Issue Brief

Bare-Bones Health Plans: Are They Worth the Money?

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Health insurance premiums rise with the generosity of the benefit package. Both public and private sector policymakers are interested in making less-costly health insurance available by offering a bare-bones benefit package. This analysis develops several alternative insurance policies that would cost 30 percent less than a current basic benefit plan and examines the implications of these policies for purchasers. Although stripped-down policies are meant to make insurance more affordable for low-income consumers, they do so only with enormous risks.

Standard Benefits

Our starting point was a basic benefit plan currently available in the employer market. We selected as our benchmark plan the out-of-network coverage package offered to federal employees insured under the Blue Cross/Blue Shield standard option plan. In addition to the usual medical coverage, this plan incorporates comparable mental health coverage, pharmaceutical coverage, a deductible of $200 for an individual, 25 percent coinsurance, and a $3,750 out-of-pocket maximum. We assumed that the plan includes the average level of utilization management in the market today.

We estimated that for an average uninsured individual, the benefits paid under this plan would cost $1,610 (see the methodology section at the end of this brief). If this plan were purchased in the individual market, the price would reflect these benefits and an estimated administrative cost of 28.8 percent, yielding a premium of $2,073. The cost of a policy 30 percent less than this price would be $1,450 in the individual market.

Generating Savings

A bare-bones health insurance policy reduces premiums in two ways. First, some benefit costs would be shifted to the consumer. For example, if pharmacy coverage were dropped, the consumer would have to purchase his or her medicine out-of-pocket. Second, some costs would be avoided altogether because a consumer faced

with higher costs for care would choose to forgo some use of health care services.

Our interest was to determine what modifications would be needed to achieve 30 percent cost savings by a combination of cost-shifting and cost-avoidance. We used a standard actuarial method (induction) to calculate cost-avoidance, which estimates that a consumer who pays 25 percent of the cost of care out-of-pocket will use 11 percent fewer services than a person not paying anything out-of-pocket.

We considered four ways of narrowing benefits, and combinations of these: increasing deductibles, limiting covered hospital days, excluding coverage for prescription drugs, and excluding coverage for mental health. The following discussion describes combinations of these restrictions that generate significant savings.

Results

The most potent instrument for reducing the premium on health plans is to increase the share of expenses consumers must pay out-of-pocket (e.g., deductibles, coinsurance, and out-of-pocket maximums). To simplify the analysis, we held coinsurance and out-of-pocket maximums constant at the level of the benchmark Blue Cross/ Blue Shield plan and varied only the level of

deductibles. Without changing the benefits in the plan, a 30 percent savings from the basic plan requires a very large increase in the deductible, from $200 to $1,300.

The average uninsured individual has an annual income of $11,883. It is questionable whether, for such a person, insurance with a premium of $1,450 that only covers costs in excess of $1,300 provides any substantial benefit over no coverage at all. When benefit limitations are also placed on the plan, the deductible can be lower.

We tested several benefit limits to achieve a less drastic deductible. Adding a limit on days in the hospital had virtually no effect on premiums, because very few people spend more than 30 days in the hospital. Completely excluding mental health benefits generated some savings, but left the deductible fairly high at $800. The largest savings came from exclusion of prescription drugs. Excluding drug coverage brought the deductible down to $325, just $50 more than the benchmark level. Table 1 displays the deductibles required under different benefit restriction combinations.

We next examined the effects of these alternative benefit packages on the risk faced by newly insured individuals. Table 2 shows the distribution of expenses under each of the alternative benefit packages under consideration. Under

Table 1. Benefit Limits that Reduce Individual Premiums by 30 Percent Relative to Blue Cross/Blue Shield Standard Option (all figures are for individual policies)

Plan	Deductible	Premium
A. Blue Cross/Blue Shield Standard Option	$ 200	$2,073
Benefit Packages that Generate 30 Percent Savings		
Higher deductible and		
B. No other limits[a]	1,300	1,450
C. 30 hospital day limit[b]	1,300	1,450
D. Exclude mental health	800	1,450
E. Exclude prescription drugs	325	1,450
F. Exclude mental health, prescription drugs	25	1,450
G. Exclude mental health, prescription drugs, limit hospital days to 30[c]	25	1,450

[a] Pharmaceutical benefits covered with no copayment but subject to deductible.

[b] Insignificant premium reduction compared with prior plan.

