Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Health Insurance Co-Payments and Co-Insurance Assistance** (Revision Date: 5/21/15)	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:**	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition**:**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.

Service Unit Definition(s): **(RWGA only)**	1 unit of service = A payment of a premium, deductible, co-insurance, co-payment or tax liability associated with APTC reconciliation for an HIV-infected person with insurance coverage.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA meeting financial eligibility requirements and have insurance or be eligible to purchase a Qualified Health Plan through the Marketplace.
Agency Requirements:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Ensure that assistance provided to clients does not duplicate services already being provided through Ryan White Part B or State Services. The process for ensuring this requirement must be fully documented. • Have mechanisms to vigorously pursue any excess premium tax credit a client receives from the IRS upon submission of the client's tax return for those clients that receive financial assistance for eligible out of pocket costs associated with the purchase and use of Qualified Health Plans obtained through the Marketplace. • Conduct marketing with Houston area HIV service providers to inform such entities of this program and how the client referral and enrollment processes function. Marketing efforts must be documented and are subject to review. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied without notifying the Administrative Agency. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilize RWGA approved prioritization of cost sharing assistance, when limited funds warrant it. • Utilize consumer out-of-pocket methodology approved by RWGA.
Staff Requirements:	None
Special Requirements:	Agency must: • Comply with the Houston EMA/HSDA Standards of Care and Health Insurance Assistance service category program policies.

FY 2024 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/2023**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/2023**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/2023**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2023**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

Local Service Category:	**Health Insurance Premium and Cost Sharing Assistance**
Amount Available**:**	**To be determined**
Budget Requirements or Restrictions **(TRG Only)**:	Contractor must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed. ADAP dispensing fees are not allowable under this service category.
Local Service Category Definition:	**Health Insurance Premium and Cost Sharing Assistance:** The Health Insurance Premium and Cost Sharing Assistance service category is intended to help people living with HIV (PLWH) maintain continuity of medical care without gaps in health insurance coverage or disruption of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. For purposes of this service category, health insurance also includes standalone dental insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible PLWH with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental plans) within the Houston HSDA.
Services to be Provided:	Contractor may provide assistance with: • Insurance premiums, • And deductibles, co-insurance and/or co-payments.
Service Unit Definition **(TRG Only)**:	A unit of service will consist of payment of health insurance premiums, co-payments, co-insurance, deductible, or a combination.
Financial Eligibility:	Affordable Care Act (ACA) Marketplace Plans: 100-400% of federal poverty guidelines. All other insurance plans at or below 400% of federal poverty guidelines. Exception: PLWH who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.
Eligibility for Services:	People living with HIV in the Houston HSDA and have insurance or be eligible (within local financial eligibility guidelines) to purchase a

	Qualified Health Plan through the Marketplace.
Agency Requirements **(TRG Only)**:	Agency must: • Provide a comprehensive financial intake/application to determine PLWH eligibility for this program to insure that these funds are used as a last resort in order for the PLWH to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • PLWH will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied due to funding without notifying the Administrative Agency. • Conduct marketing in-services with Houston area HIV/AIDS service providers to inform them of this program and how the PLWH referral and enrollment processes function. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable PLWH of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for PLWH to physically present to Health Insurance provider.) • Utilizes the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it (premiums take precedence). o **Priority Ranking of Requests (in descending order)**: ▪ HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) ▪ Non-HIV medication co-pays and deductibles ▪ Co-payments for provider visits (eg. physician visit and/or lab copayments) ▪ Medicare Part D (Rx) premiums ▪ APTC Tax Liability ▪ Out of Network out-of-pocket expenses • Utilizes the RW Planning Council –approved consumer out-of-pocket methodology.
Special Requirements **(TRG Only)**:	Must comply with the **DSHS Health Insurance Assistance Standards of Care** and the **Houston HSDA Health Insurance Assistance Standards of Care.** Must comply with updated guidance from DSHS. Must comply with the Eastern HASA Health Insurance Assistance Policy and Procedure.

FY 2024 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/2023**
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Step in Process: **Steering Committee**		Date: **06/01/2023**
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Step in Process: **Quality Improvement Committee**		Date: **05/2023**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2023**
Recommendations:	Financial Eligibility:
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FY 2020 PERFORMANCE MEASURES HIGHLIGHTS

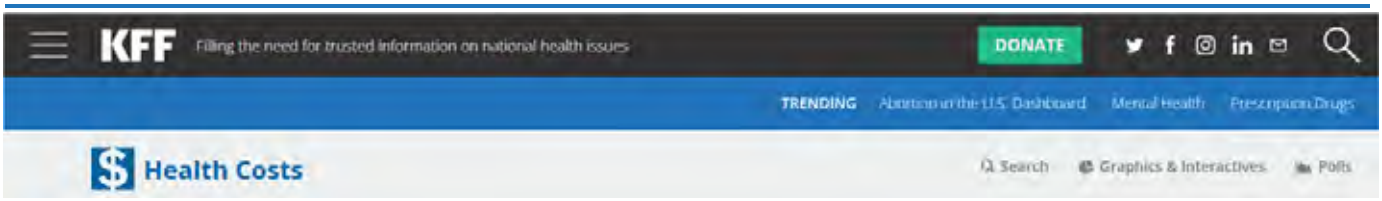
RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

Ryan White Part A
HIV Performance Measures
FY 2020 Report

Health Insurance Assistance
All Providers

HIV Performance Measures	FY 2019	FY 2020	Change
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	1,511 (80.6%)	1,367 (73.5%)	**-7.1%**



Americans' Challenges with Health Care Costs

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Published: Jul 14, 2022

For many years, KFF polling has found that the high cost of health care is a burden on U.S. families, and that health care costs factor into decisions about insurance coverage and care seeking. These costs also rank as a top financial worry. This data note summarizes recent KFF polling on the public's experiences with health care costs. Main takeaways include:

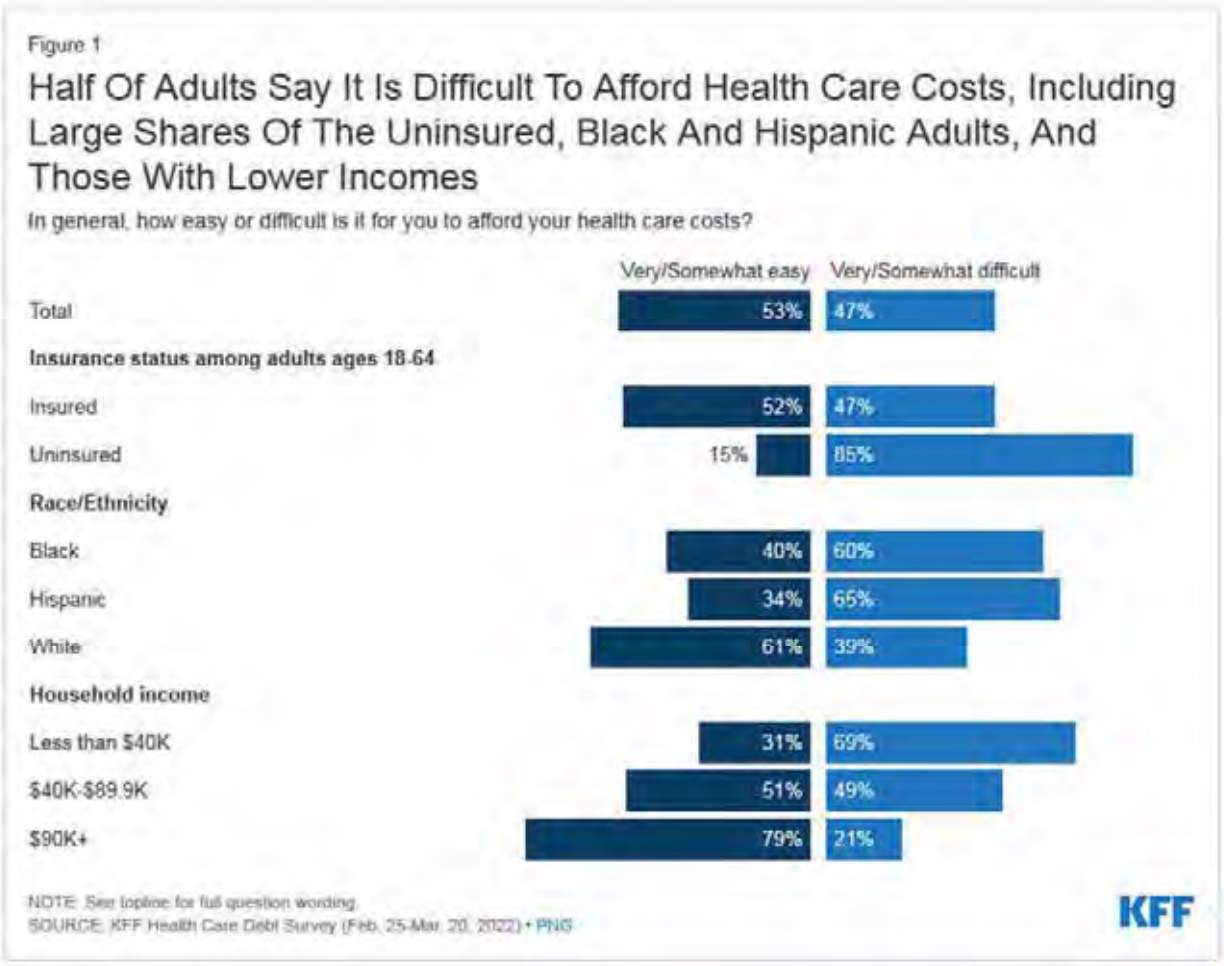
- **About half of U.S. adults say they have difficulty affording health care costs.** About four in ten U.S. adults say they have delayed or gone without medical care in the last year due to cost, with dental services being the most common type of care adults report putting off due to cost.
- **Substantial shares of adults 65 or older report difficulty paying for various aspects of health care**, especially services not generally covered by Medicare, such as hearing services, dental and prescription drug costs.
- **The cost of health care often prevents people from getting needed care or filling prescriptions.** About a quarter of adults say they or family member in their household have not filled a prescription, cut pills in half, or skipped doses of medicine in the last year because of the cost, with larger shares of those in households with lower incomes, Black and Hispanic adults, and women reporting this.
- **High health care costs disproportionately affect uninsured adults, Black and Hispanic adults, and those with lower incomes.** Larger shares of U.S. adults in each of these groups report difficulty affording various types of care and delaying or forgoing medical care due to the cost.
- **Those who are covered by health insurance are not immune to the burden of health care costs.** About one-third of insured adults worry about affording their monthly health insurance premium, and 44% worry about affording their deductible before health insurance kicks in.
- **Health care debt is a burden for a large share of Americans**. About four in ten adults (41%) report having debt due to medical or dental bills including debts owed to credit cards, collections agencies, family and friends, banks, and other lenders to pay for their health care costs, with disproportionate shares of Black

and Hispanic adults, women, parents, those with low incomes, and uninsured adults saying they have health care debt.

- **Affording gasoline and transportation costs is now a top worry for Americans followed by unexpected medical bills.** While worry over gasoline and transportation costs has risen markedly since 2020, significant shares of adults still say they are worried about affording medical costs such as unexpected bills, deductibles, and long-term care services for themselves or a family member.

Difficulty Affording Medical Costs

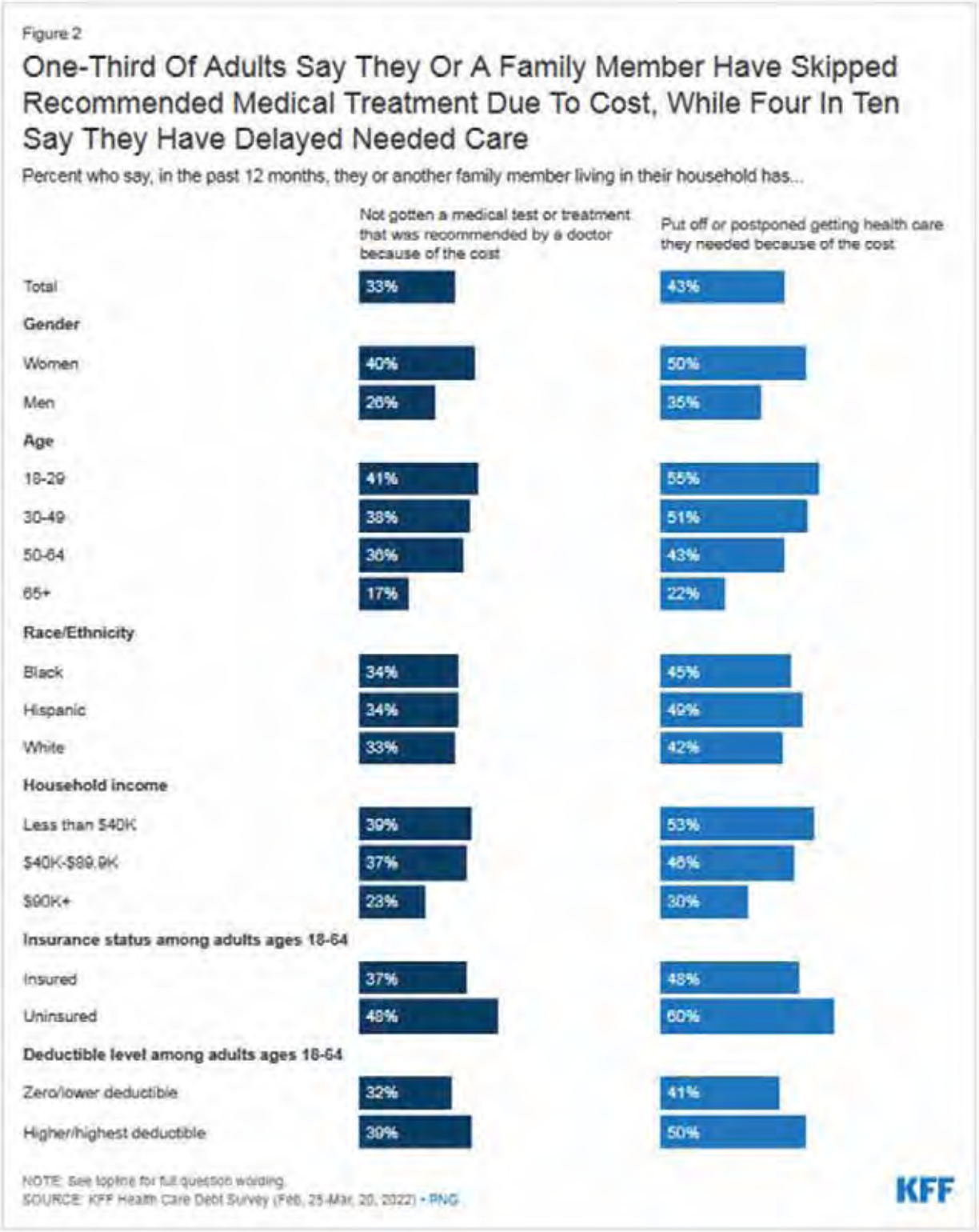
Many U.S. adults have trouble affording health care costs. While lower income and uninsured adults are the most likely to report this, those with health insurance and those with higher incomes are not immune to the high cost of medical care. About half of U.S. adults say that it is very or somewhat difficult for them to afford their health care costs (47%). Among those under age 65, uninsured adults are much more likely to say affording health care costs is difficult (85%) compared to those with health insurance coverage (47%). Additionally, at least six in ten Black adults (60%) and Hispanic adults (65%) report difficulty affording health care costs compared to about four in ten White adults (39%). Adults in households with annual incomes under $40,000 are more than three times as likely as adults in households with incomes over $90,000 to say it is difficult to afford their health care costs (69% v. 21%). (Source: KFF Health Care Debt Survey: Feb.-Mar. 2022 (https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/))



The cost of care can also lead some adults to skip or delay seeking services. One-third of adults say they or another family member living in their household has not gotten a medical test or treatment that was recommended by a doctor in the past year because of the cost, while about four in ten (43%) report that they or a family member in their household has put off or postponed needed health care due to cost. The cost of care, medical tests, and treatments can also have disproportionate impacts among different groups of people. For instance, half of women say they have put off or postponed getting health care they needed because of the cost, compared to about one-third of men (35%), four in ten women say they have not gotten a recommended medical test or treatment due to cost compared to about a quarter of men (26%). Adults ages 65 and older, who are eligible for health care coverage through Medicare, are much less likely than younger age groups to say they have not gotten a test or treatment because of cost.

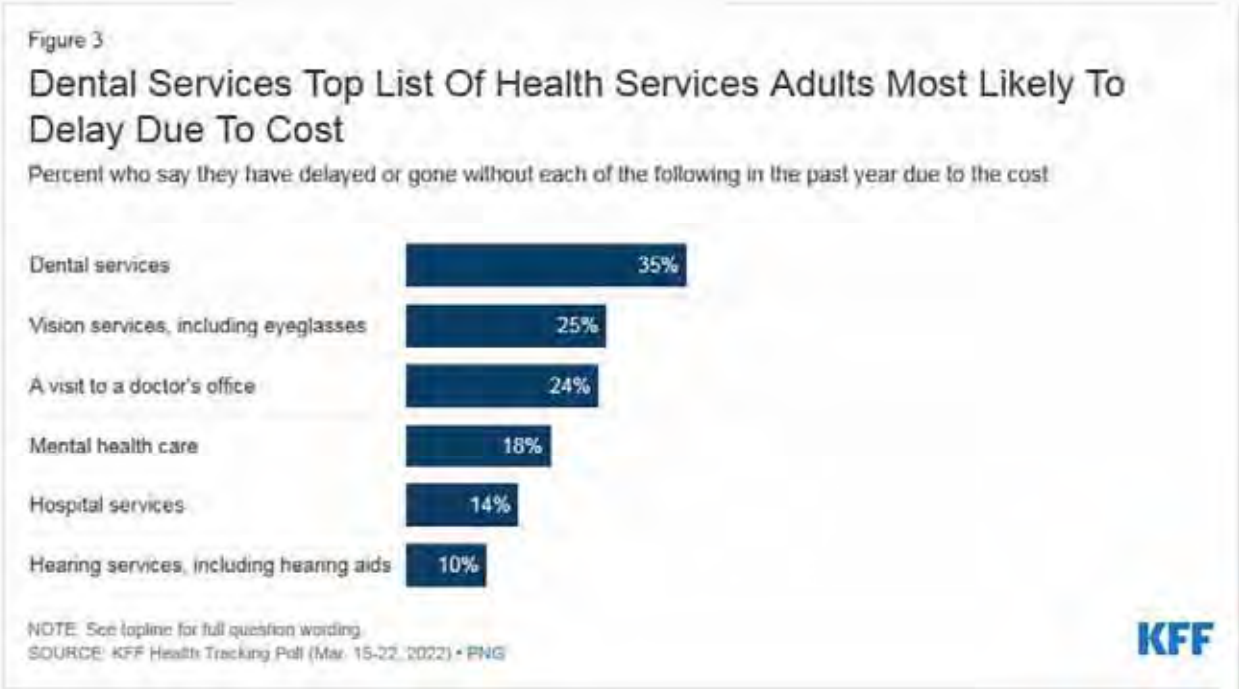
Six in ten uninsured adults under the age of 65 say they have postponed getting health care they needed due to cost compared to about half of insured adults (48%).

