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What health coverage would laid-off workers obtain under recent tax credit proposals?

Impact depends on workers' financial resources and health risks

By Stan Dorn and Jack A. Meyer

Federal policymakers in both parties have promised substantial assistance to help unemployed, uninsured workers obtain health coverage. The Bush Administration's budget proposal, for example, would offer tax credits paying 60 percent of premiums for laid-off workers. Even people not owing federal income taxes could use these credits to buy insurance. Unemployed workers could apply credits either in the individual market or to buy coverage from former employers through COBRA or state mini-COBRA laws. (These laws require certain companies to continue health coverage for departing employees who choose to pay 102 percent of full premium costs.) Although this proposal was removed from the stimulus bill before final adoption, bipartisan leaders have stated their desire to pass other legislation providing health coverage for unemployed workers. Other tax credit proposals aimed at more of the uninsured would pay, depending on income, up to \$1,000 per individual and \$3,000 per family, capping credits at 90 percent of total premiums.

This analysis addresses the impact of such tax credit proposals on laid-off workers, who are diverse. More than half have low annual incomes (below 200 percent of the federal poverty level), but some have significant spousal earnings or accumulated savings that can help pay for health insurance. Moreover, in the individual market, differences in age and health have a dramatic impact on prices and the availability of insurance. Accordingly, this paper suggests that tax credits' effectiveness would depend in large part on laid-off workers' financial resources and potential health risks:

- *Laid-off workers with limited financial resources but no health risk factors* generally would not supplement tax credits with enough dollars to buy any coverage except low-price, limited benefit plans. Frequently, such plans protect against catastrophic financial loss but impose heavy costs for more routine care. They can leave office visits, prescription drugs, and similar services uncovered or impose large deductibles. Such costs could prevent many low-

income workers from receiving necessary preventive care and early treatment of disease. Based on the limited appeal of such plans in the past, few low-income, healthy unemployed are likely to enroll if asked to pay even 40 percent of premiums.

- *Laid-off workers with limited financial resources and high health risks* likewise would usually remain uninsured. Many low-income workers are ineligible for COBRA and state mini-COBRA laws and so could use credits only in the individual market, where even limited coverage can be very costly for people with health risk factors. However, some low-income, unemployed workers who have access to COBRA and expect large health expenses would use credits to buy employer coverage.

- *Laid-off workers with more resources*, on the other hand, would typically supplement tax credits to purchase relatively broad coverage. Healthy workers could use either COBRA or the individual market, depending on their individual circumstances and needs. Most with health risk factors would avoid problems with the individual market by buying coverage from former employers through COBRA. Employer coverage would not suffer even if healthier laid-off workers used the individual market and sicker ones used COBRA; average employer costs per covered person would rise by only minor amounts for most employers, since laid-off workers would comprise a small proportion of most employer-sponsored groups.¹

- *If \$1,000 credits were used for laid-off workers* instead of 60 percent credits, such credits would nearly equal the full premium for low-priced plans. Some young, healthy, low-income workers could buy fairly broad coverage but with deductibles and co-payments higher than under most employer insurance. However, medium- and high-priced plans would be less affordable with \$1,000 credits than with 60 percent credits.

This analysis does not reject the basic concept of using tax credits to help laid-off workers with limited resources.

Very different approaches, such as Medicaid and SCHIP expansions, face challenges of similar magnitude. Rather, as we hope to explore in a forthcoming paper, current tax credit proposals include important positive elements and could be restructured to provide more effective assistance to laid-off workers with few resources and significant health risks. That paper will discuss more than credit amounts and the markets in which credits can be used, the two fundamental design issues that are the focus of this alert.²

Analysis

This brief paper begins by describing the limited purchasing power of many laid-off workers. It then identifies the types of plans likely to be bought using tax credits. Finally, it explores the benefits such plans offer.

Many laid-off workers have limited means.

Among unemployed adults who do not have COBRA coverage, 58 percent have annual family income (from both employed and unemployed periods) at or below 200 percent of the federal poverty level (now \$1,477 a month for individuals, \$3,017 for a family of four, etc.).³

Among recently unemployed workers with prior employer coverage, 41 percent receive no unemployment insurance payments.⁴ Monthly payments for those who do receive benefits average \$1,088.⁵ For single-earner households without other income, these payments must cover all household expenses, including rent, utility bills, car payments, food, credit card minimums, and clothing. Accordingly, many laid-off workers have limited capacity to supplement tax credits in purchasing insurance.

