Relative Affordability of Health Insurance Premiums under CHIP Expansion Programs and the ACA

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Abstract  Affordability is integral to the success of health care reforms aimed at ensuring universal access to health insurance coverage, and affordability determinations have major policy and practical consequences. This article describes factors that influenced the determination of affordability benchmarks and premium-contribution requirements for Children’s Health Insurance Program (CHIP) expansions in three states that sought to universalize access to coverage for youth. It also compares subsidy levels developed in these states to the premium subsidy schedule under the Affordable Care Act (ACA) for health insurance plans purchased through an exchange. We find sizeable variability in premium-contribution requirements as a percentage of family income across the three states and in the progressivity and regressivity of the premium-contribution schedules developed. These findings underscore the ambiguity and subjectivity of affordability standards. Further, our analyses suggest that the future of CHIP beyond 2015 is likely to have significant implications for health insurance coverage costs incurred by families who currently rely at least in part on CHIP for coverage.

Introduction

Affordability is integral to the success of health care reforms aimed at ensuring universal access to health insurance coverage, and affordability determinations have major policy and practical consequences. Indeed, the high cost of health insurance premiums are a key reason why so many Americans currently lack coverage (Dubay, Holahan, and Cook 2007;
Congress directly addressed the issue of affordability in developing the 2010 Patient Protection and Affordable Care Act (ACA), which requires individuals to have health insurance coverage—or face a penalty—but sets a maximum premium-contribution schedule for coverage that individuals purchase through newly formed health insurance exchanges. In addition, the ACA incentivizes employers to offer affordable coverage by penalizing them (with some exclusions) for not offering coverage to employees and dependents or offering coverage that is either not affordable or does not meet “minimum-value” criteria.

Other pieces in this issue show that understanding and operationalizing the concept of affordability can be approached from several perspectives. For example, Muennig and colleagues illustrate the advantages and limitations of relying on expert judgment. This article adds to the literature on affordability by describing factors that influenced the determination of affordability benchmarks and premium-contribution requirements for CHIP expansions in three states. The three states included in the study—Pennsylvania, Illinois, and Washington—were among the first to expand eligibility for public insurance coverage under CHIP to include all or nearly all families, regardless of income. In each state, the eligibility expansions were coupled with premium-contribution requirements that vary with family income level. Additionally, we compare subsidy levels developed in these states to the premium subsidy schedule in the ACA for health insurance plans purchased through exchanges. The states’ CHIP expansions and the ACA share the common goal of universalizing access to affordable coverage, although the CHIP expansions were more narrowly focused on youth.

The premium schedules ultimately implemented by policy makers in the three CHIP expansion states and in the context of the ACA reflect not only a notion of what is affordable but also additional, and in some cases competing, factors such as historical precedent, fiscal viability, administrative simplicity, and choices made by other states. Thus our comparisons provide insight into the choices ultimately made by policy makers under real-world constraints and their implications for affordability of health insurance coverage in practice.

In the next section, we describe the premium schedules chosen by each study state and discuss the factors each considered in developing its schedule. We then develop metrics for comparing premiums for similar families across the three states. Finally, we compare the premium-contribution requirements to maximum-contribution requirements for exchange-based
coverage in the ACA. We conclude with a discussion of key issues and the policy implications of our findings.

CHIP in Pennsylvania, Illinois, and Washington

Pennsylvania, Illinois, and Washington were leaders in expanding the availability of public health insurance coverage to all or nearly all children. Each state developed its own system for having families help cover the cost of health insurance premiums. In what follows, we describe the premium schedules implemented along with factors considered during the process of developing the schedules. We rely on documentary review as well as information obtained from interviews with staff from the government agency responsible for program administration, legislators, the governor’s policy staff, and advocacy groups in each state.

