

Medicare for All and Beyond

CONFERENCE BRIEF SERIES

SETTING STANDARDS FOR AFFORDABLE HEALTH CARE

A review of concepts to guide policymakers

EDITOR'S NOTE

Before the COVID-19 pandemic, anxiety and insecurity about health care costs were driving demands for health care reform and making it a top election issue. In February 2020, Penn's Leonard Davis Institute of Health Economics (LDI) held a [conference](#), *Medicare for All and Beyond: Expanding Coverage, Containing Costs*, which included a panel discussion on affordability.¹ COVID-19 and its aftermath have added new urgency to the need to make health care affordable, and reduce barriers to needed testing and treatment, such as out-of-network bills and out-of-pocket costs. In this critical time, making care affordable for all becomes a public health imperative.

INTRODUCTION

In the run-up to the presidential election, the affordability of health care remains a top concern of the American voting public. But how do we know when health care is affordable? On a policy level, how do we set a standard for affordability that can be implemented in a reformed system? Sometimes policy debates about affordability focus only on whether insurance premiums are affordable, although consumers tend to be concerned about both premiums and out-of-

pocket costs. At Penn LDI's *Medicare for All and Beyond* [conference](#), a panel of researchers, policy experts, and consumer advocates discussed and debated affordability in theory and practice.¹ What emerged was a clearer understanding of the value judgments needed, friction points encountered, and principles that policymakers should apply to ensure that health coverage is affordable. This issue brief summarizes the panel's insights.

WHAT'S DRIVING PUBLIC CONCERN ABOUT AFFORDABILITY?

Although headlines often point to the unaffordability of medical bills, the average amount that families are paying [out of pocket](#) for health care, adjusted for inflation, has not changed dramatically in the last decade.² But that average obscures the great variability in costs—and the root of our affordability problem lies in these cost outliers. Affordability concerns relate to the potential to incur extreme costs when health care needs arise. Care becomes unaffordable when people face a \$40,000 bill for an out-of-network air ambulance, or when a low-income family must cover a \$6,000 deductible. These bills cause financial stress, and may overwhelm a household's ability to meet other basic needs. In these cases, insurance fails in one of its primary goals: financial risk protection.

However, affordability is not just a problem for people in poor health or those facing high medical bills; it affects a much larger group of people who hesitate to seek needed care because of out-of-pocket costs they might incur. The specter of surprise billing and the general lack of cost transparency creates a sense that out-of-pocket costs are not predictable. Survey data indicate widespread hesitation to seek care; about [half of U.S. adults](#) say they or a family member put off or skipped some sort of health care or dental care in the past year because of the cost.³ This suggests that by failing to protect people from exposure to high medical bills, our current health system of health coverage is also failing in another goal: to reduce financial barriers to needed care.

The pervasiveness of high-deductible plans, even in the employer-sponsored market, has contributed to these failures. While these plan designs reduce premiums, they do so by increasing out-of-pocket costs, which can expose people to greater financial risk when they need care. And while people in high-deductible plans reduce overall health care consumption, we have [good evidence](#) that they reduce their use of both cost-effective and cost-ineffective care.⁴

EXPERTS AND THE PUBLIC HAVE DIFFERENT OPINIONS ON WHAT'S AFFORDABLE

When trying to define affordability for health care, can we look to other sectors for guidance in how to build affordability into policy? National standards for affordability exist in two other facets of American life: a general federal poverty level (FPL) and a Housing and Urban Development (HUD) standard for affordable housing. The FPL is based on a bundle of foods that the average household needs to buy; a family is poor if its income is less than three times the cost of that food bundle. In terms of affordable housing, HUD says that families should not have to pay more than 30% of their income for subsidized housing. But defining a standard for health care affordability is much harder than food or housing, because levels of “need” for health care are so variable and open to interpretation, and because the nature of health care changes so rapidly over time.