Even with credits boosting purchasing power, remaining premium costs, health risk factors, and limited access to group coverage would narrow many laid-off workers' choices of health plans.

Premium costs would vary greatly depending on the health plan chosen, the number of family members insured and (in the individual market) the age, gender, health history, area of residence, and other characteristics of the applicant. For example, a recent report on the individual market by the Council of Economic Advisers (CEA) found that, for PPO policies with \$1,000 individual deductibles and 20 percent coinsurance, annual premiums for a healthy family of four with 25-year-old parents ranged from \$1,272 in Bloomington, Illinois, to \$9,675 in Boston, Massachusetts, with a national average of \$3,287; for a healthy, non-smoking, 55-year-old couple, yearly premiums ranged from \$2,904 to \$12,099, with a \$5,145 average.⁶

Table 1 uses one case from slightly below the middle of the range to illustrate how proposed tax credits would work for the unemployed. It shows the effect of credits on premium costs for a healthy, female non-smoker, age 35, buying single coverage from three plans:

- A typical low-price, limited benefit plan (the median-price plan costing under \$105 a month in the individual market, which is also the lowest-price plan with a deductible under \$2,500);⁷
- Intermediate coverage bought in the individual market (coverage with premiums halfway between the low-price plan and average employer insurance); and
- Employer insurance at the national average price, purchased through COBRA.

This table shows costs in Chevy Chase, Maryland, where individual policies are generally less expensive than the national averages found by CEA.⁸ Table 1 and some other examples in this report focus on single rather than family coverage since many children of laid-off workers qualify for Medicaid and SCHIP and so do not need new subsidies. For laid-off workers with national average unemployment benefits as their only income, the table also expresses worker premium costs as a percentage of income.

Table 1: \$1,000 and 60 percent tax credits used to buy various health plans: premium costs for one laid-off female, age 35, living on national average unemployment benefits

	Full monthly premium	Monthly amount paid by credit	Monthly amount the worker must pay	
			Dollars	Proportion of income
Low-price, limited benefit plan (Median-price plan costing below \$105 a month)	\$79	\$1000 credit: \$71	\$8	1%
		60% credit: \$47	\$32	3%
Intermediate plan (Premiums half-way to average employer coverage)	\$163	\$1000 credit: \$83	\$80	7%
		60% credit: \$98	\$65	6%
Average price employer plan (Assuming credit used through COBRA)	\$250*	\$1000 credit: \$83	\$167	15%
		60% credit: \$150	\$100	9%

*Notes: Kaiser/HRET survey shows \$221 average premium for single employer coverage in 2001. \$250 estimate for 2002 assumes (a) 2002 premiums increase 11%, same as 2001, and (b) employer coverage purchased through COBRA, costing 102% of premium. The Table also assumes that the \$1,000 tax credit (a) could not exceed 90% of the premium, and (b) could be used through COBRA.

Sources: www.ehealthinsurance.com, analysis by ESRI 2/02; Kaiser/HRET 2001 employer benefit survey; U.S. Dept. of Labor summary data for December 2001 unemployment insurance benefits.

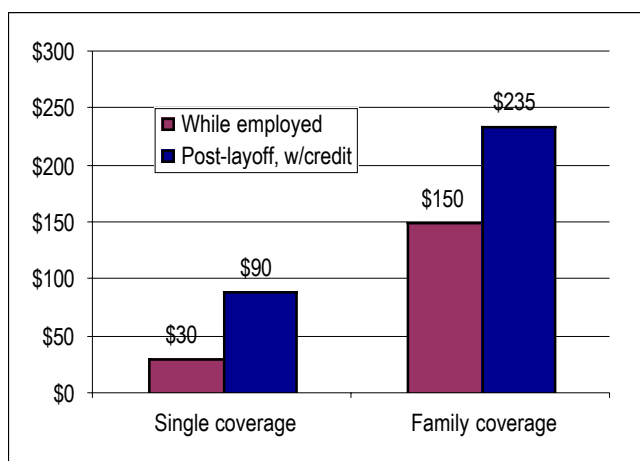
Research suggests that credits of this magnitude⁹ are unlikely to bring significant numbers of low-income, laid-off workers into employer coverage or even intermediate plans. In states with health programs for low-income workers, few have enrolled when asked to pay anything

like the 6 percent or more of income that would be required in many cases to buy employer coverage and intermediate plans like those described above. One study, for example, found that as low-income workers' premium obligations rose from 1 to 3 to 5 percent of income, participation dropped from 57 to 35 to 18 percent of eligible households.¹⁰ As the Congressional Budget Office concluded, "The amount of a tax credit would have to be fairly large—approaching the full cost of the premium—to induce a large proportion of the uninsured population to buy insurance."¹¹