Pennsylvania

In November 2006, as part of its “Cover All Kids” initiative, Pennsylvania expanded its CHIP by making public insurance available to families with incomes over 235 percent of the federal poverty line (FPL). Policy makers chose to subsidize insurance for children in families with incomes between 235 and 300 percent of the FPL and to offer insurance at full cost to children in families with incomes exceeding 300 percent of the FPL. Premium costs were specified in terms of the proportion of the full cost borne by the state and the enrollee, to ensure that premiums automatically adjust for rising health care costs. Families pay no premium if their income is less than 235 percent of the FPL, they pay between 25 and 40 percent of the full cost if their income is between 235 and 300 percent of the FPL, and they pay 100 percent of the full cost if their income is more than 300 percent of the FPL (Rendell et al. 2009). (See table 1.)

Eligibility for families with incomes above 300 percent of the FPL is limited to families who demonstrate that private insurance is unaffordable for the family, with unaffordable defined as private premiums that exceed 10 percent of family income or 1.5 times the premium for buying in to public insurance.

Our interviewees reported that Pennsylvania’s premium schedule was chosen based on a number of factors, including legislators’ and program administrators’ perceptions of what was affordable for families; views
about affordability gleaned from focus groups with uninsured individuals and employees of small firms; federal policy requiring that the cost of CHIP coverage (for which states receive federal matching funds) for families not exceed 5 percent of family income; information on premiums charged for enrollees in the state’s adultBasic health insurance program for low-income adults; and calculations of the expected fiscal viability of the program under different scenarios, given, for example, expected enrollment and health care costs.

Illinois

In July 2006 Illinois began implementing the “All Kids” program, which offered coverage to all uninsured children, irrespective of income and immigration status. Before this date, the state’s CHIP offered subsidized coverage to children in families with incomes below 200 percent of the FPL. Notably, Illinois used only state funds to expand eligibility to higher-income children, in contrast to Pennsylvania, which received federal matching funds for its expansion.

Premium costs for families in Illinois were specified using dollar amounts, not percentages of the full cost, as in Pennsylvania. As shown in table 2, families with incomes less than 150 percent of the FPL pay no premium, but premiums gradually increase with family income, up to a maximum of $300 per child for families with incomes exceeding 800 percent of the FPL. For families with incomes between 150 and 200 percent of the FPL, the premium contribution varies with family size, from $15 per month for one child to $25 for two children, up to a maximum of $40 for five or more children. For families with incomes between 200 and 500 percent of the FPL, the premium contribution is the same for two children

### Table 1 Children’s Monthly Premiums for Public Insurance in Pennsylvania

<table>
<thead>
<tr>
<th>Family Income as a Percentage of the Federal Poverty Level</th>
<th>235–250</th>
<th>250–275</th>
<th>275–300</th>
<th>300+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As percent of total cost</td>
<td>25</td>
<td>35</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>$ per child&lt;sup&gt;a&lt;/sup&gt;</td>
<td>43</td>
<td>60</td>
<td>68</td>
<td>195</td>
</tr>
</tbody>
</table>

<sup>a</sup>Actual dollar amount is for 2009.

*Source:* Rendell, Aria, and Adams 2009
Table 2  Children's Monthly Premiums for Public Insurance in Illinois

<table>
<thead>
<tr>
<th>Family Income as a Percentage of the Federal Poverty Level</th>
<th>&lt; 150</th>
<th>150–200</th>
<th>200–300</th>
<th>300–400</th>
<th>400–500</th>
<th>500–800</th>
<th>800+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premium contribution</strong></td>
<td>$0</td>
<td>$15 for 1 child; $25 for 2 children; $30 for 3 children; $35 for 4 children; $40 for 5 or more</td>
<td>$40 per child; max of $80 per family</td>
<td>$70 per child; max of $140 per family</td>
<td>$100 per child; max of $200 per family</td>
<td>$150–$250 per child</td>
<td>$300 per child</td>
</tr>
</tbody>
</table>

*Source*: State of Illinois n.d.
or more than two children. Premiums for families with incomes above 500 percent of the FPL are set above full cost; that is, the state imposes a surcharge (State of Illinois 2011).

