/BS PPO.

To determine if a plan was comparable to the 2001 FEHBP BC/BS PPO and could be identified as a "standard" health insurance plan, we first required that the plan have a deductible no larger than $250. We required a $250 deductible because it is the deductible in the 2001 FEHBP BC/BS PPO and also because a literature review of the research on cost-sharing indicated that any larger deductible would be prohibitive to the tax credit's target low-income population.

If a plan met the $250 deductible criterion, the plan was then required to meet two of the following four criteria:

- $15 or less copayment for doctor's office visits;
- no more than 20 percent coinsurance for inpatient and outpatient services (the benchmark plan has a lower, 10 percent coinsurance rate);
- 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 $3,000 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 April 2, 2002 and April 16, 2002.

[1] Larry Levitt, Erin Holve, and Jain Wang, *Employer Health Benefits: 2000 Annual Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, September 2000).

The 2001 Federal Employees Health Benefits Program Blue Cross/Blue Shield Standard Preferred Provider Organization Plan

The study used the 2001 FEHBP BC/BS PPO to evaluate the coverage in $1,000 plans. The study also used the 2001 FEHBP BC/BS PPO to define a standard health insurance plan for determining the premium charged for reasonable coverage in the private, non-group market. A standard plan is defined as comparable, but not identical, to the 2001 FEHBP BC/BS PPO, using criteria derived from the 2001 FEHBP BC/BS PPO.

Deductible: $250

Office Visits: Preferred Provider: $15 for each visit (deductible waived and no limits on number of visits); Non-Preferred Provider: plan pays 75 percent of plan allowance for visits and insured may have to pay difference between physician's charge and plan allowance

Annual Exams: Preferred Provider: $15 once every three years, preventive screening and diagnostic tests covered in full

Ob-Gyn Care: Preferred Provider: $15 per office visit (no limits on visits and deductible waived) with pap smears and mammograms covered in full; other services, insured pays 10 percent

Maternity Care: Preferred Provider: no charge to the insured

Prescriptions: If purchased through mail pharmacy service: insured pays $12 for generic and $20 for brand name 90-day drug supply. If purchased at a retail pharmacy: insured pays 25 percent of cost of prescription (no limits on number of prescriptions)

Emergency Room Care: Preferred Provider: no charge to the insured (insured pays 10 percent of the cost of the ambulance)

Dental Care: Preferred Provider: accidental injury, insured pays 10 percent; other care at defined contributions (for example, office visits, insured pays any cost over $8-$14)

Mental Health Care: Preferred Provider: $15 copayment for each office visit (deductible waived and no limits on number of visits); $100 deductible applied for inpatient hospital services; insured pays 10 percent for other services

Coinsurance Rate for Inpatient and Outpatient Hospital Services: Basically 10 percent insured/90 percent plan (Preferred Provider Hospital: insured pays $100 for unlimited days of room, board and general nursing care and pays 10 percent for other services—including inpatient surgical services, inpatient physician and pharmacotherapy services, other inpatient services, and outpatient consultations. Non-Preferred Provider Hospital: insured pays 25-30 percent of the plan allowance plus the difference between the actual charge and the plan allowance.)

Annual Out-of-Pocket Limit: $3,000

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