Unfortunately, little is known about the impact of subsidies for higher-income, laid-off workers, who may have working spouses or accumulated assets. Presumably, many would use credits to retain coverage from their former employers through COBRA. But some with resources have fixed financial obligations, like mortgage payments, that limit discretionary income when lay-offs cut earnings. It is unknown how many would save money, pending a new job, by purchasing less comprehensive coverage in the individual market.

In 2001, workers with single coverage from employers paid an average of 15 percent of premium costs, according to national surveys, or \$30 a month. For family coverage, employees paid 27 percent of premium costs, or \$150 a month, on average. If proposed 60 percent tax credits had been in effect, unemployed workers could have continued that coverage by paying \$90 per single worker and \$235 per family each month.¹² As Figure 1 illustrates, laid-off workers with such credits could have retained their previous coverage only by increasing substantially their payments for health insurance, precisely when they lost employment and earnings.

Figure 1: Worker costs of average-price, employer-based coverage: monthly costs while employed vs. monthly costs with 60 percent tax credit after layoff



Note: Average worker costs while employed are based on 2001 surveys. Estimated post-layoff costs with tax credit assume 2001 premium levels and use of COBRA.

Source: Kaiser/HRET 2001 employer surveys.

Barriers besides cost also inhibit tax credits' effectiveness. Older workers or those with health problems could often find that even low-price and intermediate plans are unaffordable or unavailable in the individual market.¹³ For example, monthly premiums for healthy, female non-smokers using the low-price plan in Table 1 for single coverage are \$57 at age 25; \$93 at age 40; and \$172 at age 55.¹⁴

Similarly, both the low-price and intermediate plans cited in Table 1 deny coverage to applicants with diabetes under control, breast cancer in remission, psychotherapy, or comparable history, according to plan literature and statements of authorized insurance brokers.¹⁵ Some outright denials (but not premium increases) would be forbidden by requirements in House-passed legislation that some insurers must cover tax credit recipients with a history of continuous coverage.¹⁶

On the other hand, young, healthy workers in the individual market would face reduced premiums. For a version of the intermediate plan in Table 1, for example, involving a slightly higher deductible (\$500, instead of the \$200 for the plan in Table 1), the monthly premium is \$105 for healthy, non-smoking women age 25. Proposed \$1,000 and 60 percent tax credits would reduce such young workers' monthly payments to \$22 and \$42, respectively, or 2 percent and 4 percent of average unemployment benefits. Some in this group are likely to purchase coverage, if experience with state health programs for low-income workers proves applicable.¹⁷

This example also suggests that a fixed \$1,000 credit and an uncapped 60 percent credit would benefit different groups. Young, healthy workers with lower premiums could get more help from the \$1,000 credit. But the 60 percent credit would give more help to those who paid higher premiums because they were higher risks¹⁸ or chose more comprehensive coverage.¹⁹

In addition to cost and health risks, a third barrier to proposed tax credits' effectiveness is that COBRA does not cover some unemployed workers, including those who worked at firms with fewer than 20 employees and those who previously lacked employer coverage. While COBRA applies to 75 percent of workers earning above 200 percent of the federal poverty level, only 40 percent of workers with incomes below that level qualify.²⁰ Although some employees at small firms benefit from "mini-COBRA" laws in many states, neither federal nor state rules protect laid-off workers without prior employer coverage, including the self-employed, the uninsured, and recipients of spousal coverage. Accordingly, credits that can be applied through COBRA and its state equivalents may not in fact provide access to employer coverage for some laid-off workers, especially at lower income levels.²¹

Proposed tax credits would allow most unemployed workers with significant resources to overcome all three of these barriers. However, market segmentation could result. As noted above, some healthy tax credit users may save money by using the individual market, and many with large, foreseeable health costs would use COBRA whenever possible.