Several factors gave rise to the premium schedule ultimately implemented in Illinois. First, state policy makers indicated that they had gathered information about health insurance premium-contribution requirements as a percentage of income for public employees in the state, as well as information about the contribution requirements imposed in other states for CHIP and other publicly funded health insurance programs for low-income individuals. Notably, because Illinois was not receiving federal funds for newly eligible children, policy makers were not constrained by the federal rule that capped premiums at 5 percent of family income. Premiums for families with incomes between 200 and 300 percent of FPL were set to equal roughly the amount that state employees pay for dependent coverage. Premiums for families with incomes over 500 percent of the FPL were set above full cost both to limit crowd-out of private insurance and to ensure the fiscal viability of the program through premium cross-subsidies from higher- to lower-income families.

Washington

Washington passed legislation in 2007 that provided a framework for phased expansions of CHIP eligibility. The first phase, effective July 2007, increased the income eligibility cutoff for immigrant and nonlegal resident children to equal that of citizens: 250 percent of the FPL. In 2009 eligibility was further increased to include children in families with incomes between 250 and 300 percent of the FPL. The framework originally included plans to expand eligibility for children in higher-income families (above 300 percent of the FPL) at a later date, but this did not ultimately occur. For families with incomes between 200 and 250 percent of the FPL, premiums were set at $20 per child, up to a maximum of $40 per family. Premium contributions for families with incomes between 250 and 300 percent of the FPL were set at $30 per child, up to a maximum of $60 per family (Revised Code of Washington). (See table 3.)

Premiums for citizen children in families with incomes between 200 and 250 percent of the FPL had been determined prior to the 2007 expansion. For families between 250 and 300 percent, Washington legislation created a unique requirement: the Department of Social and Health Services (DSHS) was required to consult with the senate majority and minority
leaders and the speaker and minority leader of the house of representatives on premium levels (Revised Code of Washington 2007). In keeping with the other states, our interviewees reported that multiple considerations and policy objectives drove decisions about premium levels. As in Illinois, policy makers assessed the premium contribution required in other states for public health insurance programs. Interviewees reported that premiums in Washington were chosen to fall in the middle of the range observed in other states, not to prevent potential migration from residents in adjacent states but to emulate perceived best practices. In addition, policy makers used requirements developed for the state’s Basic Health program, a public health insurance program for low-income adults, as a benchmark. While the federal affordability requirement of 5 percent was a ceiling, policy makers adopted a 2 percent standard instead. A final consideration was balancing the affordability of premium-contribution requirements for families against federal pressure to raise premiums. Specifically, interviewees reported being advised by federal policy makers that the proposed premium contributions were too low and might encourage crowd-out.

### Table 3

<table>
<thead>
<tr>
<th>Family Income as a Percentage of the Federal Poverty Level</th>
<th>&lt; 200</th>
<th>200–250</th>
<th>250–300</th>
<th>&gt; 300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium contribution</td>
<td>$0</td>
<td>$20 per child; $40 for 2 or more children</td>
<td>$30 per child; $60 for 2 or more children</td>
<td>Not eligible</td>
</tr>
</tbody>
</table>

Source: State of Washington n.d.

**Premium Subsidies for Exchange-Based Coverage in the ACA**

Under the ACA, health insurance exchanges will be established in each state by 2014. These exchanges will offer a set of plans categorized according to their actuarial value, with bronze plans covering an estimated 60 percent of health care costs; silver covering 70 percent; gold covering 80 percent; and platinum, 90 percent. With some exceptions, individuals and families with incomes less than 400 percent of the FPL will not be required to spend more than a specified percentage of household income
on premium costs for a silver health insurance plan purchased through an exchange.\footnote{The income used to determine eligibility for premium assistance credits is modified adjusted gross income, or MAGI (Peterson and Gabe 2010).} Individuals and families facing an insurance premium through the exchange (for a silver plan) that is greater than the specified level will receive a premium assistance credit.\footnote{Premium assistance credits are refundable tax credits that individuals may take in the form an advance payment (made directly to the insurer). Notably, because income varies over time and premium assistance credit calculations are based on the most recent reported taxable annual income, the ACA provides for a reconciliation process to determine if individuals must repay some portion of the premium credit at a later point. For more detailed information, see Peterson and Gabe 2010; Rosenbaum 2010; Kaiser Family Foundation 2011; Horner and Corlette 2010; Chaikind and Peterson 2010.} Premium-assistance credits are only available to individuals who have neither eligibility for nor an offer of other affordable health insurance coverage, such as through Medicaid, CHIP, or from an employer-sponsored plan. Employer-sponsored plans that require premium contributions of more than 9.5 percent of household income are not considered affordable coverage. By 2014, all states must offer Medicaid coverage to individuals under age sixty-five with incomes up to 138 percent of the FPL (with some exceptions based on legal status).