Similarly, uninsured adults are also more likely to report skipping recommended tests or treatment due to cost than adults with insurance. Health insurance, however, does not offer ironclad protection as more than a third of those *with* insurance (37%) still report not getting a recommended test or treatment due to cost. Among adults ages 18-64 with employer-sponsored or self-purchased health insurance, half of those with higher or highest deductible plans say they or a family member has put off getting the health care they needed due to the cost, compared to four in ten (41%) with lower or zero deductible plans. (Source: KFF Health Care Debt Survey: Feb.-Mar. 2022 (https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/))



KFF Health polling from March 2022 also looked at the specific types of care adults are most likely to report putting off and found that dental services are the most common type of medical care that people report delaying or skipping, with 35% of adults saying they have put it off in the past year due to cost. This is followed by

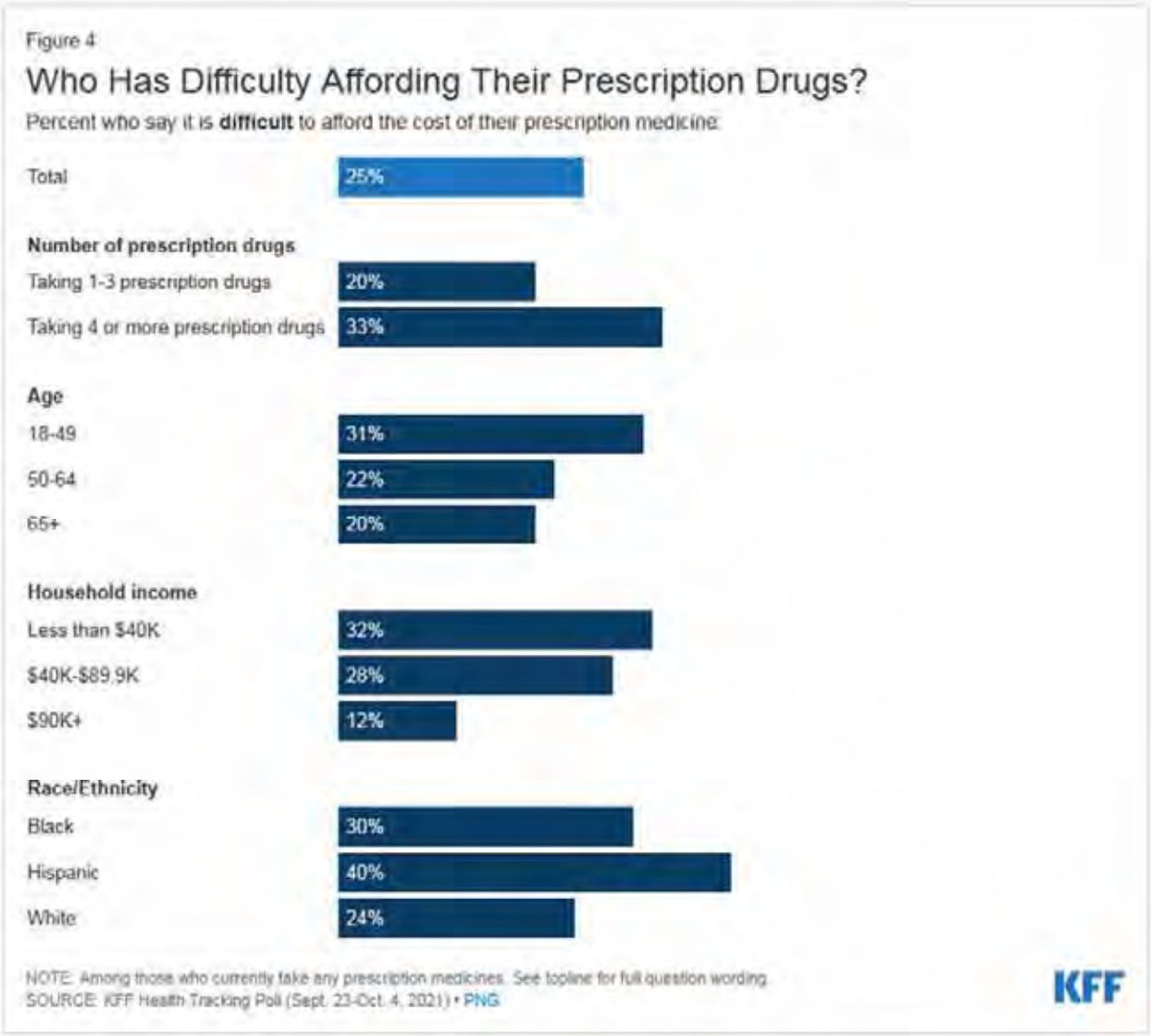
vision services (25%), visits to a doctor's offices (24%), mental health care (18%), hospital services (14%), and hearing services, including hearing aids (10%). (Source: KFF Health Tracking Poll: March 2022 (https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-march-2022/))



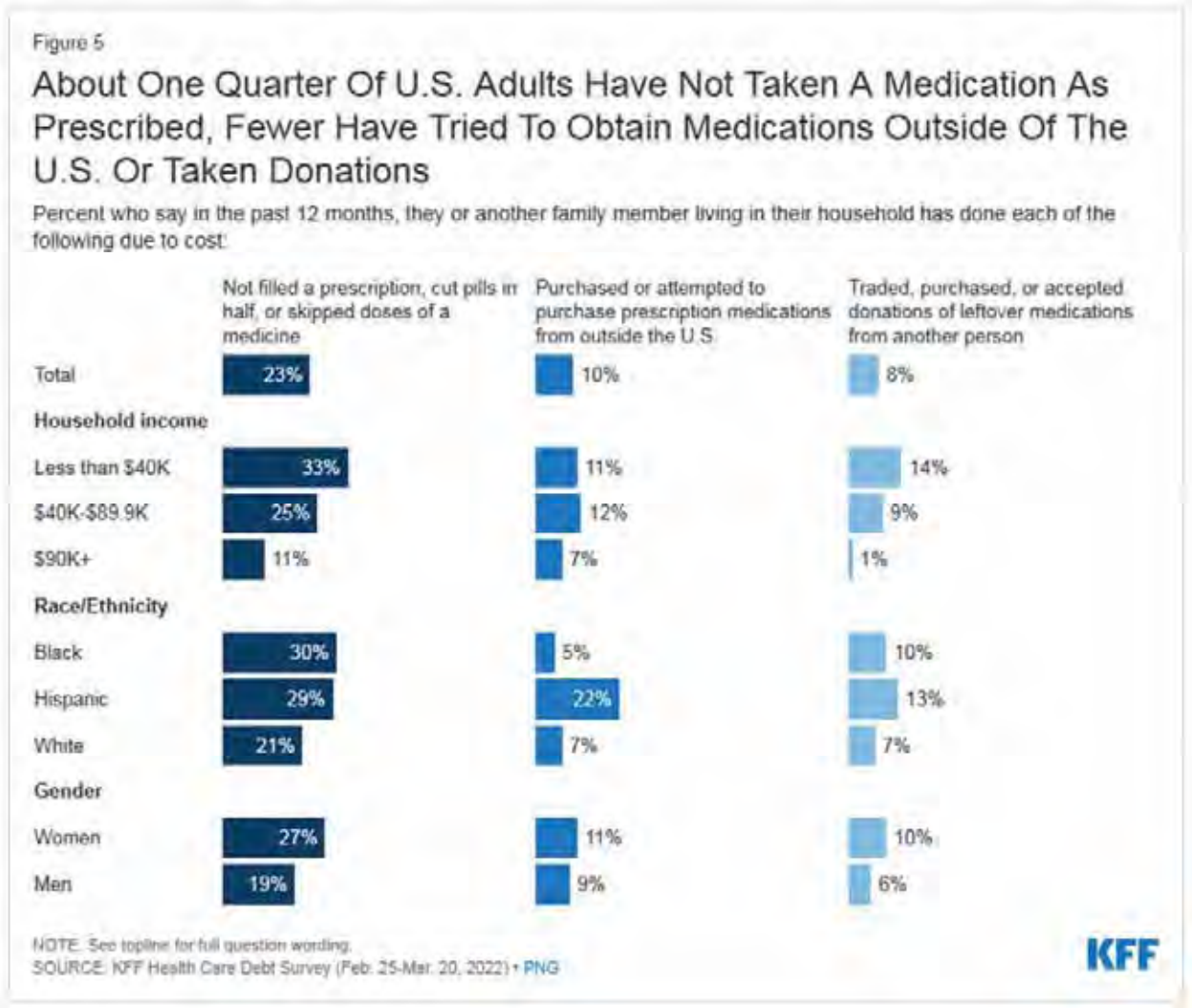
A 2022 KFF report (https://www.kff.org/health-costs/report/kff-health-care-debt-survey/) found that people who already have debt due to medical or dental care are disproportionately likely to put off or skip medical care. Half (51%) of adults currently experiencing debt due to medical or dental bills say in the past year, cost has been a probititor to getting the medical test or treatment that was recommended by a doctor. (Source: KFF Health Care Debt Survey: Feb.-Mar. 2022 (https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/))

Prescription Drug Costs

For many U.S. adults, prescription drugs are another component of their routine care. Among those currently taking prescription drugs, one in four say they have difficulty affording their cost, including about one third who take four or more prescription drugs (33%) and those in households with annual incomes under $40,000 (32%), and four in ten Hispanic adults. (Source: KFF Health Tracking Poll: October 2021 (https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-october-2021/))



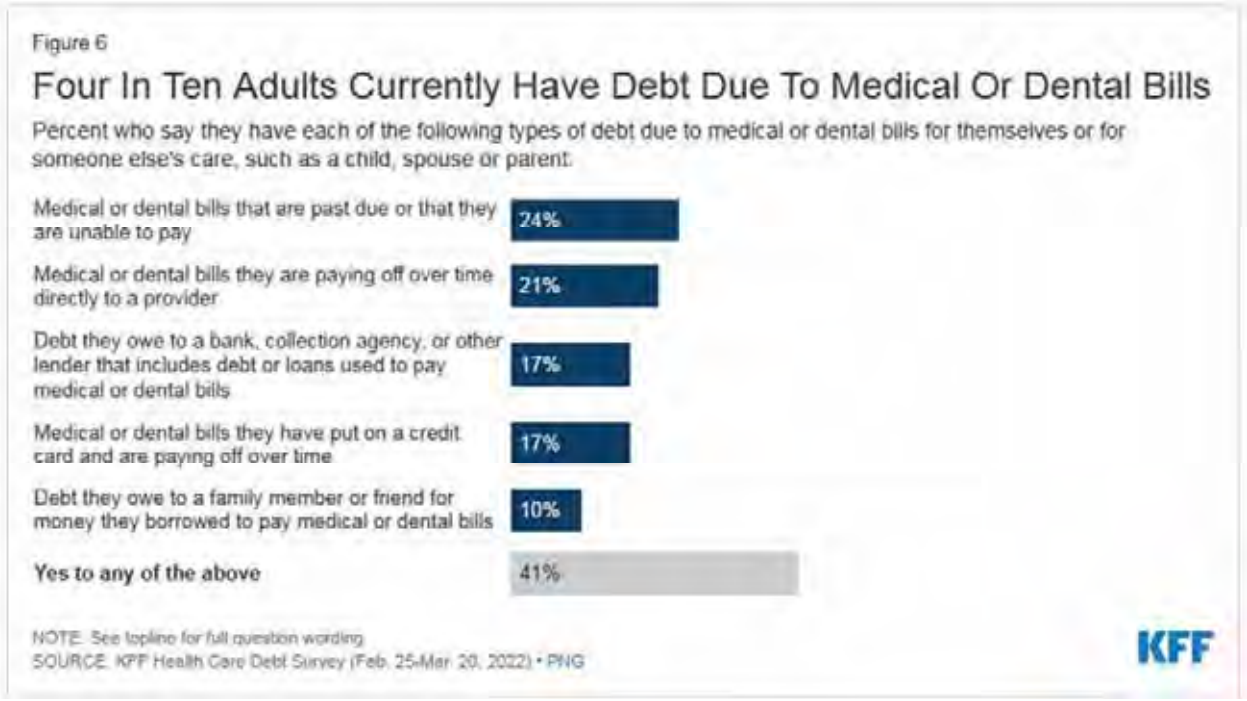
The high cost of prescription drugs also leads some people to cut back on their medications in various ways or to try to obtain medications outside of a clinical setting. About a quarter (23%) of adults say they or family member in their household have not filled a prescription, cut pills in half, or skipped doses of medicine in the last year because of the cost, with larger shares of those in households with lower incomes, Black and Hispanic adults, and women reporting this. Few adults (10% among total) across income and gender say that they or a member of their household has purchased medications outside the U.S. due to cost, though there are notable differences across race and ethnicity. About one in five (22%) Hispanic adults say they or a family member has done so. Eight percent of adults say they have traded, purchased, or accepted donations of leftover medications from another person. (Source: KFF Health Care Debt Survey: Feb.-Mar. 2022 (https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/))



Health Care Debt

In June 2022, KFF released an analysis of the KFF Health Care Debt Survey (https://www.kff.org/health-costs/report/kff-health-care-debt-survey/), a companion report to the investigative journalism project on health care debt conducted by KHN and NPR, *Diagnosis Debt*. This project found that health care debt is a wide-reaching problem in the United States and that 41% of U.S. adults currently have some type of debt due to medical or dental bills from their own or someone else's care, including about a quarter of adults (24%) who say they have medical or dental bills that are past due or that they are unable to pay, and one in five (21%) who have bills they are paying off over time directly to a provider. One in six (17%) report debt owed to a bank, collection agency, or other lender from loans taken out to pay for medical or dental bills, while similar shares say they have health care debt from bills they put on a credit card and are paying off over time (17%). One in ten report debt owed to a family member or friend from money they borrowed to pay off medical or dental bills.

While four in ten U.S. adults have some type of health care debt, disproportionate shares of lower income adults, the uninsured, Black and Hispanic adults, women, and parents report current debt due to medical or dental bills.

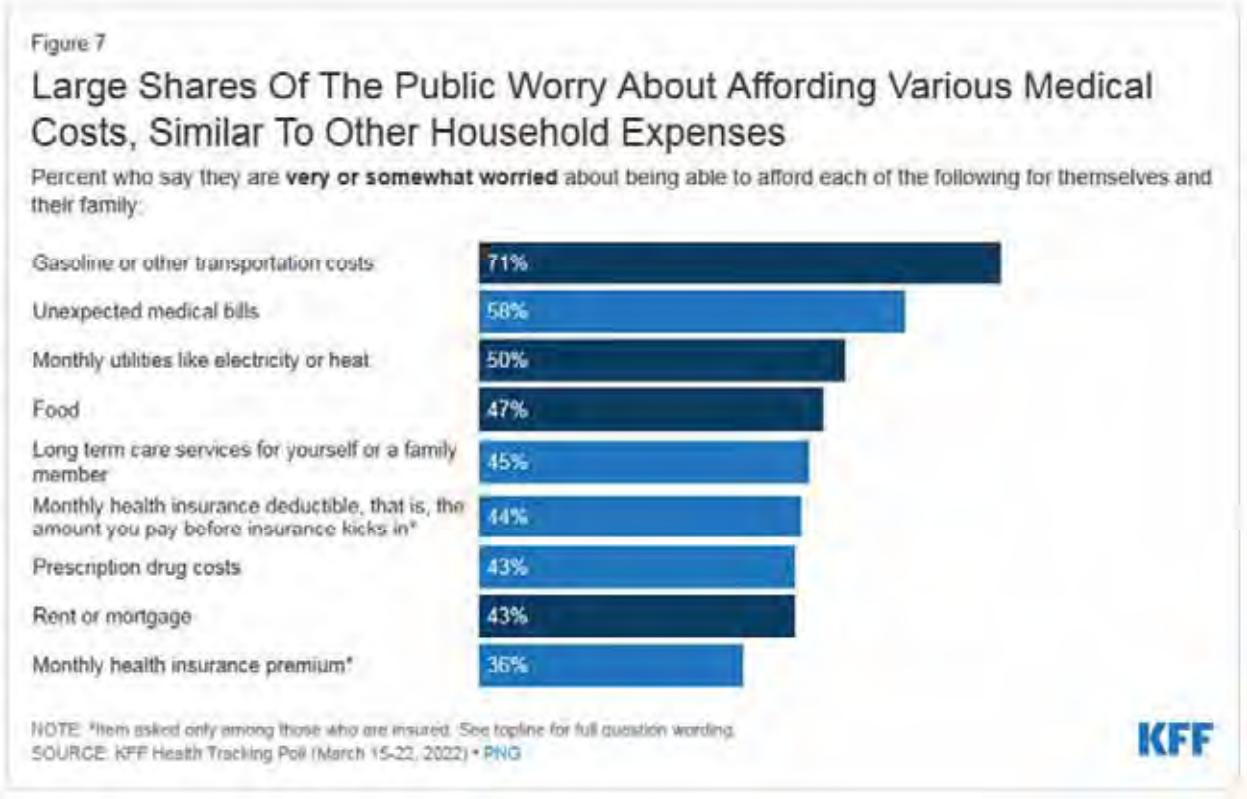


Vulnerabilities and Worries About Rising Costs

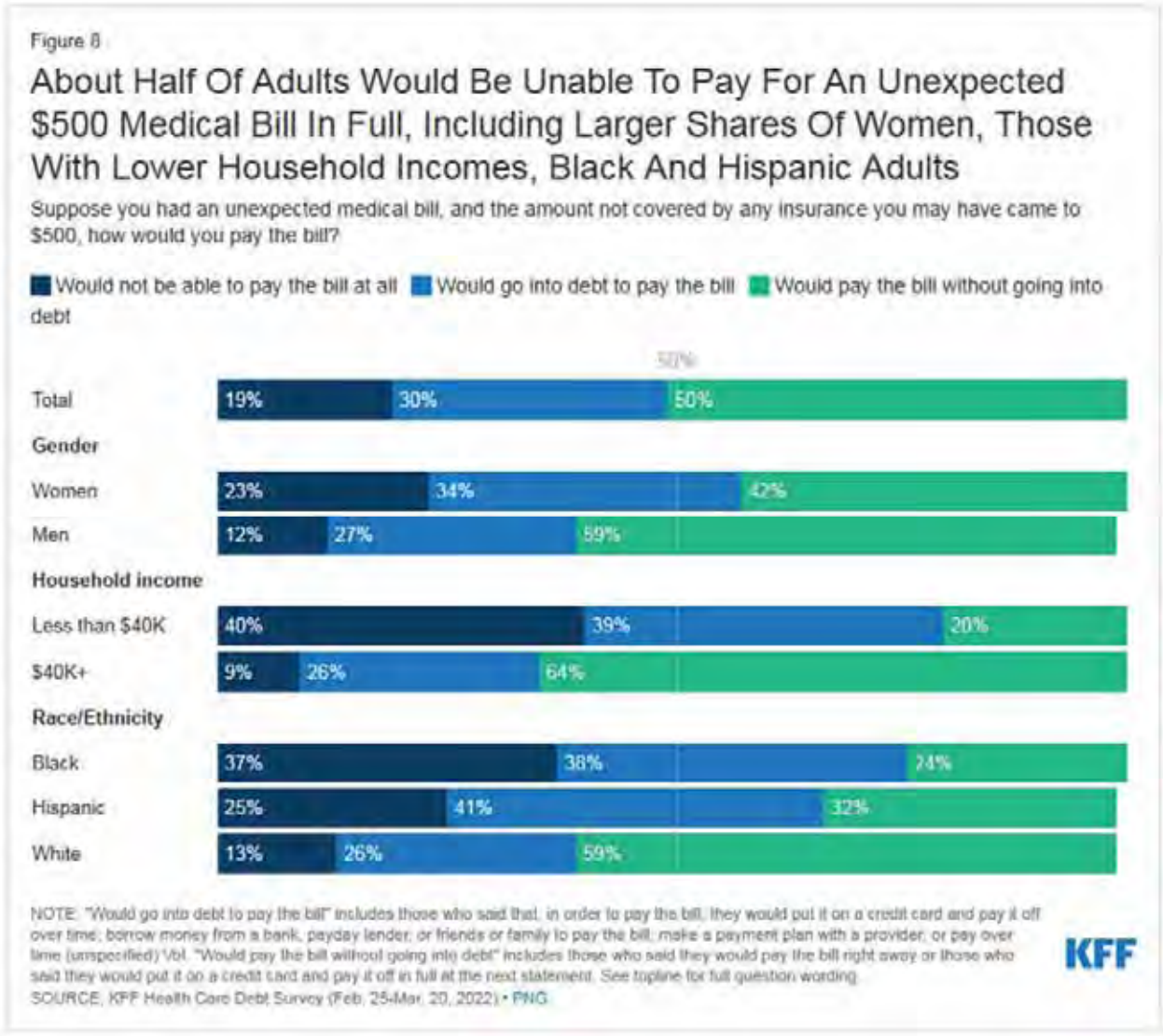
KFF polling in 2020 (https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/) found that unexpected medical bills were at the top of the list of people's financial worries, outpacing worry over affording other types of health care and basic expenses like housing, transportation, utilities, and food. More recently, inflation raised the cost of basic living expenses including, most notably, gasoline and other transportation costs. With that came increased worries about being able to afford these expenses. A March 2022 KFF Health Tracking Poll (https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-march-2022/) finds that affording gasoline or other transportation costs is now a top concern for adults in the U.S., with about seven in ten (71%) saying they are either "very worried" or "somewhat worried" about being able to afford these costs (up from 40% who said the same in February 2020). Second to gas and transportation costs, about six in ten adults report being worried about affording unexpected medical bills (58%), while half say they are worried about monthly utilities like electricity (50%). At least four in ten are worried about being able to afford food (47%), long-term care services for themselves or a family member (45%), their rent or mortgage (43%), or their prescription drug costs (43%). Those with health insurance continue to have worries about affording care, as about four in ten worry about affording their health

insurance deductible (44%) and more than one-third (36%) are worried about being able to afford their monthly health insurance premium. Those with lower household incomes are more likely to be worried about each of these things, see the full report for more details, (Source: KFF Health Tracking Poll: March 2022 (https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-march-2022/))

Affording dental, hearing, and vision care is also an issue among adults 65 and older as those benefits are not generally covered by Medicare.[1] See the October 2021 Health Tracking Poll (https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-october-2021/) for a deeper dive into health care costs and challenges among older adults.