With laid-off workers, however, such risk selection is highly unlikely to be a serious problem. All COBRA users formerly received employer coverage, so their continued coverage would not impose new costs on employers. Of course, if healthier workers who otherwise might have used COBRA instead use the individual market, average employer costs per covered worker would rise. However, such average costs are based on the entire group covered by the employer. Except in companies that lay off an unusually large percentage of their workforce, only a small shift in the average cost of the entire group would result from some healthier workers among the recently unemployed using credits in the individual market, rather than COBRA, for the often brief period until they are re-employed.

For many displaced workers with few resources, the health plans they would likely find affordable protect against catastrophic financial losses but provide little access to preventive care and early treatment of illness. Past experience suggests that few would make even modest payments for such coverage.

Table 2 compares the coverage offered by the three plans listed in Table 1. The low-price plan protects against some catastrophic financial losses without covering such services as office visits and outpatient prescription drugs. (The appendix to this report shows how other plans with similar low prices control their costs.) Many low-income workers covered by such plans may not obtain necessary preventive care and early treatment of disease, as health costs would be completely or largely paid out of pocket until they reach high levels. Several studies²² show that such costs frequently cause low-income people to go without essential care, sometimes leading to preventable hospitalization and permanent damage to health.

It is not clear how many would take advantage of such low-price, limited benefit plans. Very few small employers have used similar plans in the 43 states where they were included as “basic” plans in small-group market reforms of the 1990s. In the individual market, slightly more (but still few) choose such plans. In New Jersey, for example, no more than 0.03 percent of small employers use low-benefit plans, but such plans accounted for 4.2 percent of individual sales until the state terminated their use in the individual market.²³ With tax credits, surely more would buy such insurance. Based on this history, however, only a small proportion would likely find the coverage sufficiently valuable to pay even 40 percent of premiums.²⁴

As noted above, some young, healthy workers could use credits to buy the intermediate plan, particularly if a fixed, \$1,000 tax credit rather than a 60 percent credit were used. Intermediate coverage, however, is not simply a more efficient version of the more comprehensive benefits that employers typically offer. Intermediate plans have premiums in reach of some uninsured only because of some combination of high deductibles, stiff co-payments, and benefit limits or exclusions. We do not know how many would supplement credits to buy such “lean” coverage and how

many young, healthy workers instead would simply remain uninsured, hoping to stay healthy but requiring charity care if major health problems develop before employment and coverage are regained.

Table 2: Single coverage for healthy female, age 35: low-price plans, intermediate plans, and average employer insurance

	Low-price, limited-benefit plan	Intermediate plan	Average employer coverage
Total monthly premium	\$79 in 2002	\$163 in 2002	\$250 average premium (updated to 2002 – see note to Table 1)
Deductible	\$1,000 in network; \$2,000 non-network	\$200	\$201 average in network; \$407 outside network
Hospital care	20% coinsurance, after deductible, in network; 40% coinsurance non-network	20% coinsurance, after deductible	HMOs: no copays for 78% of workers. Other plans: 68% have copays or coinsurance (usually 10-20%).
Office Visits	Not covered	Covered. 20% coinsurance, \$10 copay for annual physical	All surveyed workers covered. HMOs: \$10/visit or less for 66% of workers. PPOs: 82% have network copays or coinsurance up to \$15 or 20%; non-network, 64% have coinsurance up to 30%.
Prescription drugs (out-patient)	Not covered	Covered. 20% coinsurance, \$500 annual limit on covered drugs	98% covered. 3 cost tiers based on generics vs. named brand; \$8/15% lowest to \$20/21% highest tier
Mental health	Not covered	Covered. 20% coinsurance rises to 35% after 5 visits, 50% after 30	95% of workers covered. For 58% of enrollees, capped at 50 visits or less.
Maternity care	Not covered	Covered. 20% coinsurance.	97% covered.
Emergency room care	Not covered	Covered. No coinsurance for first \$300 of emergency services.	No exclusions noted. More specific survey information unavailable.
Annual caps on patient copays	\$3,000 in network; \$9,000 non-network	\$2,000	\$1,578 average
Lifetime benefits cap	\$3 million	\$1 million	\$1.1 million

Sources: same as Table 1, plus, for annual and lifetime caps, hospital care and percentage of workers with coverage of office visits, Department of Labor survey of 1997 benefits at medium to large firms, and, for non-network costs of the low-price plan, www.healthcareshopper.com.