As shown in table 4, below, maximum premium as a percentage of income ranges from 4 percent to 9.5 percent for families with incomes between 150 and 400 percent of the FPL. While individuals and families with income at or above 400 percent of poverty are not eligible for premium credits, they are not precluded from purchasing coverage through the exchange. The ACA also allows for cost-sharing subsidies (such as for deductibles and co-payments) for individuals eligible for premium subsidies.

\begin{table}[h]
\centering
\begin{tabular}{lcccccc}
\hline
\textbf{Family Income as a Percentage of the FPL} & 150–200 & 200–250 & 250–300 & 300–400 & 400–600 & 600–800 \\
\hline
\textbf{Maximum premium as % of family income} & 4.0–6.3 & 6.3–8.05 & 8.05–9.5 & 9.5 & N/A & N/A \\
\hline
\end{tabular}
\caption{Maximum Premiums as a Percentage of Family Income for a Silver Exchange Plan under the ACA}
\end{table}

\textit{Source:} Reconciliation Act of 2010, H.R. 4872 (see www.opencongress.org/house_reconciliation)

\textit{Notes:} FPL = federal poverty level; N/A = not applicable
Methods

We first compare the premium costs of public insurance for children across the three study states using common metrics: the premium for one child and the premium for three children, in both cases as a percentage of family income. Next, we compare the costs of insuring all family members through a combination of CHIP (for children) and employer-sponsored insurance (for parents) in each of the three states. We consider the costs for two types of families: a one-child, one-parent family and a three-child, two-parent family. Finally, we compare the premium costs associated with a combination of CHIP and employer-sponsored insurance coverage for families in each of the three study states with the maximum premium costs that families will face when purchasing health insurance coverage through an exchange in the future.

The cost comparisons of public insurance for children alone (one child and three children) are intended to reflect the perspective of state policy makers and CHIP officials, who are likely focus on ensuring that children’s coverage is affordable. The cost comparisons of insuring an entire family (one parent—one child and two parent—two child) across the three states are intended to reflect the perspective of parents who wish to secure coverage for all family members.

We determined the premium costs of public coverage for children in each of the study states using 2009 premium schedules, as described in the previous section. To estimate the premium cost of employer-sponsored insurance for parents in each state, we used state-specific data on the employee share of premiums for employer-sponsored insurance from the 2006 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC). We accounted for premium inflation through 2008, the most recent year for which data were available, using information on premium inflation rates from the Kaiser Family Foundation’s Employer Health Benefits Annual Surveys (2006, 2007, 2008). We then obtained premium estimates for 2009 using an inflation rate of 5 percent, based on the change in total health insurance premiums from 2008 to 2009 for plans offered through the California Public Employees’ Retirement System (CalPERS 2011).

To account for the fact that employer-sponsored insurance is purchased with pretax dollars, we discounted the employee share of the premium

3. There is evidence in the economic literature that workers actually bear most of the cost of the employer contribution to employer sponsored insurance premiums through lower wages. However, this is not the public's perception. Moreover, including the employer contribution in the premium calculation results in extremely high percentages of income devoted to premiums, much higher than established affordability benchmarks.
by the sum of the federal and state marginal tax rates for each income level. We accounted for the standard head-of-household (one-parent) and married-filing-jointly (two-parent) deductions as well as exemptions for dependents when determining the marginal tax rate for each family. We estimated the total premium costs for families by summing the premium costs for children (for public insurance) and parents (for employer-sponsored insurance). Because Illinois has a program called Family Care that allows parents with incomes below 200 percent of the FPL to buy into public insurance if their children are enrolled, we include a separate estimate for the premium costs in Illinois associated with family coverage if parents and children both purchase public insurance.