Many U.S. adults may be one unexpected medical bill from falling into debt. About half of U.S. adults say they would not be able to pay an unexpected medical bill that came to $500 out of pocket. This includes one in five (19%) who would not be able to pay it at all, 5% who would borrow the money from a bank, payday lender, friends or family to cover the cost, and one in five (21%) who would incur credit card debt in order to pay the bill. Women, those with lower household incomes, Black and Hispanic adults are more likely than their counterparts to say they would be unable to afford this type of bill. (Source: KFF Health Care Debt Survey: Feb.-Mar. 2022 (https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/))



Endnotes

1. Freed, M., Ochieng, N., Sroczynski, N., Damico, A., Amin, K. July 28, 2021. "Medicare and Dental Coverage: A Closer Look" Available at https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/

Insurance Coverage and Viral Suppression Among People with HIV, 2018

Lindsey Dawson (https://www.kff.org/person/lindsey-dawson/) (https://twitter.com/LindseyH_Dawson)

and **Jennifer Kates** (https://www.kff.org/person/jennifer-kates/) (https://twitter.com/jenkatesdc)

Published: Sep 24, 2020

DATA NOTE

Key Findings

- Health insurance and access to care improve health outcomes, including viral suppression, for people with HIV in the United States (U.S.). Our prior research documented (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/) an increase in insurance coverage among people with HIV, after implementation of the Affordable Care Act (ACA). In this update, we find that in 2018, just 1 in 10 (11%) nonelderly people with HIV were uninsured, a rate on par with that of the general population (10%).
- While the overall rate of uninsurance is now similar for people with HIV and the population overall, there are substantial differences in the type of coverage. Medicaid plays a much more significant role for people with HIV compared to the general population (40% v. 15%), and it is their single largest source of coverage, and people with HIV are much less likely to be covered by private insurance (35% v. 56%).
- The main driver of coverage increases for people with HIV has been the ACA's expansion of the Medicaid program (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/). As with our earlier research, in 2018, we continue to find that adults with HIV in sampled expansion states are significantly more likely to be covered by Medicaid (46% v. 30%) and less likely to be uninsured (6% v. 20%), compared to those in non-expansion states sampled.
- We observed coverage differences among adults with HIV by a range of demographic indicators. For example, men with HIV were almost twice as likely to have private coverage than women. Whites were also more likely to have private coverage compared to Blacks and Hispanics, who were more than three times as likely to be uninsured. We also noted differences by income, place of birth, and sexual orientation.
- The Ryan White HIV/AIDS Program plays a major role in providing outpatient care and support services to people with HIV, regardless of insurance coverage. In 2018, almost half of all people with HIV (46%) relied on Ryan White, including more than eight in ten (82%) of those who are uninsured.

Finally, we find that sustained viral suppression rates varied by payer, and were

- higher among those with private insurance or Medicare, compared to the uninsured. Viral suppression among those with Medicaid was not significantly different from the uninsured, a finding that could reflect the equalizing role of the Ryan White Program for the uninsured and lower incomes among individuals in these coverage groups. Additionally, those with Ryan White support were significantly more likely to have sustained viral suppression compared those without, regardless of payer.

Introduction

Health insurance coverage and access to care improve health outcomes, including viral suppression, for people with HIV in the United States. Our previous work, based (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/) on analysis of nationally representative data from the Centers for Disease Control (CDC) and Prevention's Medical Monitoring Project (MMP), demonstrated that implementation of the Affordable Care Act's (ACA) 2014 coverage provisions increased insurance coverage among adults with HIV. In this analysis, using the same data source and building on recent work (https://cattendee.abstractsonline.com/meeting/9289/Presentation/2850), we provide a detailed analysis of coverage in 2018, including by state Medicaid expansion status, race/ethnicity, gender, and income. For the first time, we include data on coverage among people with HIV by place of birth and sexual orientation.

Findings

Overall Coverage Findings

Our earlier research (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/) found that prior to the ACA's major coverage reforms, approximately 18% of people with HIV were uninsured in 2012. While not directly comparable to the current dataset, the share of people with HIV without insurance was just 11% in 2018, suggesting a substantial decline in uninsurance rates among this population. Indeed, implementation of the ACA resulted in a significant increase in coverage and since that time, rates have remained stable (Fig. 1). [1] (https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/view/footnotes/#footnote-98765432-1) In 2018, Medicaid was the single largest source of insurance coverage for adults with HIV, covering 4 in 10. Private insurance was the second largest source of coverage, reaching more than one-third of the population (35%) and as noted, just 1 in 10 (11%) were uninsured (Fig. 2), on par with the general population).

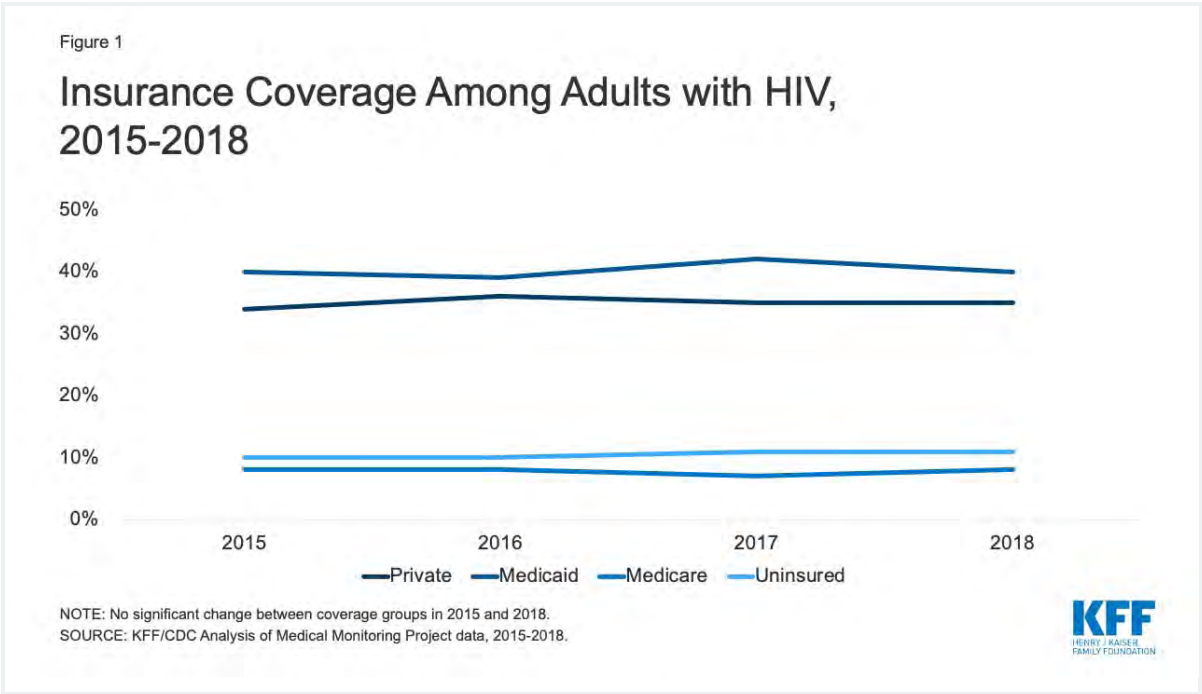


Figure 1: Insurance Coverage Among Adults with HIV, 2015-2018

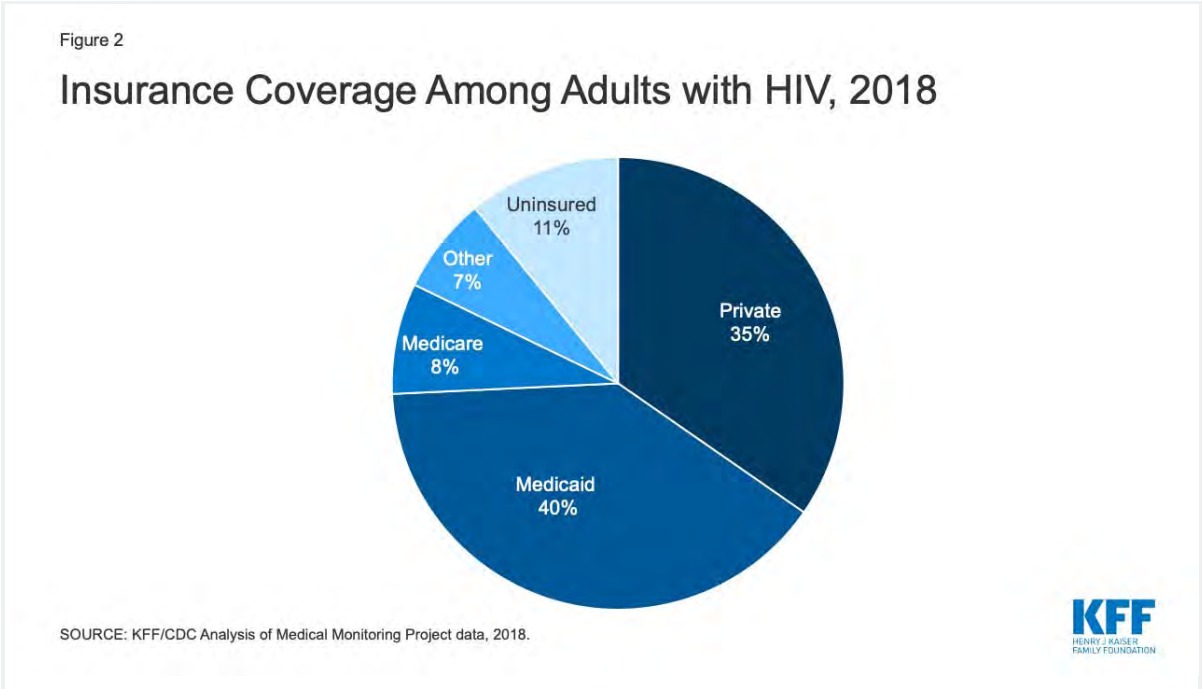


Figure 2: Insurance Coverage Among Adults with HIV, 2018

Coverage patterns among adults with HIV differ from those of the general population (Fig. 3). Medicaid plays a much larger role (40% v. 15%) and private insurance a smaller role (35% v 56%) among those with HIV compared to the general population. In addition, people with HIV are less likely to have private coverage through an employer (26% v. 49%) and more likely to have it through the individual market, including the ACA's marketplaces (7% v. 4%) (not shown). As noted above, uninsurance rates are comparable between the two populations (about 10%).

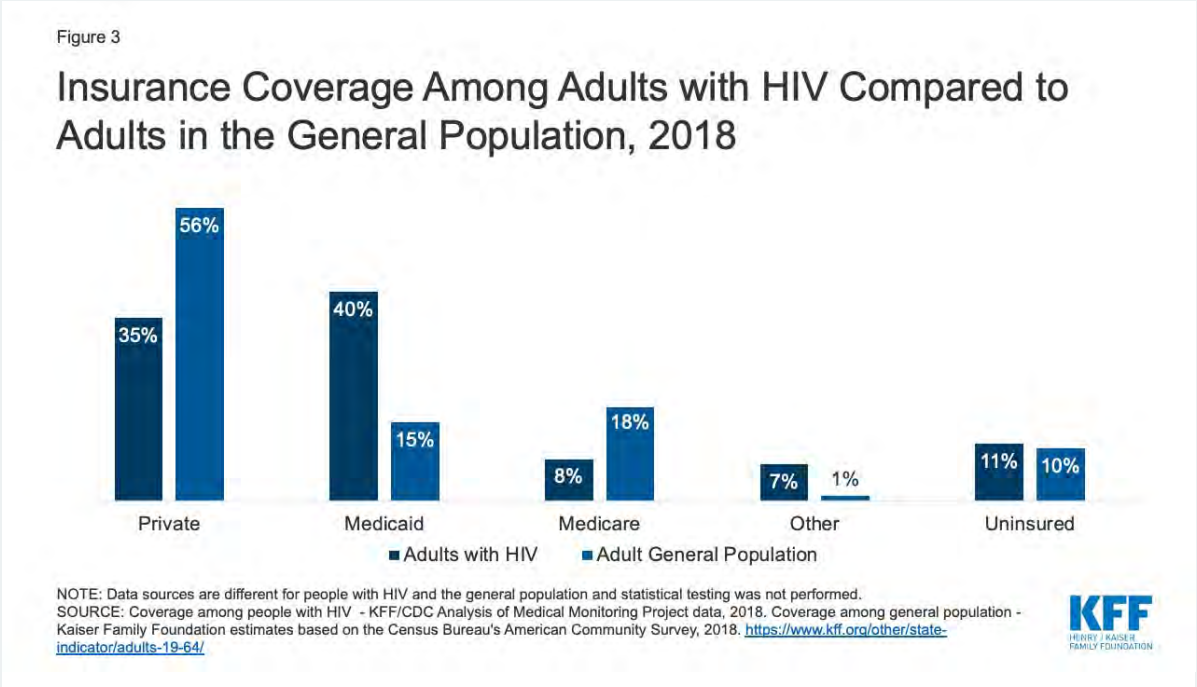


Figure 3: Insurance Coverage Among Adults with HIV Compared to Adults in the General Population, 2018

Coverage and Medicaid Expansion Status

Our earlier analysis (https://www.kff.org/health-reform/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/) found that Medicaid coverage among adults with HIV grew under the ACA and that this shift was driven by coverage gains in states that expanded their Medicaid programs. In 2018, the outsized role Medicaid plays in expansion states remains; adults with HIV in the expansion states sampled are significantly more likely to be covered by Medicaid compared to those in the sampled states that have not expanded (46% v. 30%). In addition, uninsurance rates in expansion states sampled are nearly three times lower than those in non-expansion states sampled (6% v. 20%). (Fig. 4)

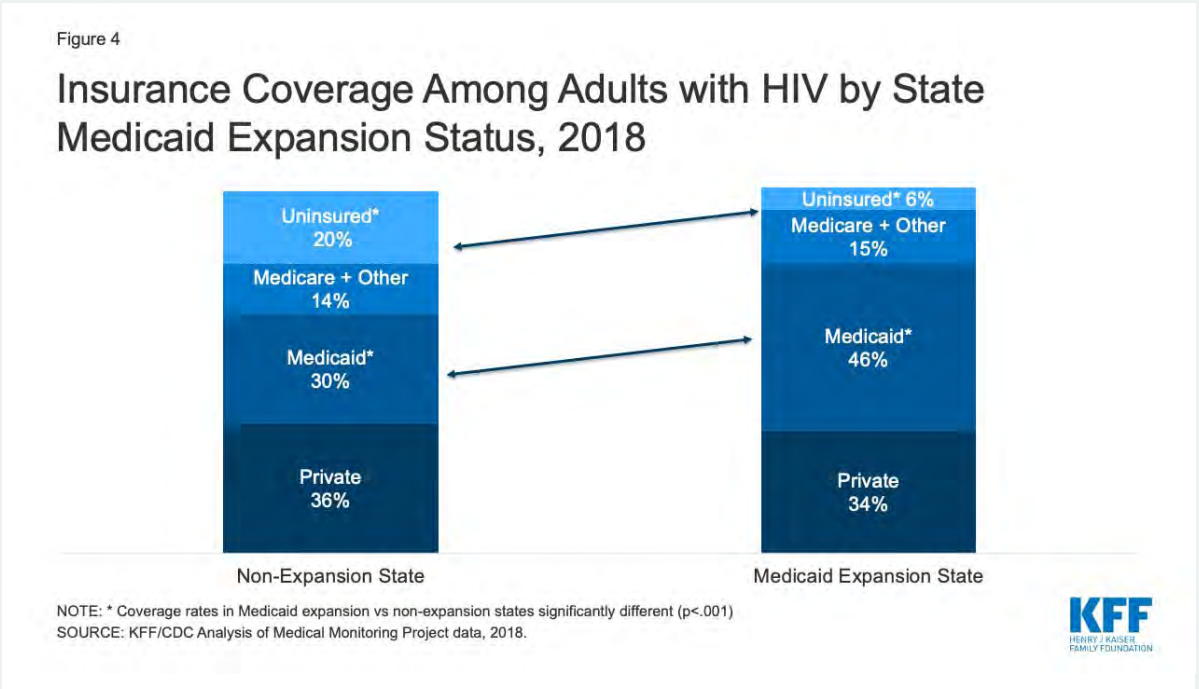


Figure 4: Insurance Coverage Among Adults with HIV by State Medicaid Expansion Status, 2018

Coverage by Key Demographics

We observed coverage differences among adults with HIV by a range of demographic indicators, including, race/ethnicity, gender, income, and, for the first time, place of birth and sexual orientation.

Gender: Male adults with HIV were almost twice as likely to have private coverage (39% v. 23%) and more likely to have Medicare than females (8% v. 6%), while females were more likely to have Medicaid (54% v. 36%). Women's greater likelihood of Medicaid coverage could reflect eligibility based on lower incomes and categorical eligibility based on being pregnant, parent of a dependent child, higher rates of disability. Rates of uninsurance do not differ significantly by gender. (Fig. 5)

Race/ethnicity: White adults with HIV were more likely than Blacks and Hispanics to have private insurance (45% v. 31% and 28%, respectively) and Medicare (11% v. 7% and 5%, respectively) and less likely than Blacks to have Medicaid (35% v 45%). Notably, Blacks and Hispanics were more than three times as likely as Whites to be uninsured (14% and 15%, respectively vs. 4%). These trends reflect in part, disparities seen in coverage by race/ethnicity nationwide, including that people of color are more likely than White to live in non-expansion states, (Fig. 5)

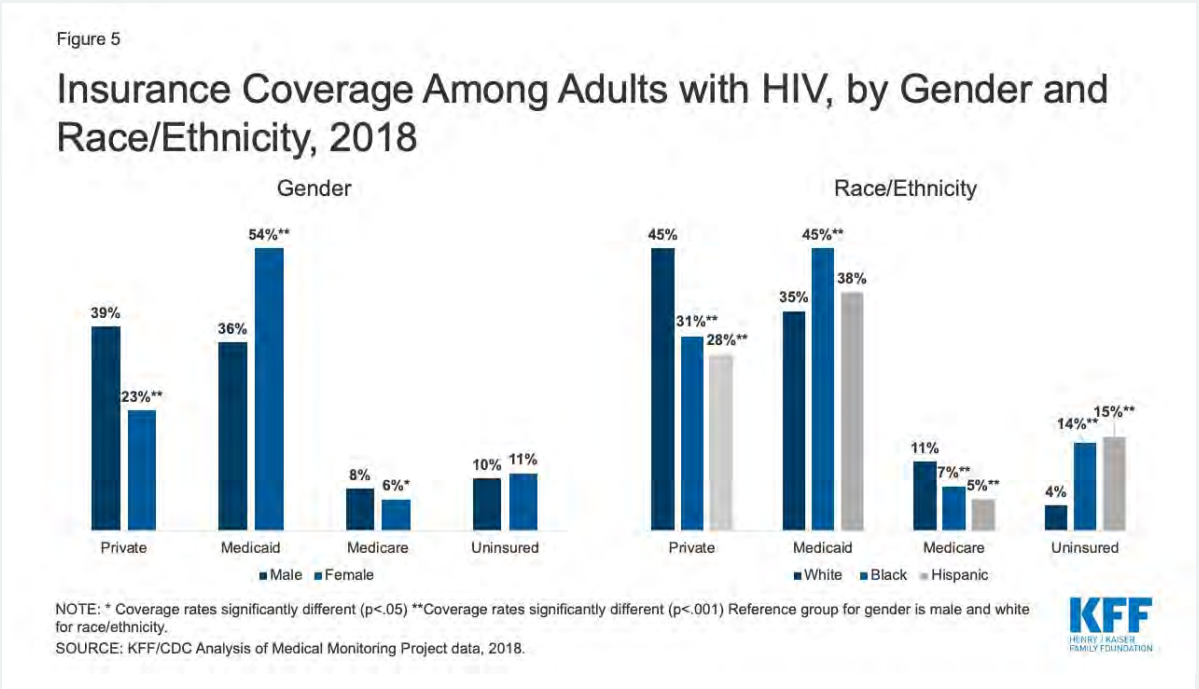


Figure 5: Insurance Coverage Among Adults with HIV, by Gender and Race/Ethnicity, 2018