Looking ahead

For many laid-off workers at comparatively higher income levels among the unemployed, the 60 percent tax credit would provide affordable access to fairly comprehensive coverage. Nevertheless, in its current form, the 60 percent credit may not yield substantial benefits for most laid-off

workers with fewer resources, including both the healthy and those with health risks.

A revised tax credit policy could help lower-income and higher-risk workers buy broad health coverage, building on positive elements in current proposals. For example, some have suggested that credits could be made usable in large-group settings beyond COBRA, such as the Federal Employees Health Benefits Program and state Medicaid and SCHIP programs. Likewise, the size of the credit could be increased significantly for beneficiaries with fewer resources. Of course, such changes must be designed carefully to remain within federal budgetary constraints and to avoid creating other major problems, such as risks to existing systems of coverage, work disincentives, and serious administrative complexities. A forthcoming paper in the *Covering America* series will address these and related issues.

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Notes

¹ Displaced workers' gains from this proposal would be affected by numerous other factors, including variations in state laws regulating the individual market and high-risk pools, defining Medicaid and SCHIP coverage, establishing COBRA-like requirements for very small firms, etc.

² Such other issues include eligibility for tax credits, work disincentives, risks to coverage from employers and state Medicaid and SCHIP programs, barriers to acceptance of advanceable tax credits, structuring credits to provide more assistance for laid-off workers with low incomes, and outreach.

³ Stephen Zuckerman, Jennifer Haley and Michael Fragale. *Could Subsidizing COBRA Health Insurance Coverage Help Most Low-Income Unemployed?* Urban Institute, Oct. 17, 2001.

⁴ Ed Neuschler and Lynn Taylor. *Covering Displaced Workers and Their Children: Issues and Alternatives*. Institute for Health Policy Solutions, January 2002, citing unpublished 1997 study by Jacob A. Klerman of Rand. Some low-income workers losing employment involuntarily are denied unemployment insurance (UI) for many reasons: low-wage workers are less likely to meet UI's minimum earnings requirements; most states do not use current earnings to determine eligibility, thereby denying UI to some workers who recently transitioned into employment; most states deny UI to people seek-

ing part-time work; etc. General Accounting Office. *Unemployment Insurance: Role as Safety Net for Low-Wage Workers is Limited*. (GAO-01-181 December 29, 2000).

⁵This figure is based on January 2002 claims. Department of Labor. *Claims Summary Data for State Program, Jan. 2002*.

⁶ Council of Economic Advisers. *Health Insurance Tax Credits*. February 13, 2002.

⁷ For a listing of plans in the individual market, we used www.ehealthinsurance.com, which claims to be the internet's most frequently used site for purchasing health coverage.

⁸ Premium costs for PPOs like those in the CEA survey (i.e., with \$1,000 deductibles, 20% coinsurance, and coverage for office visits and E.R. care) were below the national average for four of the six categories CEA surveyed. Chevy Chase premiums were 11% below the national average for families of four, 9% below for young men, 17% below for young couples, and 18% below for single mothers with children. PPO premiums were 22% above the national average for older men and 3% above for older couples; surprisingly, premiums for indemnity insurance offering comparable coverage were 40% and 35% below the national averages, respectively, found by CEA for PPO coverage. Source: www.ehealthinsurance.com, analysis by ESRI (March 11, 2002).

⁹ House-passed proposals would provide grants that states could use to supplement federal tax credits for low-income, laid-off workers. However, existing health care stakeholders could persuade state officials to use such grants for other purposes, such as ameliorating proposed state-level health care cutbacks.

¹⁰ Leighton Ku and Teresa A. Coughlin. *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*. Urban Institute, March 1997. Our forthcoming paper will discuss both this and other varied studies of the relationship between worker premium costs and subsidy acceptance.

¹¹ Congressional Budget Office. *Options to Expand Federal Health, Retirement, and Education Activities*. June 2000.

¹² The numbers in the text and Figure 1 assume year 2001 health insurance costs, to allow a fair comparison of worker costs while employed and with credits after layoffs. Table 1 estimates costs in 2002, incorporating current information about coverage in the individual market.