We compared our estimated costs of family coverage through employer-sponsored and CHIP coverage in each of the three states to the exchange-plan affordability schedule created in the ACA (table 4). Our analyses assume that all family members receive coverage through the exchange. In practice some families may receive coverage through a combination of sources. For example, in some low-income families, children may be eligible for Medicaid or CHIP while adults may only be eligible for exchange-based coverage. Little information appears to be available about how premium subsidies will be calculated for families with mixed-source coverage—for example, whether families’ premium contributions to CHIP for their children will be considered when determining premium-subsidy amounts for coverage parents purchase for themselves in an exchange. Nonetheless, the importance of coordination between CHIP, Medicaid, and the exchanges has been highlighted in recent reports (Kaiser Family Foundation 2010a; Horner and Corlette 2010).

**Results**

We report the maximum premium cost as a percentage of family income for families enrolling in public insurance for one child and for three children across the three study states (table 5). The maximum premium as a percentage of family income is also shown (table 6) for entire families insured through a combination of public insurance coverage (for children) and employer-sponsored insurance coverage (for parents).

For families earning less than 300 percent of the FPL, premium costs for insuring one or three children through CHIP are less than 5 percent of family income across all three states (table 5). These proportions conform to federal guidelines. Nonetheless, premiums as a percentage of income vary substantially across states. For example, families earning
<table>
<thead>
<tr>
<th></th>
<th>Pennsylvania</th>
<th>Illinois</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 child</td>
<td>3 children</td>
<td>1 child</td>
</tr>
<tr>
<td>150–200</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>200–250</td>
<td>1.8</td>
<td>3.0</td>
<td>0.8</td>
</tr>
<tr>
<td>250–275</td>
<td>2.0</td>
<td>3.4</td>
<td>1.3</td>
</tr>
<tr>
<td>275–300</td>
<td>2.0</td>
<td>3.5</td>
<td>1.2</td>
</tr>
<tr>
<td>300–400</td>
<td>5.4</td>
<td>9.1</td>
<td>1.9</td>
</tr>
<tr>
<td>400–500</td>
<td>4.0</td>
<td>6.8</td>
<td>2.1</td>
</tr>
<tr>
<td>500–800</td>
<td>3.2</td>
<td>5.4</td>
<td>2.9</td>
</tr>
<tr>
<td>800+</td>
<td>2.0</td>
<td>3.4</td>
<td>3.1</td>
</tr>
</tbody>
</table>

**Notes:** Percentage of income calculated using the lower level within each family income range (e.g., 200 for 200–250 percent of FPL). Families with incomes above 300 percent of the FPL in Washington are currently ineligible for public purchase. FPL = federal poverty level; N/A = not applicable.
just over 300 percent of the FPL would pay more than 9 percent of their income each month to insure three children in Pennsylvania, compared to 2.2 percent of their income in Illinois. While children in families with incomes above 300 percent of the FPL are ineligible for CHIP in Washington, children in families with incomes below that level pay lower premiums in Washington than in Pennsylvania or Illinois. For example, a family earning between 200 and 250 percent of the FPL in Washington would pay at most 0.8 percent of their income to insure one child through CHIP, compared to double that (1.6 percent) in Illinois and Pennsylvania (1.8 percent).