Income. Those with household incomes <100% of the federal poverty level (FPL) ($12,140 for an individual in 2018 (https://aspe.hhs.gov/2018-poverty-guidelines)) were significantly less likely to have private coverage compared to all other income groups and most likely to have Medicaid coverage. This likely reflects the association between income and access to employment benefits and marketplace subsidies. The percentage of people with HIV with private healthcare coverage increased, and Medicaid coverage decreased, with increasing household income. (Fig. 6)

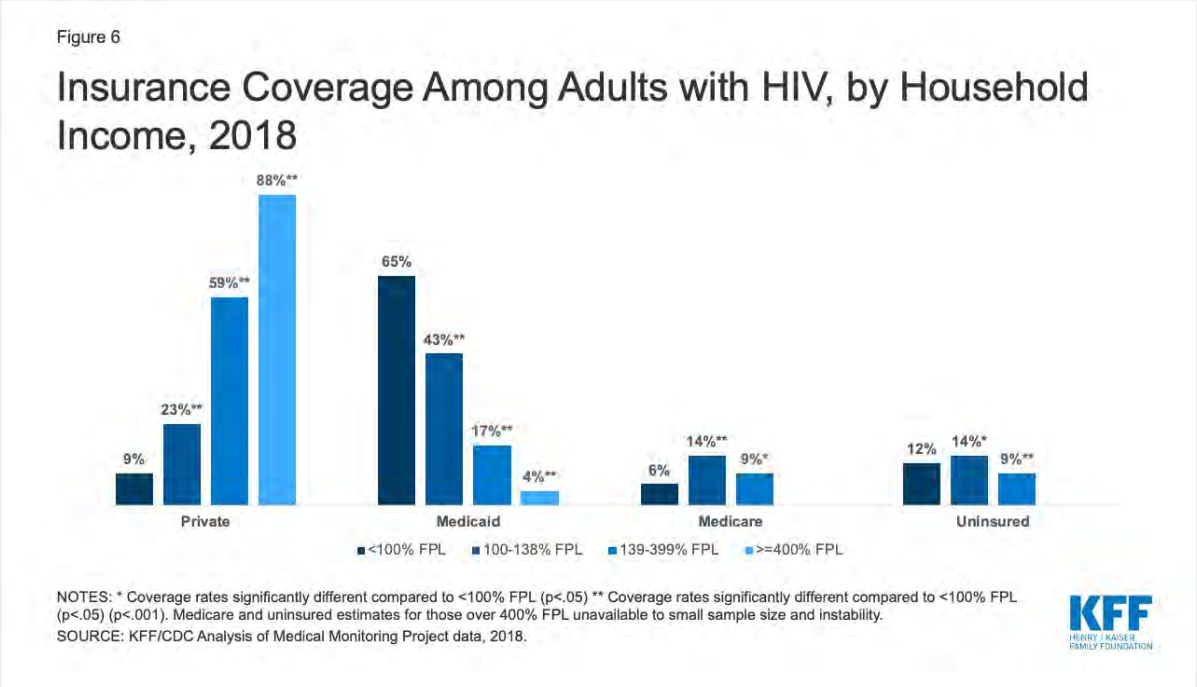


Figure 6: Insurance Coverage Among Adults with HIV, by Household Income, 2018

U.S. Born. Nine in 10 adults (86%) with HIV in the U.S. were born in country whereas 15% were born abroad.[2] (https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/view/footnotes/#footnote-98765432-2) These individuals were significantly less likely to have the publicly funded health coverage sources, Medicaid and Medicare, than those born in the U.S (28% v. 42% and 4% v. 8%, respectively), potentially reflecting citizenship and residency requirements in public coverage. This group was also three times as likely to be uninsured compared to U.S. born counterparts (24% v. 8%). (Fig. 7)

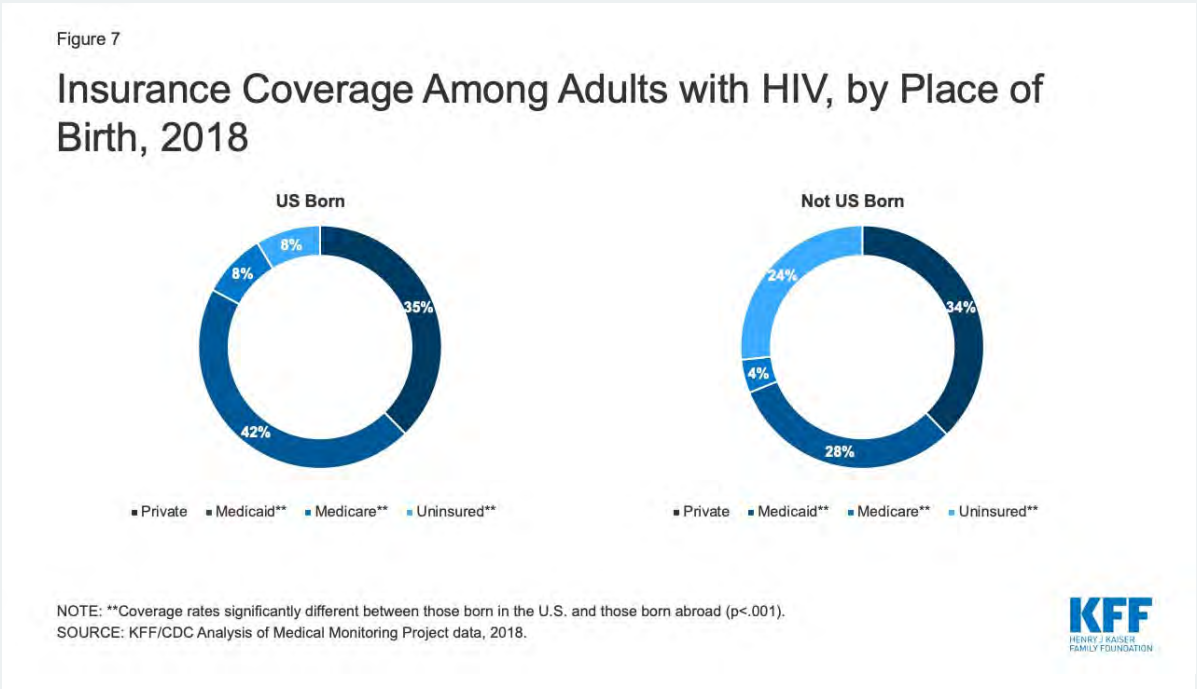


Figure 7: Insurance Coverage Among Adults with HIV, by Place of Birth, 2018

Sexual Orientation. Overall, 47% of adults with HIV identify as heterosexual and 41% as lesbian or gay. Smaller shares identify as bisexual (9%) or as “something else” (3%). Heterosexual adults with HIV, who are disproportionally Black and Latina women, were less likely than lesbian and gay adults with HIV to have private insurance coverage (25% v. 48%) and more likely to have Medicaid (49% v. 30%). Bisexual adults with HIV were less likely to have Medicaid (40% v. 49%) and more likely to be uninsured than heterosexuals (17% v. 11%). (Fig. 8)

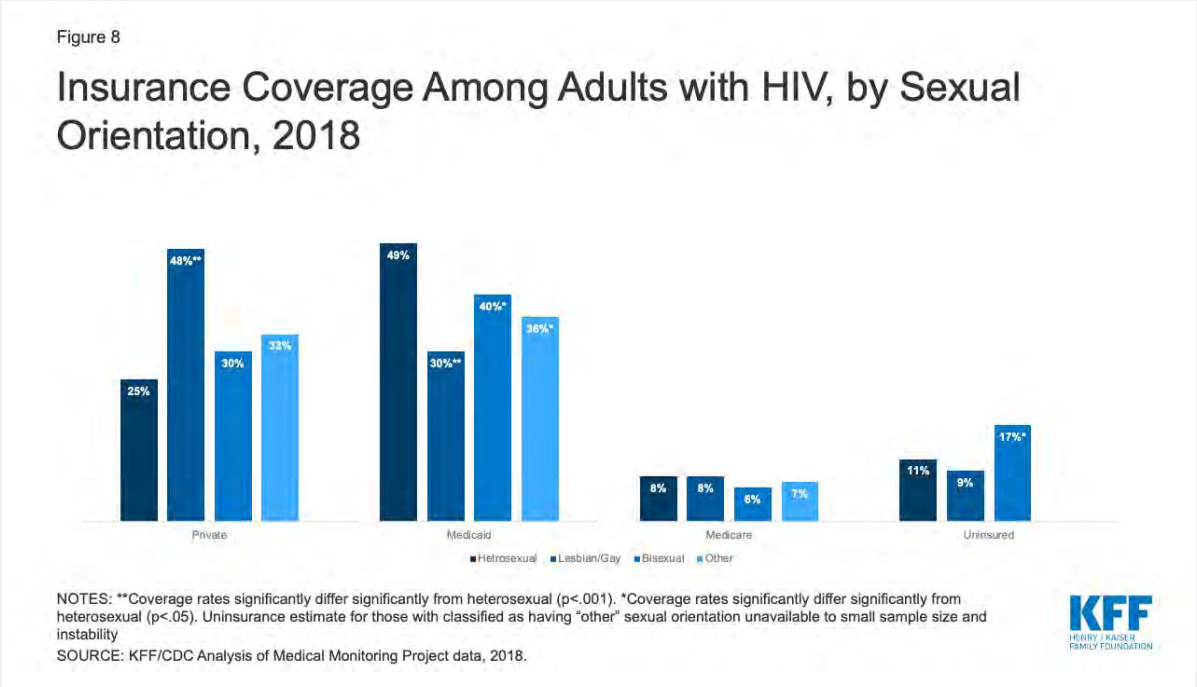


Figure 8: Insurance Coverage Among Adults with HIV, by Sexual Orientation, 2018

Coverage and Ryan White

The federal Ryan White HIV/AIDS Program provides outpatient HIV care, treatment, and support services to people with HIV who are underinsured and uninsured. In 2018, nearly half (46%) of adults with HIV received support from the program. The program provides assistance to those with and without coverage but plays an especially significant role for the uninsured, 82% of whom receive program services. Those who are uninsured may receive direct medical care and prescription drugs through the program, as well as support services. Ryan White also plays a meaningful role for those with insurance coverage, addressing gaps in coverage (e.g. providing support services not included in traditional coverage) and assisting with costs associated with insurance (e.g. insurance premiums and out-of-pocket costs related to HIV medication). Sixty-two percent (62%) of those with Medicare receive Ryan White support. Among those with private insurance, almost 4 in 10 (38%) receive assistance through the program. This share was significantly higher among those with marketplace coverage (56%) compared to employer-based coverage (32%), potentially reflecting the role Ryan White plays in helping clients purchase individual insurance (https://www.kff.org/report-section/the-ryan-white-program-and-insurance-purchasing-in-the-aca-era-introduction/) coverage. It could also reflect higher cost-sharing for many in individual insurance (Fig. 9).

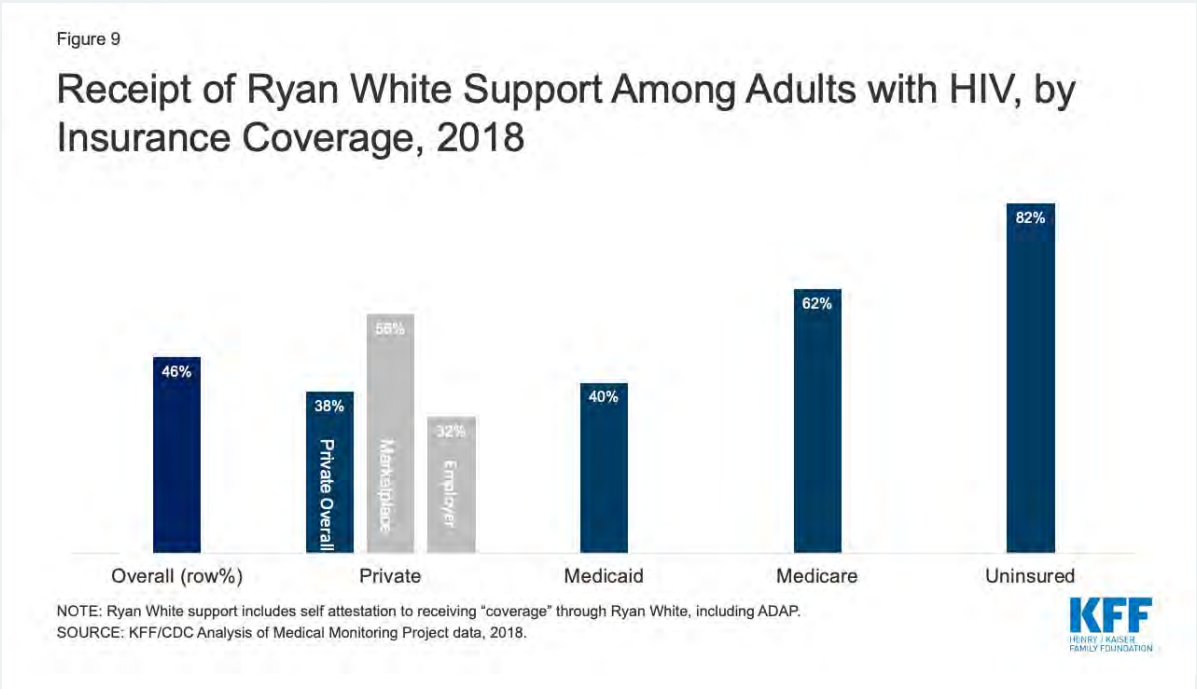


Figure 9: Receipt of Ryan White Support Among Adults with HIV, by Insurance Coverage, 2018

Coverage and Viral Suppression

Viral suppression (defined as having an undetectable viral load at the time of last available laboratory data) is a critical health indicator, affording optimal health outcomes at the individual level and, because when an individual is virally suppressed they cannot transmit HIV, significant public health benefit (https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/0). However, because viral suppression can change over time, especially depending on treatment adherence, it is particularly important to look at sustained viral suppression (defined as having an undetectable viral load over all tests in the preceding 12 months), a stronger indicator of long-term adherence antiretroviral treatment and its associated preventive benefits. In 2018, 68% of people with HIV were virally suppressed at last test and 62% had sustained viral suppression, the same share as in 2015. (Fig. 10)

Certain insurance types were positively associated with sustained viral suppression. The proportion of people with sustained viral suppression was significantly higher among those with private insurance, including those with employer-sponsored and marketplace coverage, and among those with Medicare, compared to the uninsured. Viral suppression rates among those with Medicaid were not significantly different from the uninsured, a finding that could reflect the equalizing role of the Ryan White Program for the uninsured. Lower viral suppression rates among those with Medicaid and the uninsured compared to those with other coverage types, could be accounted for by lower household income, among other, largely related, factors. (Fig. 10)

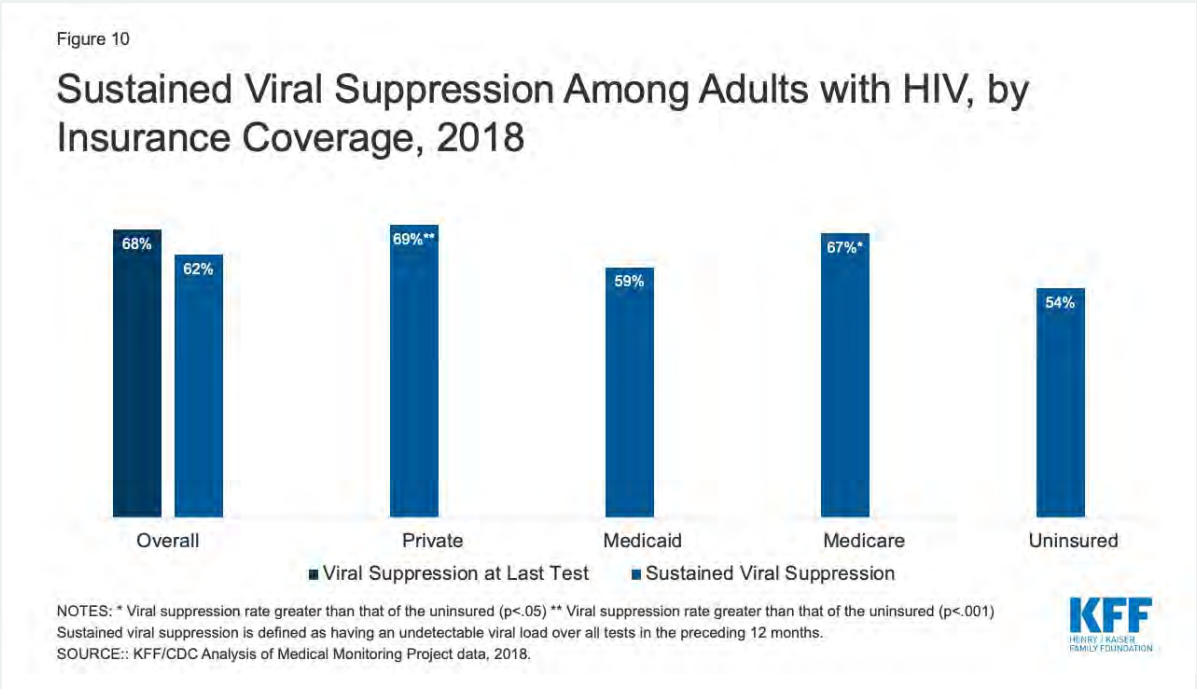


Figure 10: Sustained Viral Suppression Among Adults with HIV, by Insurance Coverage, 2018

Ryan White support appears to make a significant difference in achieving sustained viral suppression. Overall, those with Ryan White support were significantly more likely to have sustained viral suppression compared to those without (68% v. 58%) and this pattern was observed across all coverage types, and was especially apparent among the uninsured (60% v 26%). (Fig. 11)

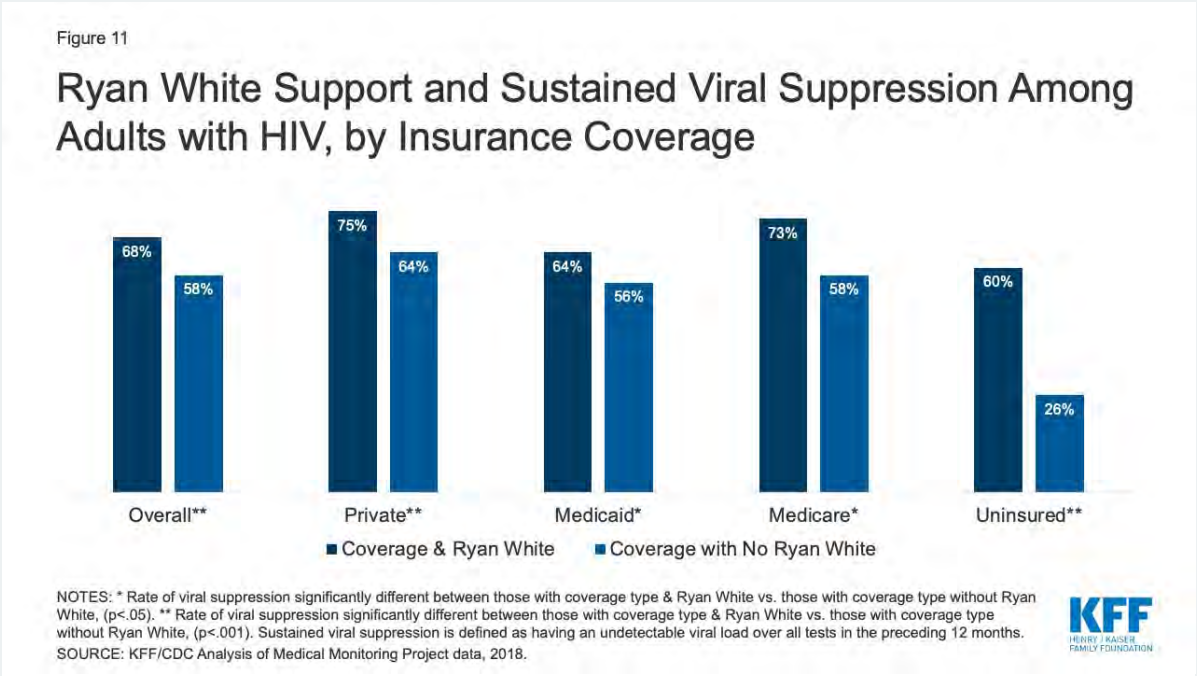


Figure 11: Ryan White Support and Sustained Viral Suppression Among Adults with HIV, by Insurance Coverage

Discussion

In 2018, the uninsurance rate among people with HIV was similar to that of the public at large. Medicaid represented the single largest source of coverage for people with HIV, particularly in Medicaid expansion states, followed closely by private insurance. We observed significant differences in coverage by gender, income, and race/ethnicity, with notable disparities related to rates of uninsurance by race/ethnicity. We also provide the first national data on adults with HIV and insurance coverage by place of birth and sexual orientation. The Ryan White Program is a significant source of care, treatment, and support for people with HIV, especially for the uninsured but also for a substantial share of those with coverage. Certain insurance sources and support from Ryan White were associated with greater rates of sustained viral suppression, a crucial indicator of optimizing the individual and public health benefits associated with antiretroviral treatment.