The Affordable Care Act (ACA) set affordability standards for employer-sponsored insurance and plans purchased on the individual marketplace. At its onset, it defined employer-sponsored insurance as “affordable” if the employee contribution for individual coverage was no more than 9.5% of household income, and it limited out-of-pocket costs to roughly \$6,500 per individual and \$13,000 per family for covered services. Although these thresholds were necessary for program purposes, they do not measure the overall financial burden to households when combining premiums and out-of-pocket costs, nor do they consider whether these costs are affordable for families of different income levels.

Experts disagree when asked to judge whether health coverage is affordable in different situations. In one [study](#), 18 experts could not reach consensus on how to factor in deductibles, children, debt, savings, and many other considerations into what is deemed affordable.⁵ However, they agreed that lower income households could spend a smaller share of their income on health care and higher income households a larger share. The median affordability cutoff for insurance, in these experts' opinions, was slightly lower than ACA standards.

A different answer emerges when the public is asked about affordability. In a [study](#) of 6,000 random people, respondents felt that households could afford to spend about 5% of income on health insurance, regardless of income.⁶ They thought that young people could afford to spend more than older people, and people in debt could afford to spend less. Respondents also did not pay any attention to deductibles: there was no difference in the amount they thought people could afford to pay based on the plan with a more or less generous deductible. People in more conservative-leaning states gave the same answers as those in progressive-leaning states. Higher income people generally thought everyone could pay more for health care than lower income people did.

IN THE END, AFFORDABILITY IS A VALUE JUDGMENT

Although we often think of affordability as an economic or financial question, it is really a question of values. Any measure of affordability involves a value judgment, whether affordability is defined based on an arbitrary threshold or the relative value of spending on other important goods and services. For example, one economic perspective suggests that a household can “afford” to pay for health insurance if it would be left with enough income to meet its other socially-defined minimum needs. But defining “needs” entails a value judgment. A different approach to measuring affordability relies on what people already purchase: if most people at a certain income level buy insurance, they consider it affordable. Even this simple measure involves a value judgment about the percentage: if 51% of people purchase coverage (or 75% or even 95%), does it mean that coverage is affordable for everyone at that income level, regardless of other circumstances?

Value judgments bring up key considerations of equity. An important and early question to ask is “affordable to whom and for whom?” This starting point acknowledges that the existing system has longstanding [inequities](#) in access to care, particularly for racial and ethnic minorities.⁷ A significant point of friction in developing a standard is how to bring in the perspectives of people who have not been able to access care and achieve the health outcomes that they have wanted from the beginning.

TOWARD A STANDARD: What Connecticut is Doing

In the absence of a national standard for affordability, a number of states have begun to look at ways to develop one themselves. Connecticut’s ongoing initiative provides a good example. Through a consensus process, the state developed this [definition](#) of affordability:

“Health care is affordable in Connecticut if a family can reliably secure it to maintain good health and treat illnesses and injuries when they occur without sacrificing the ability to meet all other basic needs including housing, food, transportation, childcare, taxes and personal expenses, or without sinking into debilitating debt.”⁸

With foundation and state-level funding, a coalition of state officials and stakeholders set out to develop a standard for affordable health care, premised on an [updated self-sufficiency standard](#) for Connecticut.⁹ The self-sufficiency standard is based on detailed information on the resources needed to meet basic needs for more than 700 types of families in different locations across the state, making it much more finely-grained than the federal poverty level. This update demonstrated a great mismatch between the growth of the economy in Connecticut and where people reside. It highlighted geographic differences in retail and service industry employment, characterized by low-wage jobs, and growth of high-tech and biotech jobs with generally higher wages.

The coalition has updated and expanded the health care component of the self-sufficiency standard’s household budget. This work has involved integrating detailed data on race, ethnicity, income, premiums, and cost-sharing to provide a more accurate picture of household needs and expenses. As a next step, these data will be used to develop a modeling tool that can help policymakers and advocates estimate the effects of different policy options for different types of families in Connecticut. By implementing the affordability standard as a modeling tool, it will allow policymakers to consider differences by geography, race and ethnicity, and disease states. It acknowledges that what is affordable to someone with multiple chronic conditions is different from what is affordable to someone who is generally healthy at any given time.