[c] Insignificant premium reduction compared with prior plan.

the Blue Cross/Blue Shield standard plan, the mean out-of-pocket expenditures for the population are $469. Increasing the deductibles to $1,300 increased mean out-of-pocket expenditures to $787. Nonetheless, the out-of-pocket maximum and broad coverage in this plan mean that virtually no one would face out-of-pocket costs greater than $3,750.

Limiting benefits in other ways, while it reduced deductibles, had little effect on the level of out-of-pocket expenditures for the average person. It did, however, expose a small number of people to potentially very large expenses. Under policies that place limits on hospital stays, a very few people would face out-of-pocket expenses in excess of $100,000. Under policies that limit coverage for mental health or drugs (and reduce deductibles correspondingly), a few people would have out-of-pocket expenditures in excess of $75,000 and 2 percent to 3 percent of the population would face out-of-pocket expenses in excess of $4,500. The out-of-pocket maximum would not apply because excluded benefits are not subject to the cap.

Conclusions

To achieve a significant reduction in premiums, policies would have to include major cuts in benefits. In any of the alternative plans discussed, consumers would lose a key benefit or increase the deductible substantially, or both. Although bare-bones policies are meant to make insurance more affordable for low-income consumers, they do so only with enormous risks. Out-of-pocket costs could easily exceed 10 percent of income for low-wage people, leaving them to face catastrophic costs well in excess of their annual income.

To the extent that employers or federal policymakers move in the direction of a stripped-down benefit package, a wraparound benefit is needed to cap individual risk. In the State Children's Health Insurance Program (CHIP), for example, low-income families need not spend more than 5 percent of their annual income on their child's health care. A similar safeguard would be needed in conjunction with stripped-down policies.

It is important to keep in mind an additional risk to consumers—they may delay care or forgo preventive care in response to high out-of-pocket costs. Findings from earlier research have shown that with even minimal cost-sharing, low-income consumers will forgo needed primary and preventive care.[1]

Table 2. Out-of-Pocket Expenses Under Various Bare-Bones Benefit Plans

| | Insurance Package | | | | | | |
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
Premium	$2,073	$1,450	$ 1,450	$ 1,450	$ 1,450	$ 1,450	$ 1,450
Mean out-of-pocket costs	469	787	798	788	777	770	777
Median consumer spending (premium plus out-of-pocket costs)	2,315	1,841	1,840	1,841	1,808	1,645	1,644
Risk of high spending (out-of-pocket costs)							
50% of consumers pay at least	242	391	390	391	358	195	194
5% of consumers pay at least	2,079	2,902	2,893	2,957	3,205	3,507	3,497
2% of consumers pay at least	3,741	3,750	3,750	3,777	4,586	5,478	5,487
1% of consumers pay at least	3,741	3,750	3,750	4,943	6,135	7,572	7,617
A few consumers pay	3,741	3,750	119,108	76,615	78,058	77,976	122,446

METHODOLOGY

Data source: The Actuarial Research Corporation model of expenditures is calibrated to the Centers for Medicare & Medicaid Services National Health Accounts for 2001. The universe used for these calculations principally includes those people under age 65 who had nonemployer-sponsored (individual) private health insurance at some time during the year. Expenditure patterns for people with employer-sponsored coverage as well as for the entire private insurance (under 65) market also were examined to obtain consistent estimates with sufficient data, although covered expenses were benchmarked to our assumed levels for individual insurance.

Modeling: We applied plan specifications to individual annual utilization and expenditures data to estimate the effects of enrolling in each type of plan. For each plan, we estimated for each (weighted) person in the population an amount paid by the plan, an amount paid out-of-pocket by the person for covered services, and an amount paid out-of-pocket by the person for services not covered by the plan (including those beyond a plan's limit). We included regular hospital care, physician services (office-based separate from all other), prescription drugs, inpatient and outpatient mental health care, and other professional (outpatient) services. Nonmedical services such as dental and vision care were not evaluated.

We modeled consumer response to a change in insurance plan using a standard actuarial method known as the induction equation.[2] We reported results with an induction value of 0.5. This level of induction implies that a person who must pay 25 percent of the cost of a service would spend about 89 percent as much as an identical person who did not face any out-of-pocket costs for the same service. Results assuming no induction are available from the authors.

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NOTES

[1] Joseph P. Newhouse, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).

[2] In this approach, the total spending for covered services is assumed to be proportional to $1/(1 + \alpha*P)$ where α is the "induction parameter" and P is the average fraction of the cost of services paid by the consumer.