The ACA has made a significant difference in expanding insurance coverage for people with HIV, yet its future continues to be contested terrain. On the one hand, the Trump Administration is seeking to invalidate the law before the Supreme Court, while on the other hand, states, including states with leadership that has opposed the ACA, continue to adopt Medicaid expansion through voter led ballot initiatives; as of September 2020, 39 states (including D.C.) have adopted Medicaid expansion. In addition, health care could be a major issue in the 2020 elections with candidates President Trump and Democratic nominee Joe Biden holding deeply diverging views on the issue (https://www.kff.org/slideshow/health-care-and-the-2020-presidential-election/). Their different policy perspectives and positions stand to significantly impact coverage, and likely care outcomes, for people with HIV, as well as the success of the administration's "Ending the HIV Epidemic" initiative (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/).

Acknowledgments

The authors wish to thank Dr. Sharoda Dasgupta, Dr. Linda Beer, and Dr. Yunfeng Tie of the CDC, who were instrumental in this work in providing access to data, guidance, and conducting statistical analysis.

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Peterson-KFF
Health System Tracker

Access & Affordability

How does cost affect access to healthcare?

By Shameek Rakshit, Matthew McGough, Krutika Amin, and Cynthia Cox *KFF*

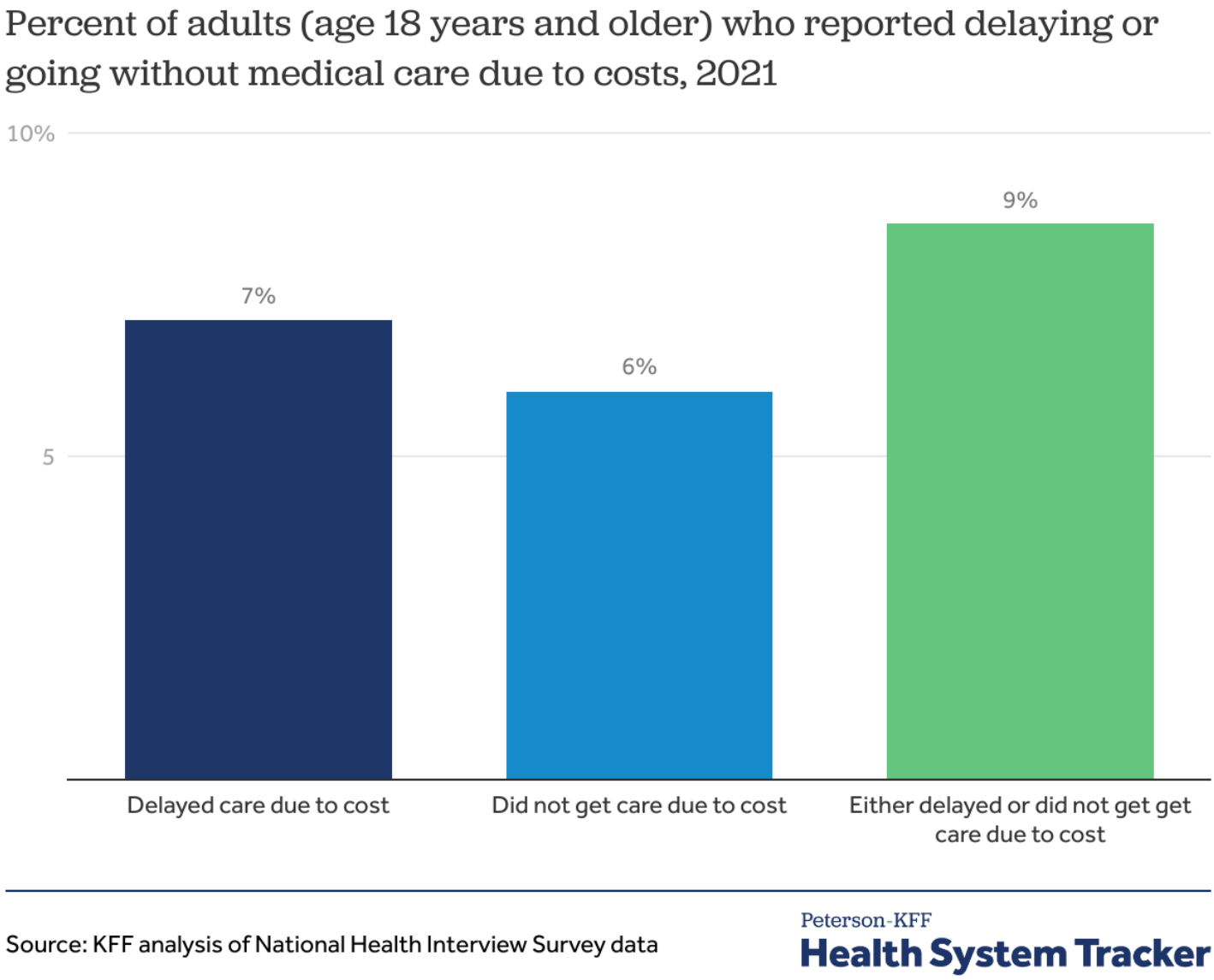
January 30, 2023

In this chart collection, we explore trends in how costs affect access to healthcare in the U.S. based on National Health Interview Survey (NHIS) data through 2021.

As background, at any given point in time, most adults (90%) have health insurance, and the majority (87% of adults) also report their health as at least good. Adults in worse health (reported as fair or poor health status), and the uninsured are much more likely than others to delay or forego health care due to costs.

In the 2021 NHIS, one in 11 adults reported delaying or not getting medical care due to cost reasons. KFF polling from March 2022 found four in ten adults (43%) report that they or a family member in their household put off or postponed needed health care due to cost. While most adults are in good health at a given time, they may have a sick, uninsured, or underinsured family member, leading to medical bills putting a strain on their household budgets.

One in 11 adults reported that they delayed or did not get care because of cost reasons

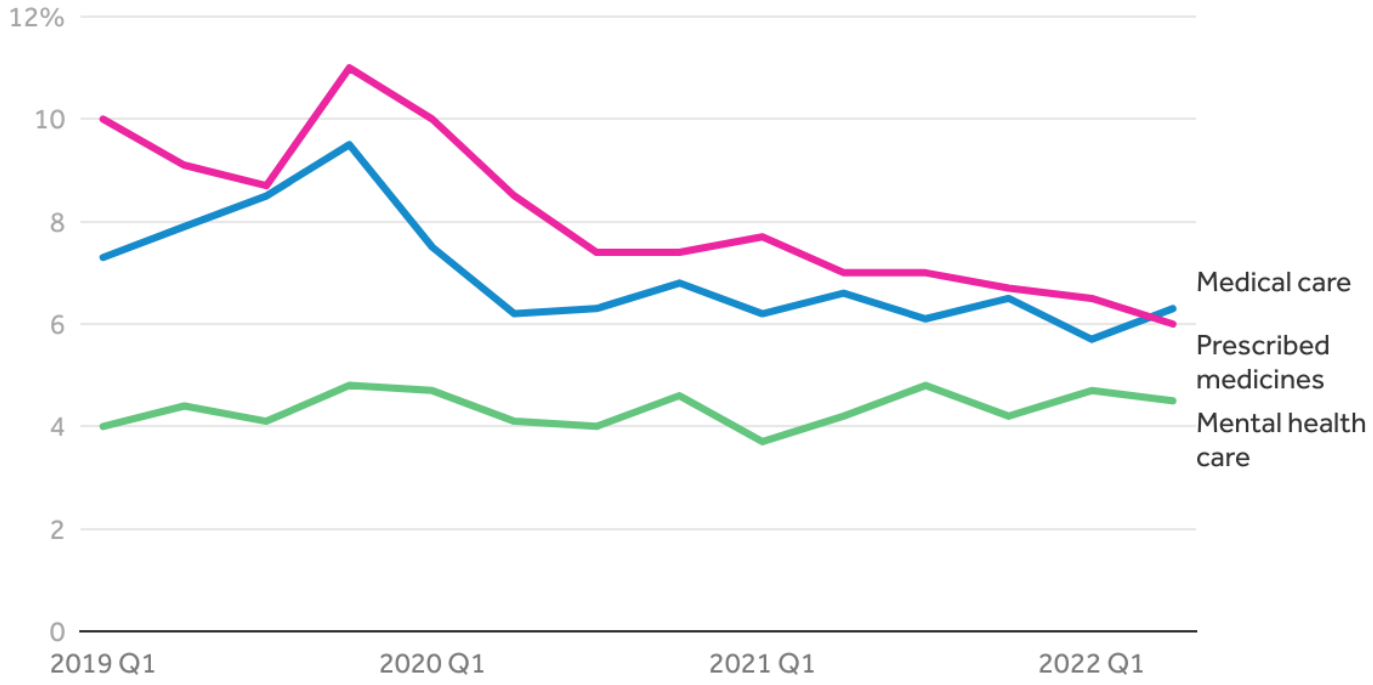


Most Americans do not report cost-related access barriers to health care. Still, a substantial portion of the population – about one in every 11 adults (9%) – said that they either delayed or did not receive medical care due to cost reasons in 2021.

The chart above is based on NHIS questions asking about missed or delayed "medical care." There are subsequent questions that ask about missed or delayed mental health care, dental care, and prescriptions due to costs. While some people answer yes to multiple questions, others say that they only missed or delayed one type of care. As shown in later charts, adding all types of missed or delayed care results in a larger share of adults delaying or foregoing care.

The share of adults going without medical care due to costs remained stable in 2021 through mid-2022 after declining in 2020

Percent of adults (age 18 years and older) reporting going without healthcare due to costs, by type of care, 1st quarter 2019 - 2nd quarter 2022



Note: Categories are not mutually exclusive; respondents may have reported going without more than one type of care. Going without prescribed medicines includes not taking prescribed doses, taking less medicine than prescribed, or delaying prescriptions.

Source: KFF analysis of National Health Interview Survey data

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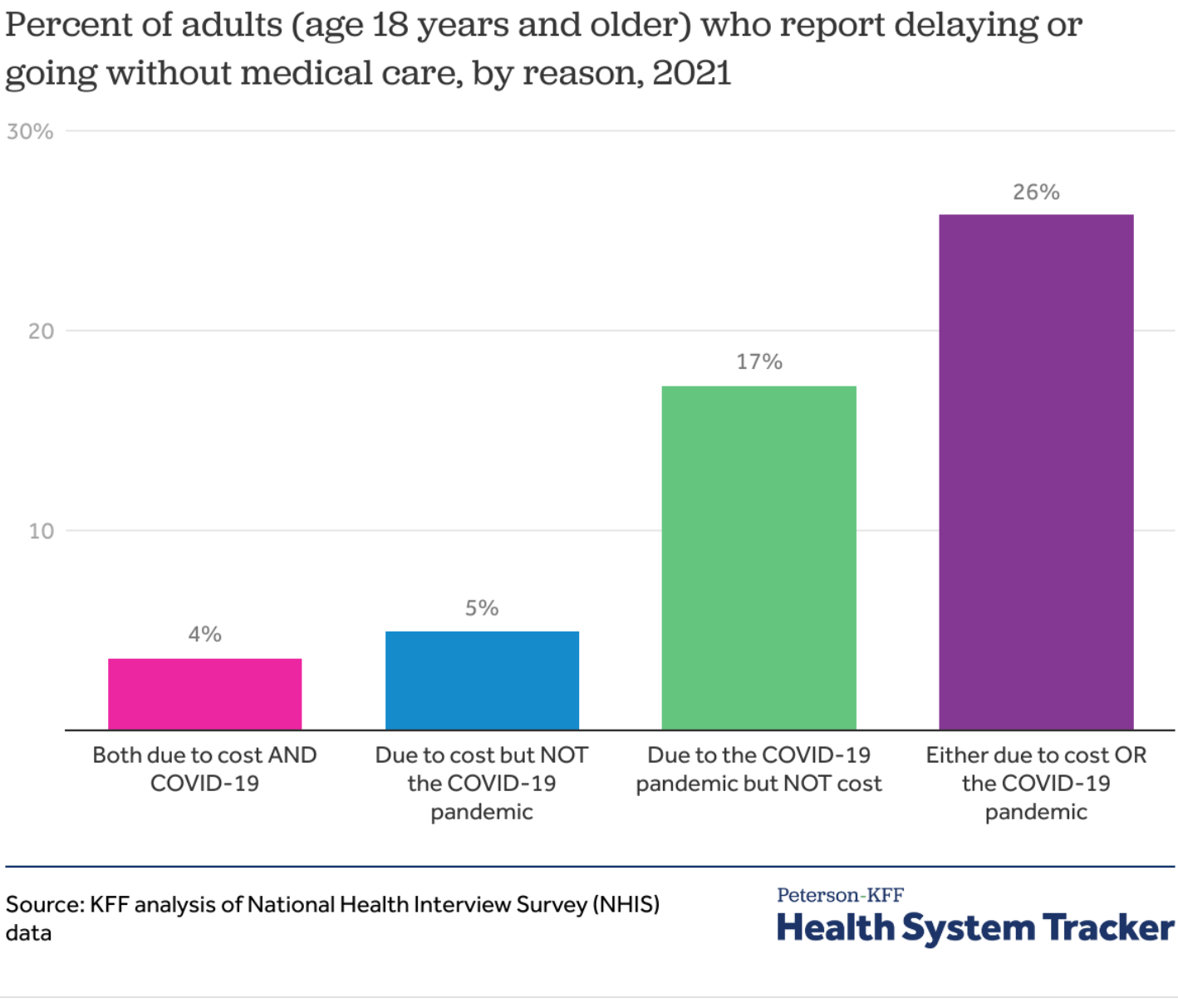
The share of adults reporting going without medical care or not taking medicine as prescribed due to cost declined through 2020. This is possibly a result of people **foregoing care due to COVID-19**.

Costs are a significant access barrier, but the pandemic has posed another significant access barrier and it is difficult to disentangle the reasons why people are missing care. In 2021, a greater share of the population attributed delaying or foregoing care due to the COVID-19 pandemic (21%) than due to cost-related reasons (9%).

Compared to 2021, in the second quarter of 2022, a similar share of adults reported going without needed medical care (6.3%), not taking medicine as prescribed (6.0%), and going without needed mental

health care (4.5%) due to cost reasons. Note that respondents may answer yes or no to any of these questions so they should not be totaled.

One in four adults reported delaying or foregoing care either due to cost or the pandemic

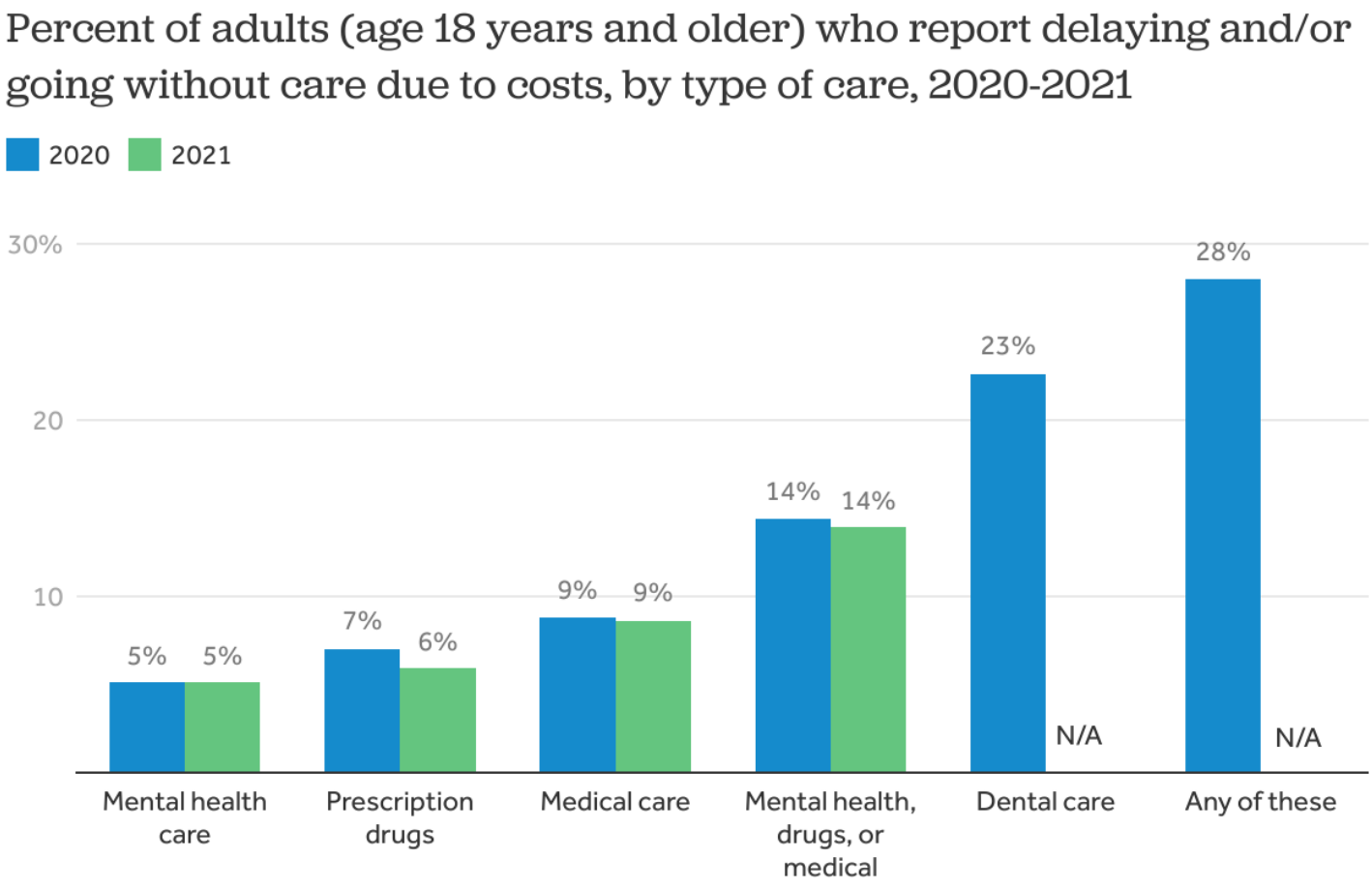


In 2021, one in four adults (26%) reported delaying or going without medical care due to either healthcare costs or the COVID-19 pandemic. A smaller share of adults (4%) delayed or went without medical care due to both costs and the pandemic.

Meanwhile, 17% of adults delayed or went without care due to the pandemic but not costs, and 5% of adults delayed or went without care due to costs but not the pandemic.

In addition to costs and the pandemic, there could be additional reasons for delaying or foregoing care, such as an inability to take time off from work, a lack of transportation, or a lack of available appointments.

Including dental care, one in four adults delayed or did not get some form of care due to cost reasons in 2020



Note: Delaying and/or going without care due to costs for dental care and "Any of these" are only from 2020 due to omission of the delayed or foregone dental care due to cost question in the 2021 NHIS.

Source: KFF analysis of National Health Interview Survey data

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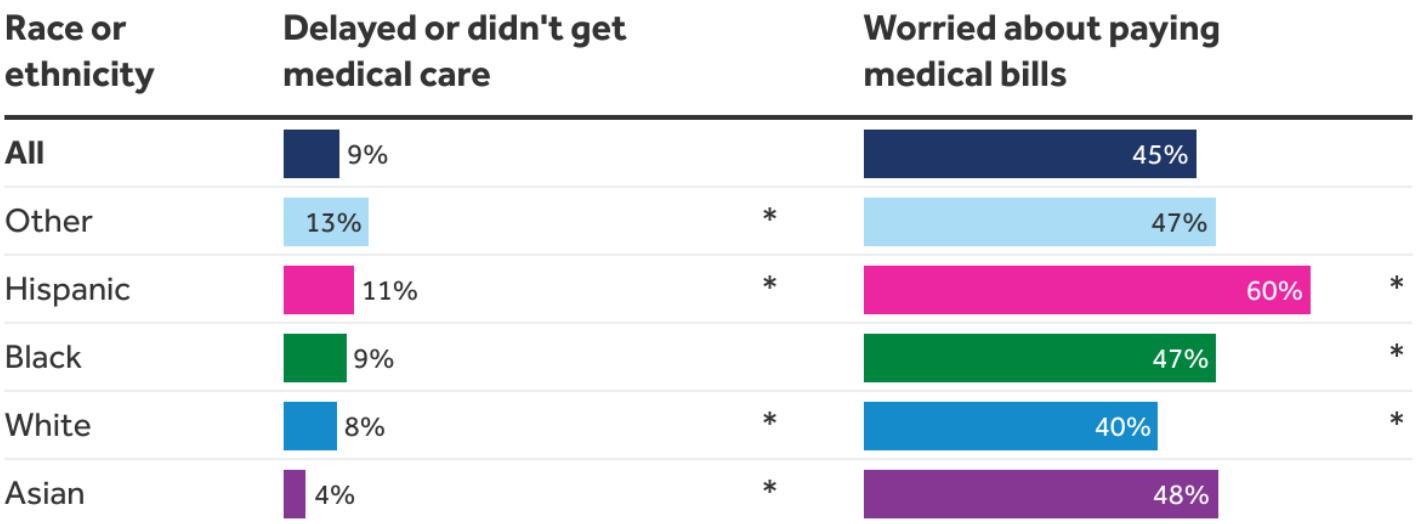
In 2020, 28% of adults reported delaying or going without either dental care, prescription drugs, medical care, or mental health care due to cost. Almost one in four adults went without dental care (23%) due to cost that year.