TOWARD A STANDARD: Some Principles and Guideposts

Given the complexity and nuance of developing a health care affordability standard, how might policymakers begin to build affordability into health reform proposals? The panel provided some principles to apply, and guideposts to look for in current proposals:

- **Universal coverage.** Without insurance, nearly everyone is at risk for catastrophic and unaffordable health care, given the extremely high costs of that care. Thus, an affordable health care system presupposes that all residents have coverage.
- **Equitable costs and equitable subsidies.** A core principle (and goal) of an affordability standard is to ensure that similarly situated people are expected to pay costs that are similar. Our current system has built-in inequities in how coverage is subsidized. For example, in the employer-sponsored market, the regressive nature of the tax break means that the largest subsidies go to the wealthiest employees. On the individual marketplaces, subsidy “cliffs” mean that a few dollars of additional income can result in large differences in the amounts people are expected to pay. Affordability standards can begin to harmonize how we subsidize health coverage across the board.
- **Adequate access to care.** At its core, an affordability standard is a threshold for ascertaining whether people face financial barriers to needed care. Thus, a standard must take into account premiums and cost-sharing—for both covered services and cost-effective services that might be excluded from benefits, such as dental and vision care. It must consider the timing, structure, and level of cost-sharing to ensure that the cost of care—at the time of need—does not create a barrier to access.
- **Predictable and transparent cost-sharing.** Out-of-pocket payments are more affordable when they are clear, predictable, and spread out over time so that large spikes in spending do not overwhelm household budgets. Cost-sharing can be made more consumer-friendly, while still being used to lower premiums and incentivize use of cost-effective care. Consumers [prefer](#) flat-fee copayments rather than percentage coinsurance and set deductibles.¹⁰ Coinsurance can threaten affordability when the underlying price of a service skyrockets (as with prescription drugs). Deductibles can threaten affordability when they require people to pay thousands of dollars before coverage kicks in, which [most people](#) do not have at the point of care.¹¹ And by definition, surprise billing lacks transparency and predictability, leaving people unable to plan for these costs in their budgets.

MEETING AFFORDABILITY STANDARDS MEANS CONTROLLING COSTS

Affordability standards can help identify who falls above and below a threshold, but policy actions will be needed to achieve and maintain these standards. Controlling the underlying costs of care is inextricably linked to making sure that care is affordable; even with universal coverage and fairly designed subsidies and cost-sharing, ever-rising costs will erode wages and crowd out spending on other important goods and services. In a concluding exercise, the panelists suggested one policy or strategy that could improve the affordability of care by addressing these underlying costs. The wide range of their answers drives home the challenges of finding a solution to providing affordable care:

- Control excessive prices paid for drugs and hospital services. For drugs, consider pricing by cost-effectiveness or reference pricing; for hospitals, consider regulating prices in non-competitive local markets.
- Tie prices to quality. Expand value-based payment strategies that tie reimbursement levels to achieving outcomes and lessening disparities.
- Pass legislation to control prices or out-of-pocket costs for prescription drugs that are absolutely necessary, such as insulin.
- Eliminate the tax exclusion for employer-sponsored coverage, which is an inequitable way to provide subsidies and distorts both labor and health insurance markets.
- As part of the infrastructure needed for sustainable universal coverage, establish an all-payer claims database (including self-insured employers) that can help states understand their cost and utilization trends.