Within each state, the pattern of contribution requirements across income levels is noteworthy. In Pennsylvania, premium contributions are progressive through family incomes up to 400 percent of the FPL and then become regressive. Specifically, Pennsylvania requires no contribution for those with incomes 150–200 percent of the FPL, up to 1.8 percent of income for families with income between 200 and 250 percent of the FPL, up to 2 percent for families with incomes between 250 and 300 percent of the FPL, and up to 5.4 percent for families with incomes between 300 and 400 percent of the FPL. Thereafter, premium contributions decline as a percentage of family income. This pattern reflects that, in Pennsylvania, families pay the full cost of CHIP coverage if family income exceeds 300 percent of the FPL. Because the cost of coverage does not vary with income, premiums represent a larger share of income for families with incomes near the threshold level, compared to those with incomes farther from the threshold.

In Washington, the maximum in premium-contribution requirements as a percentage of family income is 250 percent of the FPL. Families in Washington with incomes above 300 percent of the FPL are ineligible for CHIP coverage; however, in general families that purchase coverage through the individual market will pay a higher share of income for coverage the closer they are to the 300 percent threshold.

Illinois stands in sharp contrast to Pennsylvania and Washington. As shown in the table, required premium contributions in Illinois are progressive from 300 percent up to 800 percent of the FPL. This reflects the decision in Illinois to charge families in the highest income levels more than the actual cost of coverage as a way to subsidize premiums for the lowest-income families.

The results in table 6 show substantial variability in premiums across states for family insurance coverage. For one parent–one child families in all states, premiums are less than 5 percent of family income among
<table>
<thead>
<tr>
<th>Family Income as a Percentage of the FPL</th>
<th>150–200</th>
<th>200–250</th>
<th>250–275</th>
<th>275–300</th>
<th>300–400</th>
<th>400–500</th>
<th>500–800</th>
<th>800+</th>
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<tr>
<td>Pennsylvania</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 parent, 1 child</td>
<td>4.2</td>
<td>4.7</td>
<td>4.3</td>
<td>4.2</td>
<td>7.3</td>
<td>5.5</td>
<td>4.2</td>
<td>2.7</td>
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<td>2 parent, 3 child</td>
<td>4.5</td>
<td>6.4</td>
<td>6.0</td>
<td>5.9</td>
<td>11.3</td>
<td>8.3</td>
<td>6.6</td>
<td>4.1</td>
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<td></td>
<td></td>
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<tr>
<td>1 parent, 1 child</td>
<td>4.8</td>
<td>4.4</td>
<td>3.5</td>
<td>3.2</td>
<td>3.8</td>
<td>3.4</td>
<td>3.4</td>
<td>3.7</td>
</tr>
<tr>
<td>2 parent, 3 child</td>
<td>5.5</td>
<td>5.1</td>
<td>4.1</td>
<td>3.7</td>
<td>4.3</td>
<td>3.7</td>
<td>5.3</td>
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<td>Family Care</td>
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<tr>
<td>1 parent, 1 child</td>
<td>1.4</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>2 parents, 3 child</td>
<td>1.2</td>
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<td>N/A</td>
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<td>Washington</td>
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<tr>
<td>1 parent, 1 child</td>
<td>3.1</td>
<td>3.0</td>
<td>2.7</td>
<td>2.5</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2 parent, 3 child</td>
<td>4.8</td>
<td>4.6</td>
<td>4.0</td>
<td>3.7</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Notes: Premium rates for parents are based on employer-sponsored insurance. Percentage of income calculated using the lower level within each family income range (e.g., 200 for 200–250 percent of FPL). Families with incomes above 200 percent of the FPL are not eligible for Family Care in Illinois. Families with incomes above 300 percent of the FPL in Washington are currently ineligible for public purchase. FPL = federal poverty level; N/A = not applicable.
those with incomes up to 300 percent of the FPL. Among larger families (two parent, three child) with incomes less than 300 percent of the FPL, premium costs for combination CHIP and employer-sponsored coverage range from 3.7 to 6.4 percent of family income. Premium costs exceed 10 percent of family income for some larger families in Pennsylvania with incomes above 300 percent of the FPL; these families are ineligible for CHIP in Washington, and in Illinois they pay between 3.7 and 5.9 percent of family income.