In 2021, 14% of adults reported delaying or going without either prescription drugs, medical care, or mental health care due to cost. This share is not comparable to the 28% of adults who went without some form of care due to cost in 2020 because the 2021 NHIS did not ask participants about delaying or foregoing dental care due to cost.

Compared to 2020, a similar share of adults reported delaying or going without prescription drugs (6%), medical care (9%), and mental health care (5%) due to cost in 2021. Additionally, a similar share of adults reported delaying or going without any of these types of care excluding dental care in 2020 and 2021 (14% for both years).

Hispanic adults are more likely than other groups to report cost-related barriers in accessing care

Percent of adults (age 18 years and older) reporting barriers to accessing care due to cost, by race and ethnicity, 2021



Note: *Estimate is statistically different from all others (p<0.05). The "Hispanic" category could be any race, but all other groups are non-Hispanic. The "Other" category groups people of any race or ethnicity not otherwise stated.

Source: KFF analysis of National Health Interview Survey data

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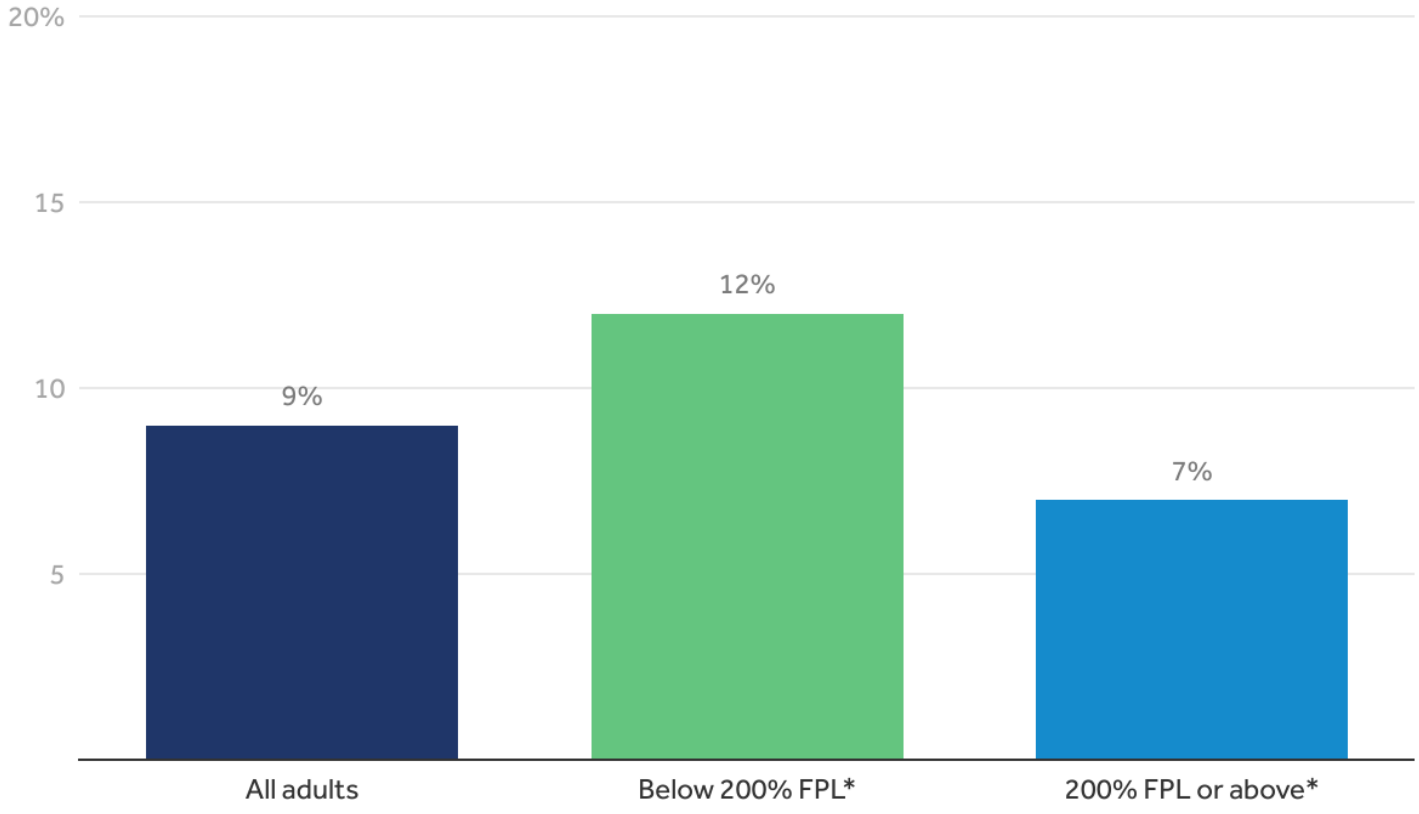
Hispanic adults had higher rates of delaying or going without medical care due to costs than most other groups (11%). Other racial and ethnic groups, which include American Indian or Alaska Native people, Native Hawaiian or Other Pacific Islander people, and people who identified with other or multiple racial and ethnic groups (grouped together due to small sample size), had the highest share of adults that report delaying or foregoing care (13%). Estimates for Asian people were the lowest among all groups for delaying or foregoing care due to cost (4%). Hispanic adults had the highest rates of being worried about being able to pay medical bills in case of an illness or accident (60%). White adults had the lowest rate of being worried about paying medical bills in case of an illness or accident (40%).

Adults with incomes below 200% of the federal poverty level are more likely to go without medical care due to cost reasons

Percent of adults (age 18 years and older) who report delaying and/or going without medical care due to costs, by income, 2021



Note: *Estimate is statistically different from the estimate of the other income levels ($p < 0.05$).

Source: KFF analysis of National Health Interview Survey data

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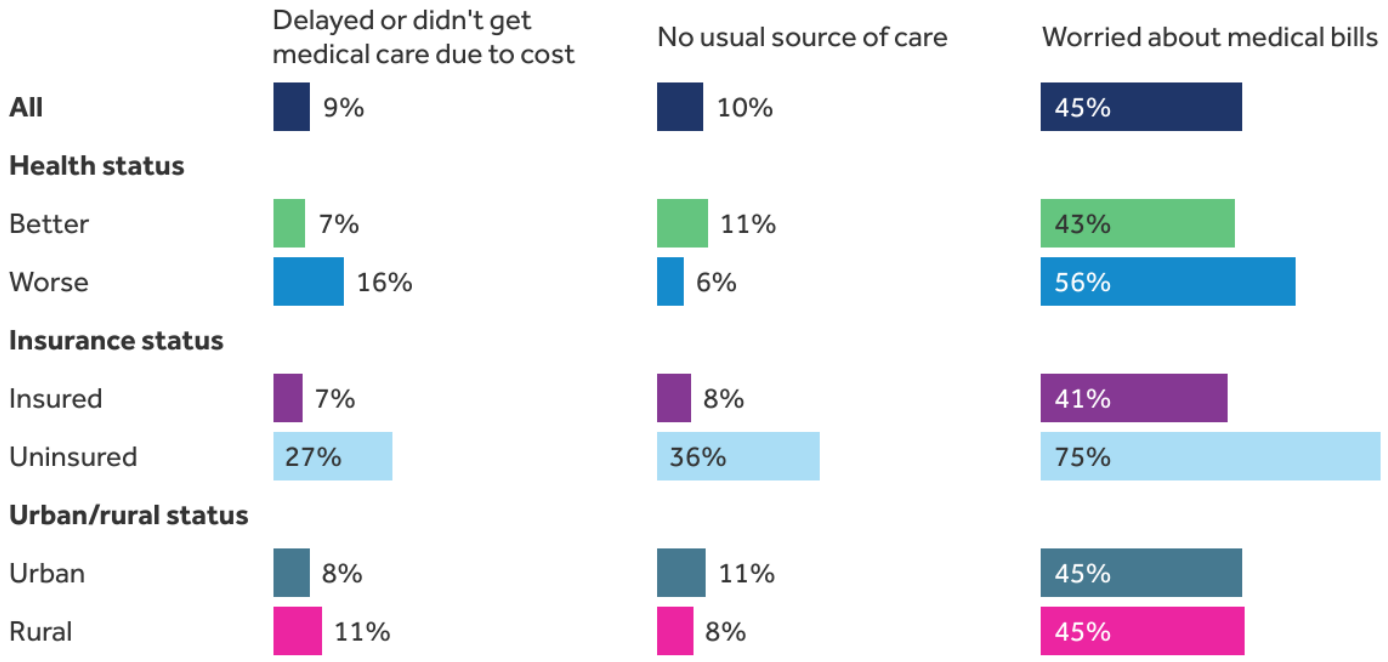
Adults with incomes below 200% federal poverty level (FPL) are more likely to delay or go without medical care than those with incomes above 200% FPL (12% versus 7%). Additionally, among people with employer-sponsored insurance, those with lower incomes spend a **larger share** of their incomes on insurance premiums and cost-sharing.

Adults who are in worse health are twice as likely as those in better health to delay or not get care due to cost reasons

Percent of adults (age 18 years and older) who delayed or didn't get medical care due to cost, have no usual source of care, and are worried about medical bills, by selected chartacteristics, 2021



Note: All estimates for each status are statistically different from its comparable status for each outcome ($p<0.05$), except for worried about paying bills by urban/rural status.

Source: KFF analysis of National Health Interview Survey data

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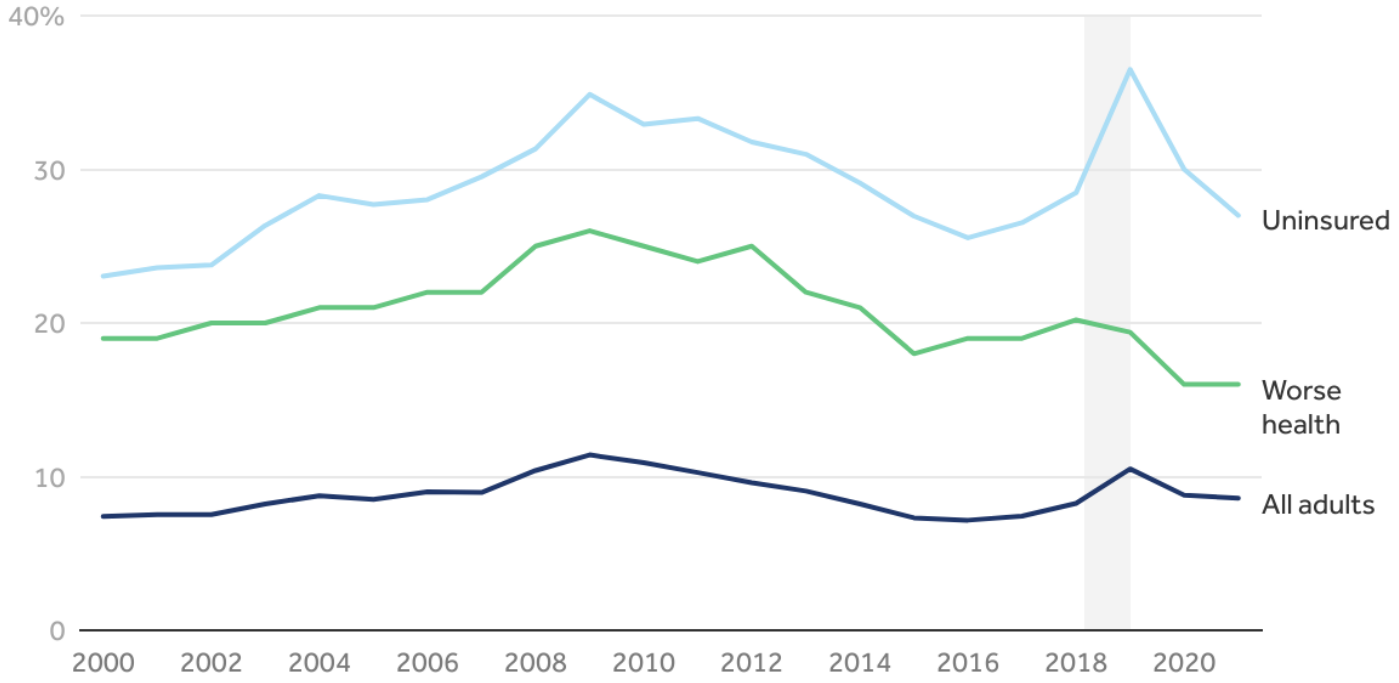
Adults in worse health are more likely to report delaying or not getting medical care due to cost reasons compared to adults in better health (16% versus 7%). Those who are uninsured at any point in the year reported delaying or not getting care due to cost at much higher rates compared to those who are insured (27% versus 7%) or do not have a usual source of care (36% versus 8%). Meanwhile, nearly half of all adults (45%) and three in four uninsured adults (75%) report being worried about medical bills in case of an illness or accident.

Uninsured adults and those in worse health continue to report higher rates of not getting care due to costs

Percent of adults (age 18 years and older) reporting delaying or going without medical care due to costs, by selected characteristics, 2000-2021



Note: Gray region represents the CDC redesign of NHIS. Changes from 2018 to 2019 are at least in part due to the NHIS questionnaire redesign, the updated weighting approach, or both, in addition to any actual change over time

Source: KFF analysis of National Health Interview Survey data

Peterson-KFF Health System Tracker

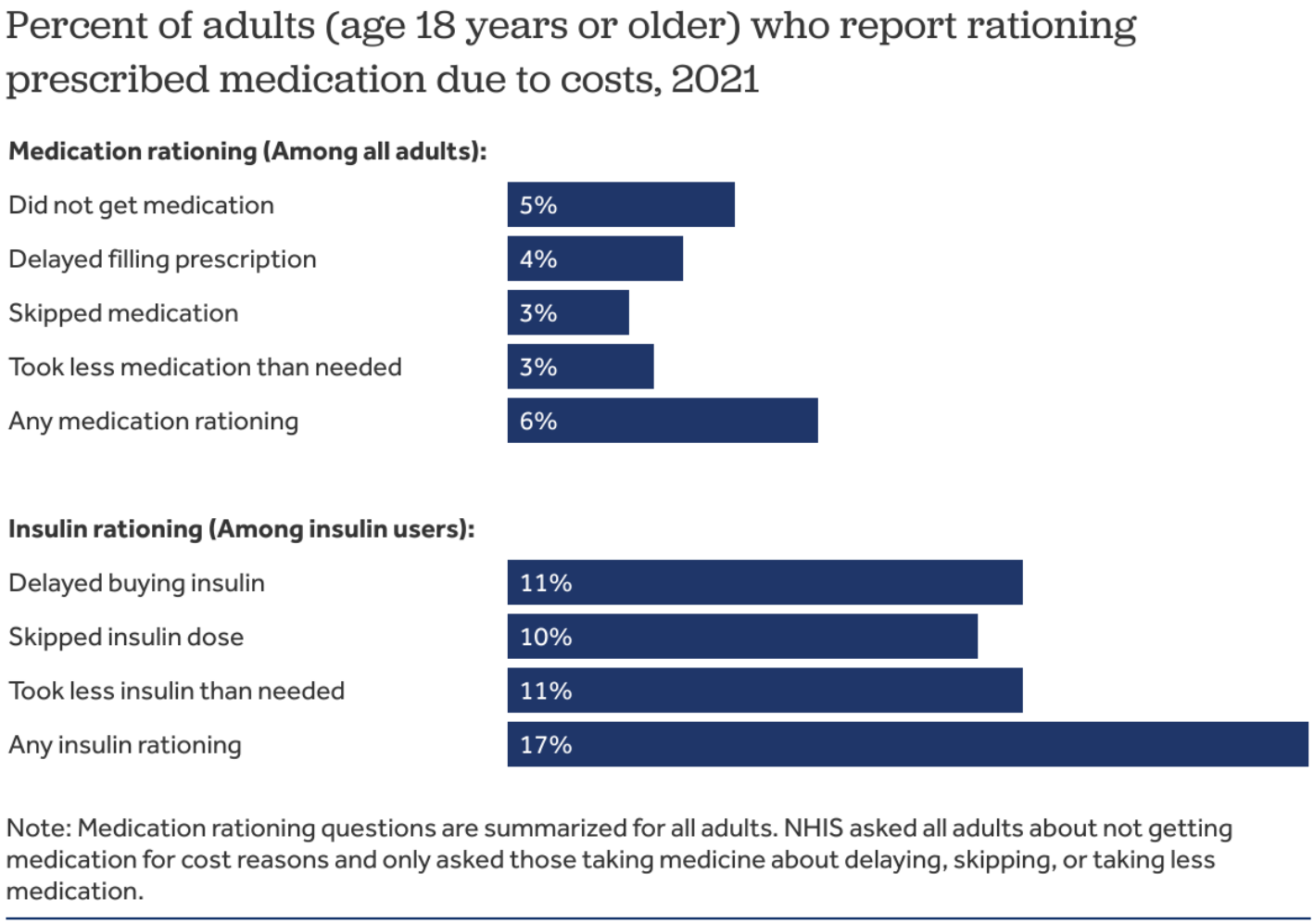
From 2000 to 2009, there was an increase in the share of all adults, adults who report worse health, and uninsured adults who reported delaying or going without care due to cost. However, between when the Affordable Care Act (ACA) was signed into law in 2010 and 2015, there was a decline in the share of adults who report delaying or going without care because of cost.

Starting with the 2019 NHIS, the U.S. Centers for Disease Control and Prevention (CDC) redesigned the questionnaire and updated the sampling weights methodology. As a result, changes in estimates from 2018 to 2019 cannot be attributed to actual change over time alone. We have indicated the break in the survey when presenting measures over time with the shaded gray region. The trend from 2018 to 2019 in the percent of adults delaying or foregoing care is likely at least partly due to changes to NHIS questionnaire and sampling weights, rather than actual changes in access to care alone.

Uninsured adults and adults in worse health continue to face access barriers due to cost of care. In 2021, 27% of uninsured adults reported delaying or not getting care due to cost reasons compared to 7% of insured adults.

While the share reporting delaying or not getting care due to cost reasons decreased from 2019 to 2021, part of this might be because COVID-19 presented another reason care was delayed or foregone. COVID-related stay-at-home measures, potential risk of infection at doctors' offices and hospitals, and concerns over hospital capacity led to sharp declines in utilization. The decline in the uninsured rate from 2019 to 2021 could have also contributed to fewer adults reporting cost-related barriers to accessing care in this period.