REFERENCES

1. Penn LDI. (2020). *Medicare for All and Beyond: Expanding Coverage, Containing Costs*. Philadelphia, PA: University of Pennsylvania. Retrieved from <https://ldi.upenn.edu/hcreform2020>
2. Glied, S.A. & Zhu, B. (2020). *Catastrophic Out-of-Pocket Health Care Costs: A Problem Mainly for Middle-Income Americans with Employer Coverage*. The Commonwealth Fund. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2020/apr/catastrophic-out-of-pocket-costs-problem-middle-income>
3. Kirzinger, A., Muñana, C., Wu, B., & Brodie, M. (2019). *Data Note: Americans' Challenges with Health Care Costs*. Kaiser Family Foundation. Retrieved from <https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/>
4. Brot-Goldberg, Z.C., Chandra, A., Handel, B.R., & Kolstad, J.T. (2017). What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. *The Quarterly Journal of Economics*, 132(3), 1261–1318.
5. Muennig, P., Sampat, B., Tilipman, N., Brown, L.D., & Glied, S.A. (2011). We All Want It, But We Don't Know What It Is: Toward a Standard of Affordability for Health Insurance Premiums. *Journal of Health Politics, Policy and Law*, 36(5), 829–53.
6. Glied, S.A. & Muennig, P. (2018). Reforming Reform: Public Assessments of the Affordability of Health Insurance Policies. *SocArXiv Papers*. Retrieved from <https://osf.io/preprints/socarxiv/8g4n6/>
7. Buchmueller, T.C. & Levy, H.G. (2020). The ACA's Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care. *Health Affairs*, 39(3), 395–402.
8. Connecticut State Office of Health Strategy and Office of the State Comptroller (2020). *Healthcare Affordability Standard*. Retrieved from <https://portal.ct.gov/-/media/OHS/Affordability-Standard-Advisory/Self-Sufficiency-Standard/Healthcare-Affordability-Standard-Overview.pdf?la=en>
9. Connecticut State Office of Health Strategy (2020). *Healthcare Affordability Standard – Self-Sufficiency Standard*. Retrieved from <https://portal.ct.gov/OHS/Pages/Healthcare-Affordability-Standard/Self-Sufficiency-Standard>
10. Ditre, J. (2017). *Consumer-Centric Healthcare: Rhetoric vs. Reality*. Healthcare Value Hub, Research Brief No. 18. Retrieved from <https://www.healthcarevaluehub.org/advocate-resources/publications/consumer-centric-healthcare-rhetoric-vs-reality/>
11. Dixon, A. (2020). Survey: Nearly 4 in 10 Americans Would Borrow Money to Cover a \$1K Emergency. *Bankrate*. Retrieved from <https://www.bankrate.com/banking/savings/financial-security-january-2020/>

LEONARD DAVIS INSTITUTE OF HEALTH ECONOMICS

Since 1967, the University of Pennsylvania's Leonard Davis Institute of Health Economics (Penn LDI) has been the leading university institute dedicated to data-driven, policy-focused research that improves our nation's health and health care. Penn LDI works on issues concerning care for vulnerable populations; coverage and access to health care; improving care for older adults; and the opioid epidemic. Penn LDI connects all twelve of Penn's schools, the University of Pennsylvania Health System, and the Children's Hospital of Philadelphia through its more than 300 Senior Fellows.

LDI.UPENN.EDU

 @PENNLDI

UNITED STATES OF CARE

United States of Care is a non-partisan non-profit organization mobilizing stakeholders to achieve long-lasting solutions that make health care better for all. United States of Care aims to ensure every American has access to an affordable regular source of health care; protection from financial devastation due to illness or injury; and to accomplish this in an economically and politically sustainable fashion.

UNITEDSTATESOF CARE.ORG

 @USOFCARE

AUTHOR

Janet Weiner, PhD, MPH
Co-Director for Health Policy
Leonard Davis Institute of Health Economics
University of Pennsylvania

THANK YOU

We thank our conference speakers for their valuable insights and contributions to the panel: **Sherry Glied**, PhD (moderator); **Tekisha Dwan Everette**, PhD; **Ezekiel Emanuel**, MD, PhD; **Frances Padilla**, MPA; **Mark Pauly**, PhD; and **Lynn Quincy**, MA.