There are discernable differences within each state for families of varying income levels (table 6). Without an income-based subsidy for either CHIP or employer-sponsored coverage, families in Pennsylvania with incomes just above the 300 percent FPL threshold pay the highest share of income for premiums, compared to families at higher income levels. In Washington, the ineligibility of families with incomes above 300 percent FPL for subsidized public coverage suggests that families near this threshold will also contribute the most to the costs of health insurance coverage compared to families of all other income levels. In Illinois, while CHIP premium contributions progressively increase from 300 percent through 800 percent of the FPL, employer-sponsored insurance premiums are constant regardless of income level. As a result, the relationship between premium contributions as a share of income and income level is not monotonic. For example, families with incomes between 300 and 400 percent of the FPL pay more as a share of income for health insurance premiums than do families with incomes between 400 and 500 percent of the FPL.

We compared our estimated costs of family coverage through employer-sponsored and CHIP coverage in each of the three states to the exchange-plan affordability schedule created in the ACA (table 4). As shown in table 6, for families with income levels between 150 and 200 percent of the FPL, the premiums for family coverage range from 1.2 percent (for Family Care in Illinois) to 5.5 percent of family income. Thus premiums as a percentage of family income fall below or within the range of the costs associated with family coverage through an exchange for that income level (maximum of between 4 and 6.3 percent of income). For families with income levels between 200 and 300 percent of the FPL, the premiums for family coverage through employer-sponsored insurance coverage and CHIP are generally well below the exchange-based affordability threshold. Premiums as a percentage of family income range from 3.0 to 6.4 percent for combination CHIP—employer-sponsored insurance for families with incomes between 200 and 250 percent of the FPL in the three study states, compared to the premium cap of 6.3 to 8.05 percent of
family income for exchange coverage under the ACA for such families. Likewise, the ACA caps premium contributions for exchange coverage at between 8.05 and 9.5 percent for families with incomes between 250 and 300 percent of the FPL, compared to the estimated 2.5 to 6.0 percent premium contributions (as a percentage of family income) for combination CHIP—employer-sponsored coverage in the three states. For families with incomes between 300 and 400 percent of the FPL, the ACA premium cap is 9.5 percent. This is far higher than the estimated premium contributions required for CHIP—employer-sponsored coverage in Illinois for similar families (3.8 to 4.3 percent of family income). In Pennsylvania, smaller families face an estimated 7.3 percent premium as a percentage of family income for family coverage through CHIP—employer-sponsored coverage (compared to the 9.5 percent cap under the ACA), although larger (two-parent, three-child) families would pay an estimated 11.3 percent of income.

Discussion

Affordability is integral to the success of health care reforms aimed at ensuring universal access to health insurance coverage, and affordability determinations have major policy and practical consequences. In the absence of a coverage mandate, reforms that ensure the availability of insurance without regard to its affordability are likely to continue to leave a substantial portion of the population without coverage. If coverage is mandated, low-income families could experience a serious financial burden if premiums are not affordable.

Despite the importance of affordability, there is no single, universally agreed-on standard that discriminates between coverage that is or is not affordable. This study described factors that influenced the determination of affordability benchmarks and setting of premium-contribution requirements in three states that recently expanded their Children’s Health Insurance Programs to make all, or nearly all, children eligible for public coverage. Policy makers in the three states used a variety of sources to help them determine what premium contributions would likely be affordable for families of different income levels, including the perspectives of uninsured individuals; the perceptions of legislators; the level of premium contribution required for public employees participating in their group health insurance plan; and premium schedules developed in other states for CHIP and for other state-specific public health insurance programs, such as those targeting low-income adults. Interestingly, except in Illi-
nois, policy makers seem to have focused primarily on the affordability of insurance coverage for children, as opposed to considering affordability of coverage for families more broadly. Although affordability was a key consideration in states’ decisions about appropriate premium-contribution requirements, other factors—such as historical precedent, fiscal viability, and simplicity—were influential in the premium-setting process as well. Discouraging crowd-out of private coverage and redistribution from higher- to lower-income families were additional and important considerations in determining premiums for families with relatively higher levels of income.