¹³ A small number of states regulate the individual market to prevent such outcomes.

¹⁴To offer more affordable coverage for individuals with health risk factors, House-passed proposals would provide \$100 million over two years to support state high-risk pools. While a useful, positive step, such support may not be enough to overcome these deeply entrenched problems of the individual market. Some states could have difficulty providing the 50% matching funds required for these new federal grants. More fundamentally, plans available through high-risk pools share many of the weaknesses of the individual market, including much higher premiums for demographic factors like age, excluded or sharply limited maternity care and mental health benefits, high deductibles and coinsurance, high premiums, etc. Even though such pools began in the 1970s, only 105,000 people use them in the 29 states where they operate, and nearly half the enrollees live in California and Minnesota. It is not clear what interventions and level of support would assure such pools' future success. See Lori Achman and Deborah Chollet, Mathematica. *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*. The Commonwealth Fund, August 2001.

¹⁵ For results from a broader survey, see Karen Pollitz, Richard Sorian, and Kathy Thomas. *How accessible is individual health insurance for consumers in less-than-perfect health?* Kaiser Family Foundation, June 2001.

¹⁶ These provisions would extend HIPAA “group-to-individual” conversion requirements to tax credit recipients with 12 months of prior group insurance who did not exhaust coverage under COBRA or state mini-COBRA laws. However, more than half the states meet these HIPAA requirements with high-risk pools or other HIPAA options that effectively exempt many individual insurers from conversion mandates. Atlantic Information Services. *State Implementation of HIPAA Group-to-Individual Portability Provisions*. In other states, an insurer can deny coverage through requested plans if the insurer offers two other plans that meet federal requirements. 45 CFR Part 148.

¹⁷ Some suggest that the individual market could respond to new business by expanding available options. Others maintain, however, that insurers in the individual market would avoid laid-off workers with tax credits, since adverse selection may occur and short-term coverage pending re-employment may not allow sufficient profits, given the relatively fixed per capita costs of medical underwriting and broker commissions.

¹⁸ Mark V. Pauly and John S. Hoff. *Responsible Tax Credits for Health Insurance*. American Enterprise Institute, 2002. Pauly and Hoff also note that proportional tax credits could have the unfortunate side effect of giving larger credits to people who paid high premiums because they were unwilling to

search for lower-priced plans or were excessively eager to buy the most comprehensive coverage available. They also observe that a tax credit could be structured to combine both proportional and fixed-dollar features.

¹⁹ For individuals with monthly premiums below \$139, \$1,000 credits provide greater subsidies. Above \$139, 60% credits help more. For family coverage, \$417 a month is the premium cost below which fixed \$3,000 credits do better than 60% credits.

²⁰ Michelle M. Doty and Cathy Schoen. *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility*. The Commonwealth Fund, December 2001.

²¹ Of course, in the individual market, credits could purchase coverage similar to employer-sponsored insurance. But premiums could increase dramatically even for the healthy, administrative costs would more than double compared to insurance offered by larger companies, and coverage may be unavailable or unaffordable for high-risk beneficiaries.

²² For example, see Institute of Medicine. *Coverage Matters: Insurance and Health Care*. 2001. Pp 28-32.

²³ *Report of the Task Force on Affordability and Accessibility of Health Care in New Jersey*. New Jersey Department of Health and Senior Services, January 2001.

²⁴ Unlike these earlier reforms, coverage for laid-off workers would be temporary. Some with assets to shield from catastrophic medical costs could find “bare bones” coverage worthwhile for brief periods pending re-employment.

Appendix: Single coverage costing under \$135 a month for a healthy, non-smoking woman, age 35, in Chevy Chase, Maryland