One in six insulin users rationed insulin due to costs



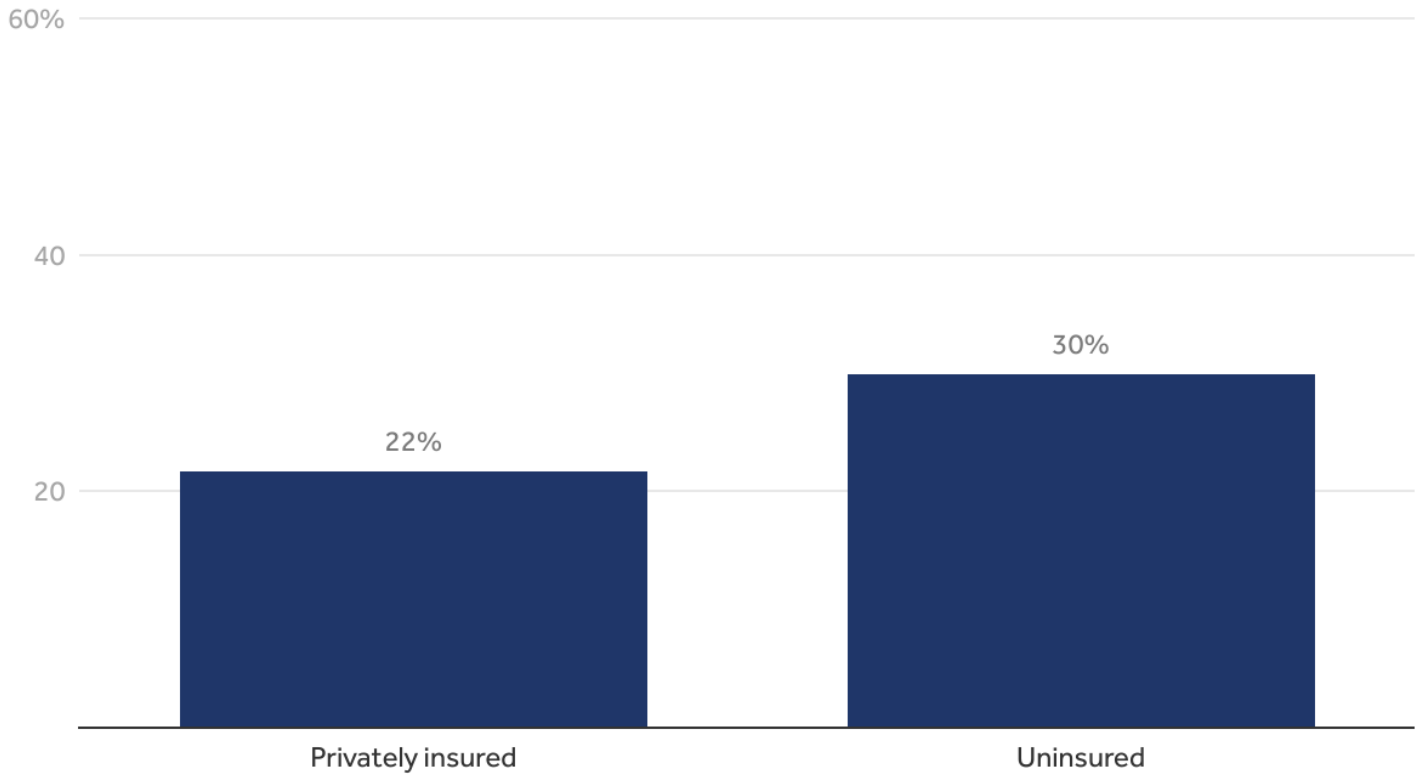
In 2021, one in six insulin users (17%) reported either delaying buying insulin, skipping an insulin dose, or taking less insulin than needed due to cost reasons.

Among all adults, 6% reported rationing prescribed medication due to cost and 5% did not get needed prescription medication to save money.

In 2022, after this data was collected, several **measures to address medication costs** for Medicare beneficiaries were signed into law as part of the Inflation Reduction Act. These provisions include a $35 monthly cap on the out-of-pocket cost of insulin for Medicare beneficiaries and federal price negotiations for certain medications covered by Medicare.

Over one in five non-elderly adults with private insurance rationed insulin due to costs

Percent of non-elderly adult insulin users who report insulin rationing due to cost, by insurance status, 2021



Note: Adults rationing insulin are those who reported delaying buying, skipping, or taking less insulin to save money. Elderly adults and people with Medicare or Medicaid/CHIP were excluded.

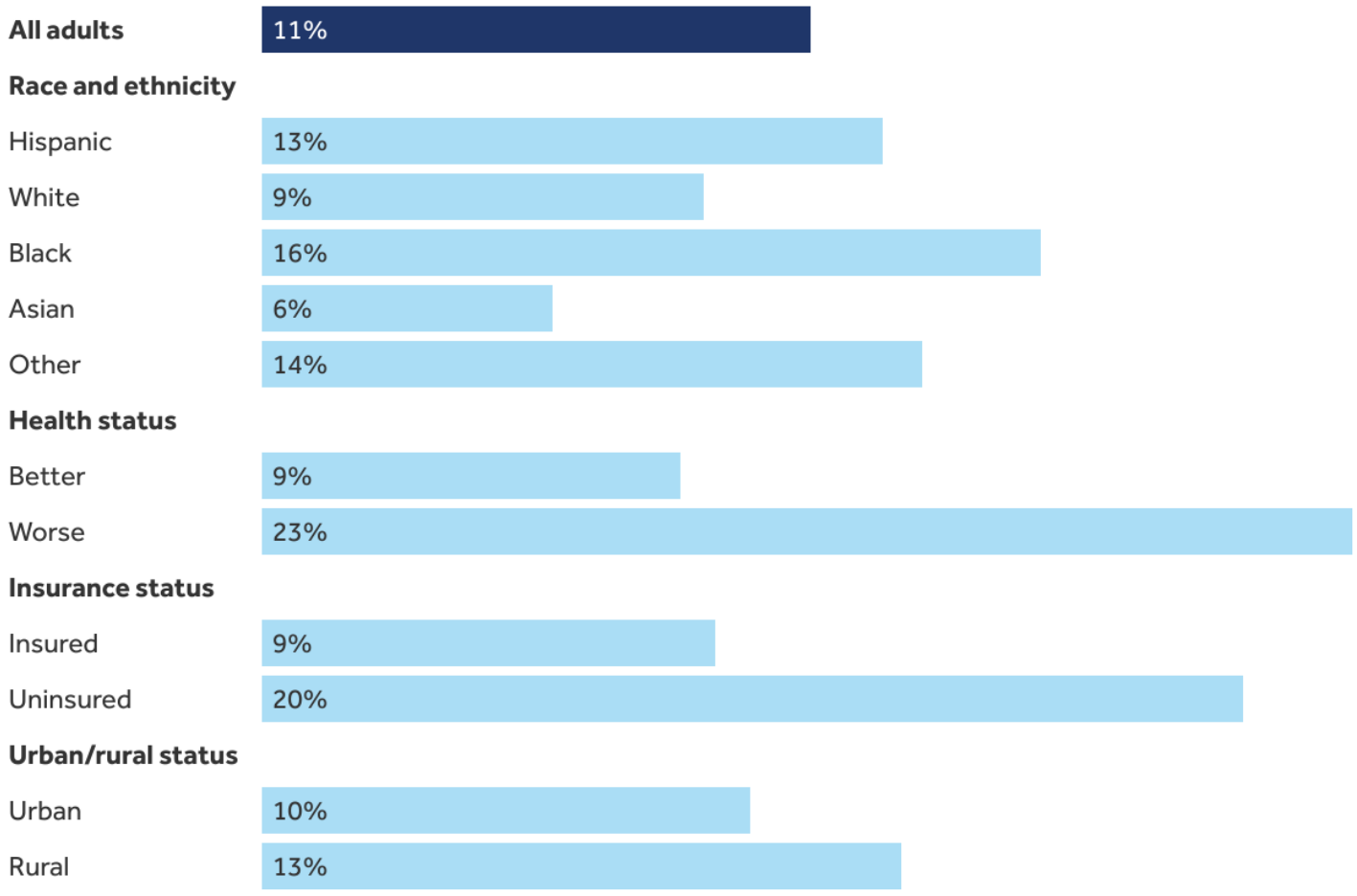
Source: KFF analysis of National Health Interview Survey data

Peterson-KFF Health System Tracker

Among non-elderly adults (ages 18-64 years) with private insurance, over 1 in 5 of those taking insulin (22%) reported delaying buying, skipping, or taking less insulin to save money. This share rises to 30% among non-elderly adults without health coverage.

Uninsured adults are twice as likely to report their family had difficulty paying medical bills

Percent of adults (age 18 years and older) reporting they or a family member had difficulty paying medical bills, by selected characteristics, 2021



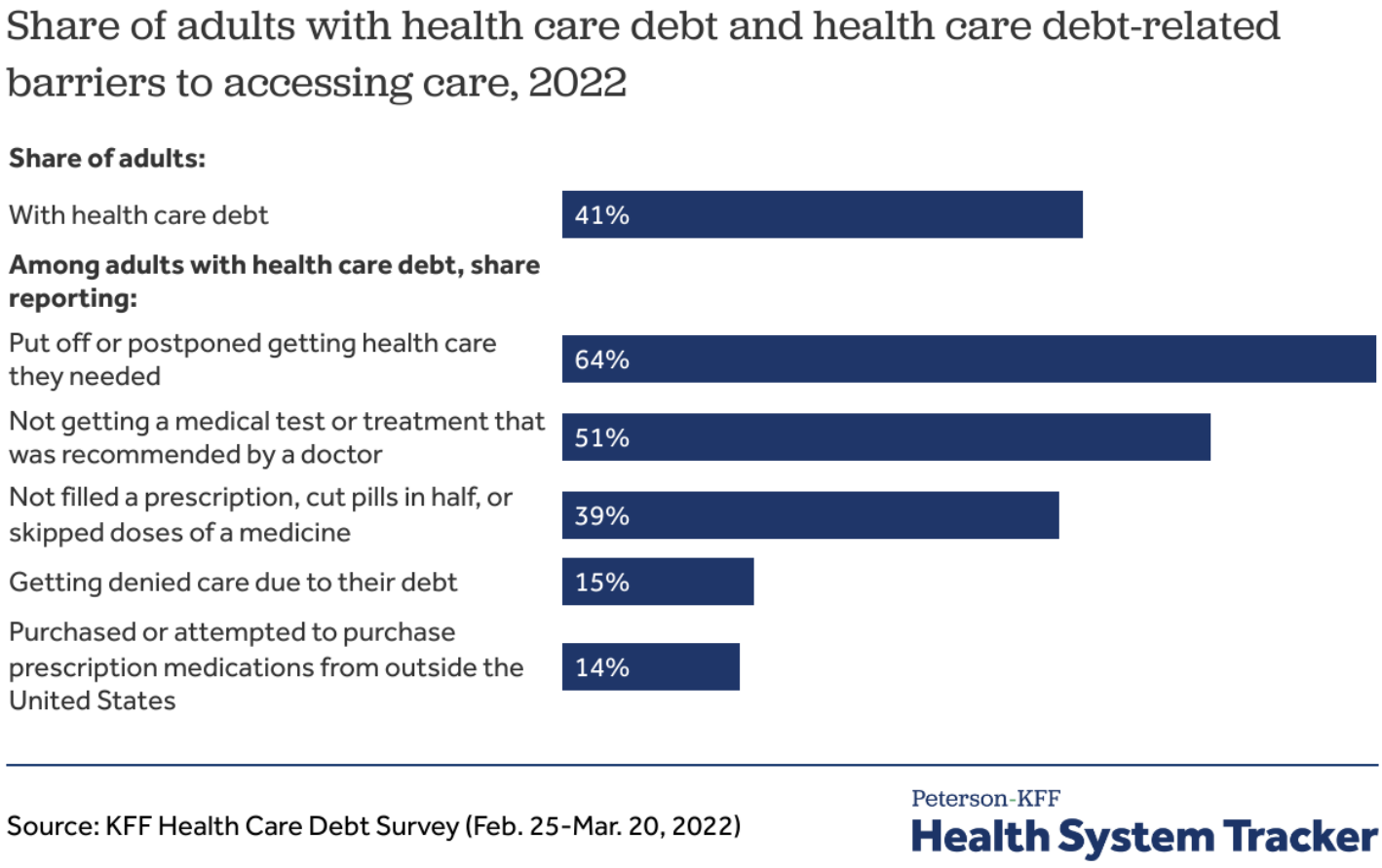
Note: Hispanic could be any race, but all other groups are non-Hispanic. Other groups people of any race or ethnicity not otherwise stated due to small sample sizes. Estimates for groups are statistically different from all other groups for each outcome ($p<0.05$).

Source: KFF analysis of National Health Interview Survey data

Peterson-KFF Health System Tracker

Among all adults, one in nine (11%) stated that they or a family member had difficulty paying medical bills. However, almost one in five uninsured adults (20%) said they or a family member had difficulty paying medical bills. Insured adults reported difficulty paying medical bills at a lower rate. Even then, 9% of insured adults reported having difficulty paying medical bills for themselves or a family member. Adults with worse health report they or a family member had difficulty paying medical bills at over two times the rate of adults with better health (23% versus 9%). Black Americans had a higher share of adults in families reporting difficulty paying medical bills compared to all other racial and ethnic groups (16%).

Nearly two in three adults with health care debt put off or postponed care they needed



According to a **2022 KFF Health Care Debt Survey**, 41% of adults reported having some amount of health care debt. Among adults with health care debt, nearly two in three (64%) either put off or postponed getting care they needed, and half (51%) did not get a medical test or treatment that was recommended by a doctor. Additionally, 15% of adults with health care debt were denied care due to their debt.

While most adults in the U.S. have health insurance, cost-sharing can place financial burdens on enrollees, **contribute to debt**, and render care unaffordable. For example, more than 40% of U.S. households **do not have enough assets** to pay a typical private plan deductible. People with lower incomes, people with worse health status, Black Americans, and people living in Medicaid non-expansion states are **more likely to have significant medical debt**.

About this site

The Peterson Center on Healthcare and KFF are partnering to monitor how well the U.S. healthcare system is performing in terms of quality and cost.

REPORT NOV 29, 2022

Health Insurance Costs Are Squeezing Workers and Employers

As premiums rise faster than wages, workers face greater cost sharing, leaving some underinsured.

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Strengthening Health, Affordable Care Act, Health, +2 More

A registered nurse cares for a patient on a stretcher in a hallway of an overloaded emergency room at a medical center in Apple Valley, California, January 2021. (Getty/Mario Tama)

Introduction and summary

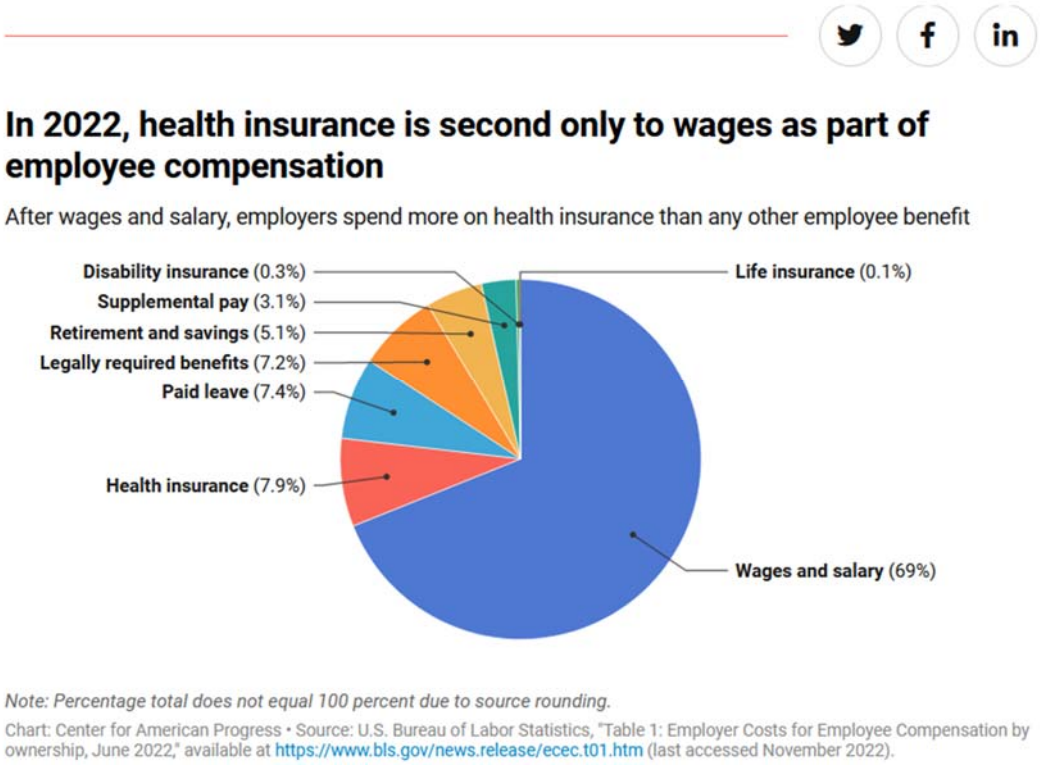
Health insurance is one of the main benefits employees look for when considering a firm's compensation package.[1] Offering robust health insurance is an important recruitment and retention tool for employers, especially considering the high level of employee attrition in 2021 and 2022.[2] In 2020, 163 million nonelderly Americans, or 60 percent of the nonelderly population, were covered by employer-sponsored insurance (ESI).[3] While the majority of employees (63 percent) report being extremely or very satisfied with their coverage,[4] many people with private coverage say that costs have prevented them from seeking needed medical care or making financial decisions to account for the rising costs that put individuals and families in a worse position, such as taking on additional credit card debt or reducing contribution to retirement savings to cover premiums.[5] A 2019 Kaiser Family Foundation and *Los Angeles Times* survey found that 2 in 5 adults covered by ESI reported difficulty affording medical care, prescription drugs, or premiums.[6]

Over the past decade, ESI premiums have risen above the rate of inflation and have outpaced wage growth.[7] The rising price of health care, rather an increase in utilization, is responsible for approximately two-thirds of per-person medical and pharmacy claims spending growth between 2015 and 2019.[8] On average, private insurance plans pay 224 percent of Medicare rates for hospital inpatient and outpatient services.[9] These high prices result in higher insurance costs, with premiums and deductibles for ESI rising at firms of all sizes.[10] As

provider markets become more concentrated, even very large employers and the insurance plans negotiating on their behalf lack sufficient market power to obtain fair prices from health systems in many markets.[11]

In addition to representing an ever-increasing cost for firms, rising premiums also put financial strain on employees. Since 2010, the share of premiums that employees bear has remained relatively constant, around 20 percent for single coverage and 32 percent for family coverage.[12] Moreover, the burden tends to be greater for lower-income workers: Firms with a greater number of low-wage employees on average contribute 10 percent less toward single coverage premiums and 13 percent less to family coverage premiums than those with fewer low-wage employees.[13] As premiums rise, the cost of health insurance grows as a share of total compensation, cutting into employees' take-home pay.[14] (see Figure 1)

Figure 1



A growing proportion of ESI plans require beneficiaries to pay a deductible, and the average deductible is rising.[15] In part, this increase is driven by employers increasingly offering high-deductible health plans (HDHPs) over the past two decades, and employer contributions toward health savings accounts (HSAs) have fallen over the past few years.[16] There is growing concern among employers that employees are already bearing the maximum share of health costs they can afford.[17] It is thus no surprise that in a 2022 survey conducted by The Commonwealth Fund, 68 percent of Democratic voters, 55 percent of independent voters, and 46 percent of Republican voters responded that lowering the cost of health care needed to be a top health priority for Congress and the Biden administration.[18]

Amid concerns about the growing costs of health insurance, policymakers are beginning to take action. Several states have established cost commissions with authority to monitor and regulate the cost of care across both public and private insurance.[19] Federal lawmakers have considered legislation to eliminate provider-insurer contract clauses that help sustain high prices for care.[20] With the challenges employers face in containing rising prices in ESI, many business leaders believe the cost is not sustainable.[21]

This report discusses the trends in the availability and affordability of ESI over the past decade and the drivers of the cost of coverage. A previous report in this series examined coalitions that are working to reduce the price of health coverage and improve the quality of care. Forthcoming reports will lay out policy proposals to combat rising costs and ensure that workers have affordable, comprehensive coverage.