Our analysis of premium-contribution requirements in the three study states for children’s health insurance coverage and for family health insurance coverage through a combination of CHIP and employer-sponsored coverage reveals sizeable variability that underscores the ambiguity and subjectivity of affordability standards. Differences in the percentage of family income required to obtain coverage for a family of a given size and with a given income level are up to nearly threefold among the states studied.

Further, the various ways states balanced competing factors influenced the progressivity and regressivity of the premium-contribution schedules. Specifically, in Pennsylvania and Washington families with incomes between 250 and 300 percent FPL were likely to face the highest premiums as a percentage of family income. By contrast, in Illinois premium costs for subsidized public coverage progressively increased for families across a wide income range. In the absence of subsidies, health insurance premiums are inherently regressive, because premiums vary much less than incomes do. Consequently, premiums necessarily consume a lower percentage of income for high-income families than for their low-income counterparts. With subsidies, premium schedules can be made progressive, but only up to the income level where the subsidies disappear. Illinois was able to make its premium schedule progressive throughout a broad range of income only by imposing a surcharge on high-income families.

In addition, our comparison of premium-contribution requirements for combination CHIP and employer-sponsored insurance coverage in the three study states to maximum premium-contribution requirements for exchange-based coverage under the ACA suggests that, for families earning above 200 percent of the FPL, family coverage through CHIP and employer-sponsored coverage is likely to be more affordable in some states than coverage through the exchange. Consequently, the future of CHIP beyond 2015—the date through which funding is certain—is
likely to have significant implications for health insurance costs for families relying at least in part on CHIP. In particular, if families in states with CHIP premiums lower than or similar to those in Pennsylvania, Illinois, or Washington are required to move from CHIP to exchange-based plans for coverage, they will likely see their premium costs as a percentage of family income rise by several points. Setting premium contributions based on competing considerations is a balancing act that may result in premiums that, while considered unaffordable by some observers, are politically feasible and ensure the financial viability of the program. Premiums for exchange-based coverage under the ACA are a good illustration of this phenomenon.

A potential limitation of our study is that in assessing affordability we only considered the premium costs of insurance coverage. The affordability of health care— as opposed to health insurance— is influenced not only by insurance premiums but also by the design of insurance benefits, which affect the out-of-pocket costs of health care services (see Muennig et al. in this issue). Our approach reflects the fact that public insurance programs have thus far eschewed deductibles and employed relatively small co-payments, at least for subsidized groups, compared to employer-sponsored or individual private health insurance policies. Indeed, the ACA includes cost-sharing subsidies for premium subsidy–eligible families, and setting cost-sharing requirements that make health care affordable will be an important consideration for the exchanges under the ACA (as discussed by Saloner and Daniels in this issue). Another limitation relates to the lack of clarity surrounding how premium subsidies will be calculated for families with mixed-source coverage. Our analysis makes the simplifying assumption that families who purchase coverage in the exchange do so for all family members. Also, we have not assessed whether the generosity of CHIP health insurance coverage differs substantially from that of a silver plan with cost-sharing subsidies purchased through the exchange.

Our study fills a gap in the understanding of how those who manage public insurance programs make decisions about the premium contributions required of enrollees, including the types of information and data used in balancing concerns about affordability with other objectives. As health care costs continue to rise, state and federal policy makers may face a difficult choice: increase premium contributions required from those who purchase public coverage or receive subsidized coverage through the exchange, further limiting affordability, or reduce the generosity of the insurance benefits. Of course, as coverage becomes less comprehensive, the potential for underinsurance increases, which in turn affects
the affordability of health care services. Another response to increasing health care costs, however, is to make changes to delivery systems that may produce cost savings. For example, Illinois established primary-care case management and disease management programs for all public insurance programs in the state and anticipated relying heavily on savings from these initiatives to help finance CHIP expansions. As states move forward with implementation of federal health care reform under the ACA, they must continue to emphasize efforts to develop cost-saving reforms to the delivery system as a means of ensuring the continued viability of their public programs, affordability of coverage, and the accessibility of health care.

References