Monthly premium and plan type	Deductible	Copays and coinsurance	Annual cap on patient costs	Lifetime benefit cap	Other features
\$36 – Indemnity	\$10,000	20% coinsurance	\$10,000	\$1 million	\$500 limit on prescr. drug benefits. Mental health coinsurance rises to 35% after 5 visits, 50% after 30 visits. Rehab care excluded.
\$52 – PPO	Network: \$5,000 Non-network: \$10,000	Network: 20% Non-network: 40%	Network: \$7,000 Non-network: \$17,000	\$3 million	No coverage of office visits, outpatient prescription drugs, emergency room visits, mental health, most outpatient lab tests, well-baby care (unless mandated by state law), maternity care, rehab care.
\$55 – Indemnity	\$5,000	20% coinsurance	\$6,000	\$1 million	\$500 limit on prescr. drug benefits. Mental health coinsurance rises to 35% after 5 visits, 50% after 30 visits. Rehab care excluded.
\$60 – PPO	Network: \$2,500 Non-network: \$5,000	Network: 20% Non-network: 40%	Network: \$4,500 Non-network: \$12,000	\$3 million	No coverage of office visits, outpatient prescription drugs, emergency room visits, mental health, most outpatient lab tests, well-baby care (unless mandated by state law), maternity care, rehab care.
\$72 – Indemnity	\$2,500	20% coinsurance	\$4,000	\$1 million	\$500 limit on prescr. drug benefits. Mental health coinsurance rises to 35% after 5 visits, 50% after 30 visits. Rehab care excluded.
\$79 – PPO	Network: \$1,000 Non-network: \$2,000	Network: 20% Non-network: 40%	Network: \$3,000 Non-network: \$9,000	\$3 million	No coverage of office visits, outpatient prescription drugs, emergency room visits, mental health, most outpatient lab tests, well-baby care (unless mandated by state law), maternity care, rehab care.
\$87 – Indemnity	\$1,000	20%	\$2,500	\$1 million	\$500 limit on prescr. drug benefits. No coinsurance for first \$300 of emergency care costs. Mental health coinsurance rises to 35% after 5 visits, 50% after 30 visits. Rehab care excluded.

Monthly premium and plan type	Deductible	Copays and coinsurance	Annual cap on patient costs	Lifetime benefit cap	Other features
\$88 – Indemnity	\$800	25%	\$2,000	\$1 million	\$500 limit on prescr. drug benefits. No coinsurance for first \$300 of emergency care costs. Mental health coinsurance rises to 35% after 5 visits, 50% after 30 visits. Rehab care excluded.
\$98 – Indemnity	\$1,000	20% coinsurance	\$3,000	\$3 million	No coverage of office visits, outpatient prescription drugs, emergency room visits, mental health, most outpatient lab tests, well-baby care (unless mandated by state law), maternity care, rehab care.
\$104 – MSA	\$1,650	Network: 0 after deductible Non-network: 25%	Network: \$1,650 Non-network: \$6,650	\$3 million	Extra \$100 deductible per emergency visit not resulting in hospitalization. Mental health: caps per visit on payment of \$50 in-network and \$37.50 non-network; \$3,000 lifetime limit on all mental health benefits. Adult preventive care uncovered during first year; subsequent \$150 annual limit after deductible. \$2,000 annual limit on back/spine treatment. No well-baby care (unless mandated by state law), maternity care, rehab care.
\$104 – PPO	Network: \$1,500 Non-network: \$3,000	Network: 0 after deductible Non-network: 25%	Network: \$1,500 Non-network: \$8,000	\$3 million	Extra \$100 deductible per emergency visit not resulting in hospitalization. Mental health: caps per visit on payment of \$50 in-network and \$37.50 non-network; \$3,000 lifetime limit on all mental health benefits. Adult preventive care uncovered during first year; subsequent \$150 annual limit after deductible. \$2,000 annual limit on back/spine treatment. No well-baby care (unless mandated by state law), maternity care, rehab care.
\$106 – PPO	Network: \$750 Non-network: \$1,500	Network: 50% Non-network: 62.5% \$35/visit copay for network office visits	Network: \$5,750 Non-network: \$11,500	\$3 million	Prescr. drugs: extra \$100 deductible; copays for generic, brand name, non-formulary of \$25, \$35, 62.5%. \$1,000 copay for hospital care. Extra \$100 deductible per emergency visit not resulting in hospitalization. Mental health: 50% coinsurance in-network, 62.5% non-network, with caps per visit on payment of \$50 in-network and \$37.50 non-network; \$3,000 lifetime limit on all mental health benefits. Adult preventive care uncovered during first year; subsequent \$150 annual limit, w/\$35 copays. \$2,000 annual limit on back/spine treatment. No well-baby care (unless mandated by state law), maternity care, rehab care.
\$110 – PPO	Network: \$500 Non-network: \$1,000	Network: 20% Non-network: 40%	Network: \$2,500 Non-network: \$8,000	\$3 million	No coverage of office visits, outpatient prescription drugs, emergency room visits, mental health, most outpatient lab tests, well-baby care (unless mandated by state law), maternity care, rehab care.
\$112 - Indemnity	\$400	25%	\$2,000	\$1 million	\$500 limit on prescr. drug benefits. No coinsurance for first \$300 of emergency care costs. Mental health coinsurance rises to 35% after 5 visits, 50% after 30 visits. Rehab care excluded.
\$116 – PPO	Network: \$1,000 Non-network: \$2,000	Network: 20% Non-network: 40%	Network: \$2,000 Non-network: \$8,000	\$3 million	Extra \$100 ded. for ER visit not resulting in hospitalization. Mental health: payment caps per visit of \$50 in-network and \$37.50 non-network; \$3,000 lifetime limit on mental health care. Adult preventive care uncovered during first year, then \$150 annual limit. \$2,000 annual limit on back/spine treatment. No well-baby care (unless mandated by state law), maternity care, rehab.

Monthly premium and plan type	Deductible	Copays and coinsurance	Annual cap on patient costs	Lifetime benefit cap	Other features
\$129 – PPO	Network: \$500 Non-network: \$1,000	Network: 50% Non-network: 62.5% \$35/visit co-pay for network office visits	Network: \$5,500 Non-network: \$11,000	\$3 million	Presc. drugs: extra \$100 deductible; copays for generic, brand name, non-formulary of \$25, \$35, 62.5%. \$1,000 copay for hospital care. Extra \$100 deductible per emergency visit not resulting in hospitalization. Mental health: 50% coinsurance in-network, 62.5% non-network, with caps per visit in payment of \$50 in-network and \$37.50 non-network; \$3,000 lifetime limit on all mental health benefits. Adult preventive care uncovered during first year; subsequent \$150 annual limit, w/\$35 copays. \$2,000 annual limit on back/spine treatment. No well-baby care (unless mandated by state law), maternity care, rehab care.
\$130 - Indemnity	\$500	20%	\$2,000	\$1 million	\$500 limit on presc. drug benefits. No coinsurance for first \$300 of emergency care costs. Mental health coinsurance rises to 35% after 5 visits, 50% after 30 visits. Rehab care excluded.
\$131 – PPO	Network: \$750 Non-network: \$1,500	Network: 20% Non-network: 40% \$35/visit co-pay for network office visits	Network: \$2,750 Non-network: \$8,500	\$3 million	Presc. drugs: extra \$100 deductible; copays for generic, brand name, non-formulary of \$25, \$35, 62.5%. \$1,000 copay for hospital care. Extra \$100 deductible per emergency visit not resulting in hospitalization. Mental health: caps per visit in payment of \$50 in-network and \$37.50 non-network; \$3,000 lifetime limit on all mental health benefits. Adult preventive care uncovered during first year; subsequent \$150 annual limit, w/\$35 copays. \$2,000 annual limit on back/spine treatment. No well-baby care (unless mandated by state law), maternity care, rehab care.
\$133 – PPO	Network: \$1,000 Non-network: \$2,000	Network: 0 after deductible Non-network: 25%	Network: \$1,000 Non-network: \$7,000	\$3 million	Extra \$100 deductible per emergency visit not resulting in hospitalization. Mental health: caps per visit on payment of \$50 in-network and \$37.50 non-network; \$3,000 lifetime limit on all mental health benefits. Adult preventive care uncovered during first year; subsequent \$150 annual limit after deductible. \$2,000 annual limit on back/spine treatment. No well-baby care (unless mandated by state law), maternity care, rehab care.

Sources: www.ehealthinsurance.com (listings 2/21/02, 3/11/02); www.healthcareshopper.com; www.carefirst.com.

Note: In addition to the above plans, ehealthinsurance.com makes available short-term plans not covered by HIPAA. Such plans exclude preexisting conditions treated or diagnosed within the past 5 years, mental health, adult preventive care, well-child care, and maternity care (except for complications of pregnancy). Coverage is available for 30-185 days. The insurer has the option to renew coverage, but renewal is not guaranteed. Renewal is not an option if any claims were submitted during the first period of coverage, the insured has experienced a significant change in health status, or the total covered period would exceed 365 days.

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