Employees report satisfaction with ESI but also concerns about cost

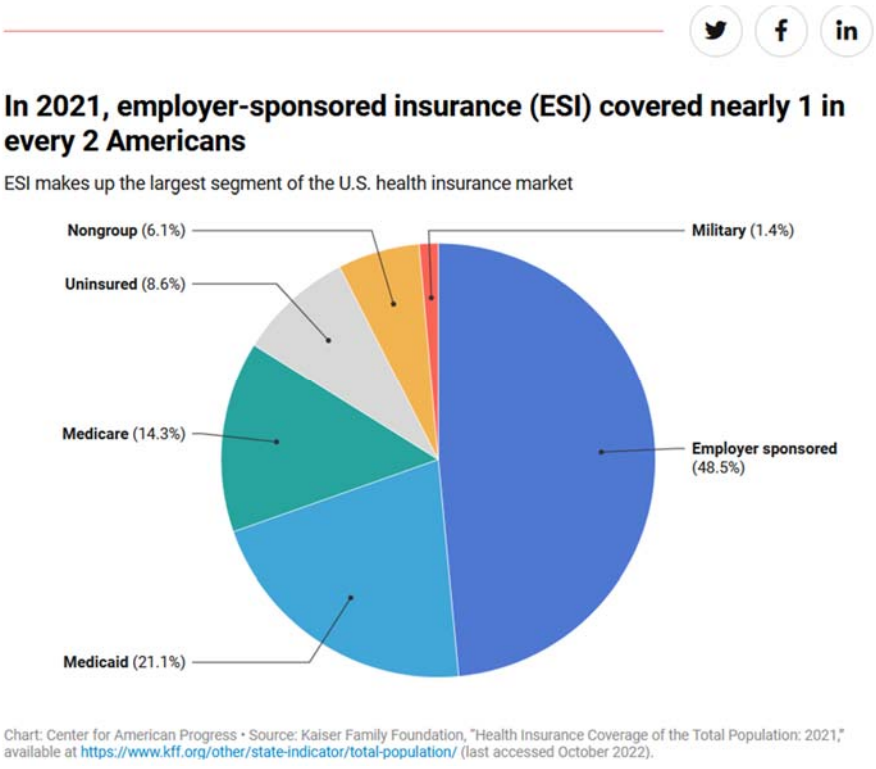
ESI is by far the largest segment of health insurance coverage in the United States, covering workers and their dependents as well as retirees. U.S. Census Bureau data show that 48.5 percent of the total population in 2021 had job-based coverage as their primary health insurance.[22] (see Figure 2) Employers offer ESI as part of workers' compensation package, with workers bearing responsibility for some portion the premium. In 2022, the average employer premium contribution was 80 percent for single coverage and 67 percent for family coverage.[23]

One major factor that drove ESI to prominence in the U.S. health care system was World War II-era laws that excepted health insurance from wartime wage controls, enabling unions to improve worker compensation though health insurance benefits.[24] The endurance of ESI is bolstered by the tax exemption for health insurance premiums: Employer contributions toward premiums are exempt from income and payroll taxes, and employee contributions are generally income tax exempt.[25]

Even prior to implementation of the Affordable Care Act's (ACA) standards on coverage of essential health benefits[26] and "minimum value,"[27] ESI plans tended to be relatively generous. A 2010 study found that the average actuarial value (AV)—the percentage of total average costs for covered benefits that a plan will cover[28]—of employer coverage was 83 percent, compared with 60 percent AV for plans in the individual market.[29] Another study, in 2011, found that only about 2 percent of people covered by ESI had plans with value below 60 percent AV—equivalent to lowest-value metal tier, or bronze, coverage in the ACA marketplaces.[30] The vast majority of ESI enrollees were in plans with an AV at or above 80 percent, which is gold tier in the marketplaces.

Workers place high value on ESI: In a 2018 survey by America's Health Insurance Plans, more than half (56 percent) of respondents said quality insurance coverage was a deciding factor to stay at their job.[31] Because sponsoring health insurance is critical for employee recruitment and retention, employers are understandably concerned about their ability to manage the cost.[32]

Figure 2



Among employees who enroll in their employer's plan, the majority are satisfied with the coverage they receive. In a 2021 poll by the Employee Benefit Research Institute, 63 percent of respondents reported being "extremely or very satisfied" with their employer-based plan.[33] However, an analysis by The Commonwealth Fund found that nearly 1 in 3 people (29 percent) covered by ESI in 2022 were underinsured, meaning that the cost sharing in their plan was unaffordable.[34] Moreover, because employees' premium contributions within a firm usually do not vary by income—in contrast to ACA health insurance marketplace coverage, which offers income-based subsidies—lower-paid workers typically owe a greater share of their income toward health coverage.[35] While an ESI offer does not preclude eligibility for Medicaid or Children's Health Insurance Coverage (CHIP), people with an ESI offer whose employee contribution is considered "affordable" by the ACA's standard are not eligible for health insurance marketplace subsidies.[36]

Coverage that is unaffordable or insufficient can harm enrollees' physical, as well as financial, health.

A 2019 survey conducted by the Kaiser Family Foundation and the *Los Angeles Times* found that 33 percent of people with ESI "put off or postponed" needed care due to cost, and 18 percent did not fill prescriptions, rationed doses, or skipped doses of medicine.[37] More than one-quarter (27 percent) of respondents also reported problems with paying medical bills, and those who reported problems with the affordability of care or coverage had taken measures such as cutting back on other spending, taking on more credit card debt, using up savings, borrowing from friends or family, or taking out loans.[38]

Glossary

Cost sharing: Costs for covered health care services that the enrollee pays out of their own pocket. It generally includes deductibles, coinsurance, and copayments but not premiums.

Deductible: The amount an enrollee pays for covered health care services before the insurance plan starts to pay.

Fully insured plan: A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

Premium: The amount paid on a regular basis—usually monthly—for enrollment in a health insurance plan. In employer-sponsored coverage, some portion of the premium is typically paid by the employer, and the other portion is paid by the employee.

Self-insured plan: A plan offered by an employer that directly assumes the major cost of health insurance for its employees. Self-insured employers bear the entire risk or can insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third-party administrators for claims processing and other administrative services; other self-insured plans are self-administered.

Sources: U.S. Bureau of Labor Statistics, "Definitions of Health Insurance Terms"; HealthCare.gov, "Glossary."[39]

Eligibility and uptake rates have remained largely the same over the past decade

Over the past decade, there has been little change in how many employers offer insurance to their employees.[40] According to Kaiser Family Foundation's 2022 Employer Health Benefits Survey, approximately 89 percent of workers are employed by a firm that offers health insurance, a 2 percent decrease from 2010.[41] Larger firms are more likely to offer ESI than smaller ones.[42] (see Figure 3) Nearly all firms (99 percent) with 200 or more employees offer ESI to at least some of their employees, while only about half (39 percent) of firms with three to nine employees offer coverage.[43]

Figure 3

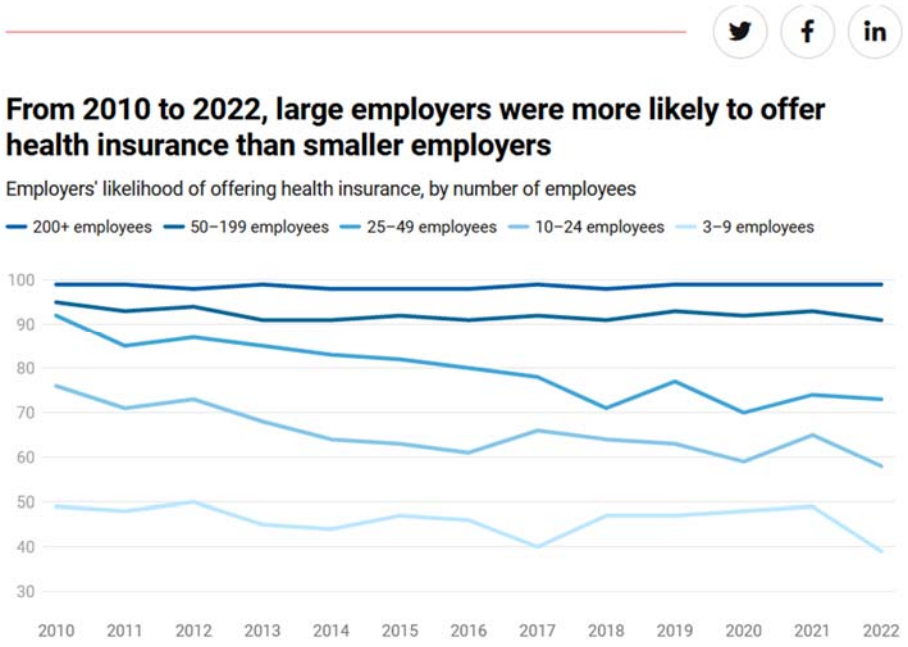


Chart: Center for American Progress Source: Gary Claxton and others, "2022 Employer Health Benefits Survey" (San Francisco: Kaiser Family Foundation, 2022), available at https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/.

Similarly, employee eligibility and uptake of ESI have remained largely unchanged over the past decade.[44] As of 2022, 58 percent of all small-firm employees and 61 percent of all large-firm employees are covered by their own employer's ESI plan.[45] Employers offering ESI typically limit eligibility to full-time employees. In 2022, 78 percent of workers were eligible for health insurance through their employer. As of 2022, a slightly higher share (79 percent) of employees were eligible on average for coverage at small employers (three to 199 employees) than at large employers (200 or more employees), at 78 percent.[46]

Reasons eligible employees may choose not to enroll in their employer's plan include lack of affordability, coverage available through a spouse's or parent's employer, or eligibility for public coverage such as Medicaid or Medicare.[47] Among ESI-eligible employees in 2022, 77 percent chose to enroll.[48] Among those eligible for ESI, employees of large employers are slightly more likely (78 percent) to enroll in their employer's insurance plans than those of smaller ones (73 percent).[49] Uptake rates also vary by employee wage level and age.[50] In firms with a large number of low-wage workers (making $30,000 or less annually), uptake was 71 percent in 2022, compared with 82 percent in firms with a large number of high-wage workers (making more than $70,000 annually).[51] Additionally, older employees are more likely than younger employees to enroll: Firms with a large share (35 percent or more) of workers ages 50 years and older had enrollment rates of 80 percent, while firms with younger workers (at least 35 percent 26 years and younger) had enrollment of 69 percent.[52]

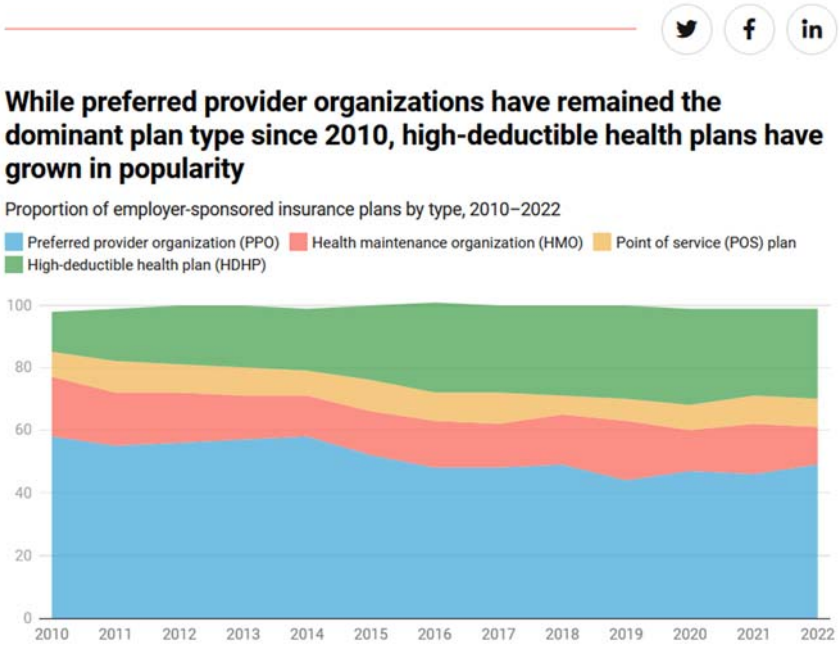
Enrollment among the 4 major plan types has stabilized since 2016

Plan type is one of the primary tools that employers use to rein in costs. Four common types are: health maintenance organization (HMO) plans, point of service (POS) plans, preferred provider organization (PPO) plans, and high-deductible health plans. Each of these plan designs takes a different approach to cost containment and access to care. In addition, within any plan design, employers may opt to offer more restrictive provider networks to direct enrollees to lower-cost or higher-quality care.

An HMO typically offers lower costs for premiums, deductibles, and other cost sharing, which it achieves through a more restrictive provider network.[53] Typically, an HMO requires subscribers to receive care from in-network providers and will only pay for care from out-of-network providers in the event of an emergency.[54] POS plans require that care be coordinated through a primary care provider but provide coverage for out-of-network providers with a referral while still incentivizing enrollees to use in-network providers by offering lower cost sharing for in-network providers.[55]

PPOs held the dominant position in the ESI market prior to the advent of HDHPs in the mid-2000s.[56] PPOs offered patients a network of providers available at reduced rates while still affording them more affordable coverage for out-of-network care when needed, without a referral.[57] However, this freedom came with the highest premiums of any plan type, and PPOs have lost ground to HDHPs, which offer lower monthly premiums in exchange for higher deductibles.[58] Between 2010 and 2022, PPOs went from 58 percent of the ESI market to 49 percent, while HDHPs jumped from 13 percent to 29 percent.[59] HDHPs' increase in market share stalled in 2016, and they captured approximately 30 percent of ESI enrollment from 2016 to 2022.[60] During this time, HMOs accounted for 16 percent to 19 percent, and POS plans represented 7 percent to 10 percent of the market.[61] (see Figure 4)

Figure 4



Note: Percentage totals may not equal 100 percent due to source rounding.

Source: Gary Claxton and others, "2022 Employer Health Benefits Survey" (San Francisco: Kaiser Family Foundation, 2022), available at https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey/.

The defining feature of HDHPs, as the name suggests, is a large deductible, and an HDHP is typically accompanied by an HSA that allows the enrollee to set aside a portion of their wages in a tax-free account that can be used for medical expenses.[62] For 2022, the IRS minimum deductible for an HSA-qualifying HDHP is $1,400 for single coverage, and it will increase to $1,500 in 2023.[63] In theory, HDHPs, which are sometimes referred to as consumer-driven health plans, incentivize enrollees to shop for lower prices for care, reducing premiums for both employers and employees.[64] This plan design is most attractive to enrollees who anticipate either having little to no health care needs or having health expenditures well beyond the deductible.

The trade-off of lower premiums is that HDHP deductibles can be in the thousands of dollars, discouraging enrollees from seeking care due to cost before the plan benefits fully kick in. A study by researchers at the Texas A&M University School of Public Health found that HDHP enrollees earning less than $75,000 are most likely to avoid care and that the care most often avoided is low-cost primary care.[65] These individuals showed significantly higher utilization of preventable and avoidable emergency department visits than their higher-wage counterparts.[66] The study authors speculate that low-income individuals have greater difficulty meeting their deductible and affording primary or maintenance care.[67] Other research shows that HDHP enrollees' care avoidance often extends to preventive services available to the patient at no cost under the ACA.[68]

Firms of all sizes are feeling the weight of rising premiums

Health care has been one of the fastest-growing segments of the economy,[69] rising from $2.6 trillion in 2010 to $4.1 trillion in 2020—at which point it represented nearly 20 percent of U.S. gross domestic product.[70] Premiums for ESI have also risen steadily for both individual and family coverage. According to the 2022 Kaiser Family Foundation Employer Health Benefits Survey, individual coverage premiums rose 58 percent, from an average of $5,049 annually in 2010 to $7,911 in 2022.[71] Over the same period, family coverage premiums rose more than 63 percent, from $13,770 to $22,463.[72] Put another way, the annual premium for individual coverage has risen more than $225 per year on average, and family coverage has risen more than $700 per year on average from 2010 to 2022.[73]

The annual premium for individual coverage has risen more than $225 per year on average, and family coverage has risen more than $700 per year on average from 2010 to 2022.

While premiums continue to rise at firms of all sizes,[74] employees working for larger firms on average pay a smaller share of the total premium. Data from the U.S. Bureau of Labor Statistics show that in 2022, the median monthly premium contribution for family coverage at a firm employing more than 500 people was $446, while the amount for an employee at a firm employing 100 to 499 people was $466, and $538 for an employee at a firm with fewer than 100 people.[75] Employee contributions toward single coverage in 2022 show a similar pattern by firm size.

Among the tactics that employers can use to address rising premiums, besides switching the type of plans offered, are self-funding their insurance plan and modifying plan benefit design to shift costs from premiums to out of pocket.

Self-funded vs. fully funded ESI plans

Employers can attempt to gain greater control over health insurance costs by self-funding their plan. A firm with a fully insured plans contracts with the insurance company that bears the financial risk. In contrast, firms that self-insure bear the claims risk themselves and purchase only administrative services from a third-party administrator, typically an insurance carrier.[76] While self-funding gives firms greater control over benefits offered, it can be more difficult for small or medium firms because of the liquid capital needed to comfortably self-insure.[77] In some instances, self-insuring firms will purchase reinsurance or stop-loss insurance for protection against claims above a certain threshold.

Another major difference between fully insured and self-funded plans is how they are regulated. Most issues of insurance are regulated at the state level, typically by state insurance commissions.[78] However, self-funded health insurance plans were exempted from these state regulations by the Employee Retirement Income Security Act (ERISA).[79] Passed in 1974, Section 514 of ERISA preempts state authority to regulate self-funded health plans.[80] As such, regulation of self-funded plans is controlled by the U.S. Department of Labor.[81]

While one might expect self-funded firms to have greater control over costs, average annual premiums for fully insured and self-funded plans have risen over the past five years, at 13 percent and 18 percent, respectively.[82] An additional concern for self-insured plans is whether the plan's third-party administrator will actually act in the best interest of the sponsoring firm. In most instances, the employer funds the plan but does not actively participate in negotiations with providers. Instead, the third-party administrator negotiates with providers and then offers plan packages to the self-insuring employer.[83] Third-party administrators are typically paid a percentage of the total claims processed or on a per-member, per-month basis, both of which create a disincentive for the third-party administrator to reduce costs.[84]

Even large employers can struggle to secure lower prices for health coverage.[85] A study by researchers at the Johns Hopkins Bloomberg School of Public Health and the Johns Hopkins Carey School of Business found that large firms operating in metropolitan statistical areas did not have sufficient market power to match providers due the concentration among providers.[86] The study authors suggest that to achieve the necessary market power to negotiate lower rates, employers should either shift to fully insured plan models to incentivize insurance companies to negotiate more zealously by placing the financial risk on the negotiating party, or, in order to remain self-funded, create purchasing alliances, including other businesses and state and local government employee groups to empower direct negotiations by employers.[87]

How higher deductibles shift costs onto employees

Deductibles are another mechanism that employer-sponsored plans have used to reduce the premiums without securing lower prices for care. Deductibles in ESI plans are becoming both more common—in part because of the growth of HDHPs—and more expensive. The percentage of plans with a deductible rose from 78 percent in 2010 to 89 percent in 2021.[88] The amounts of these deductibles have risen dramatically among firms of all sizes: The average deductible for a single coverage plan nearly doubled in the last decade, from $1,025 in 2010 to $2,004 in 2021.[89] In 2021, average deductibles for both individual and family coverage are significantly higher ($2,378 and $4,816, respectively) for plans sponsored by small firms with 50 to 99 employees, compared with those for plans at firms with 100 or more employees ($1,865 and $3,646, respectively).[90]

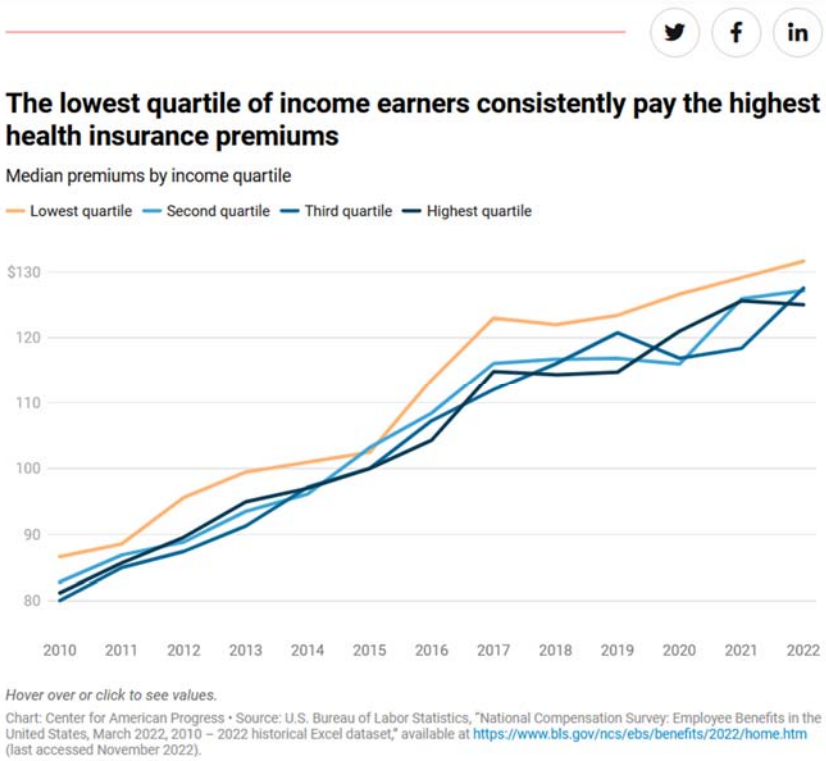
Deductibles in ESI plans are becoming both more common … and more expensive.

Amid a tighter labor market, however, employers are feeling the pressure from employees to halt the shift to HDHPs and away from traditional plan types.[91] Workers who have reached their limit to bear cost sharing may decline enrollment offers or employment offers altogether.[92] The employer benefits consultancy Mercer observed that in 2021, cost shifting as a cost-containment tool now "seems to be off the table for many employers," resulting in an "unexpected reversal" of some cost-sharing trends in plan benefit design.[93]

Low-income workers pay a greater share of income toward ESI coverage

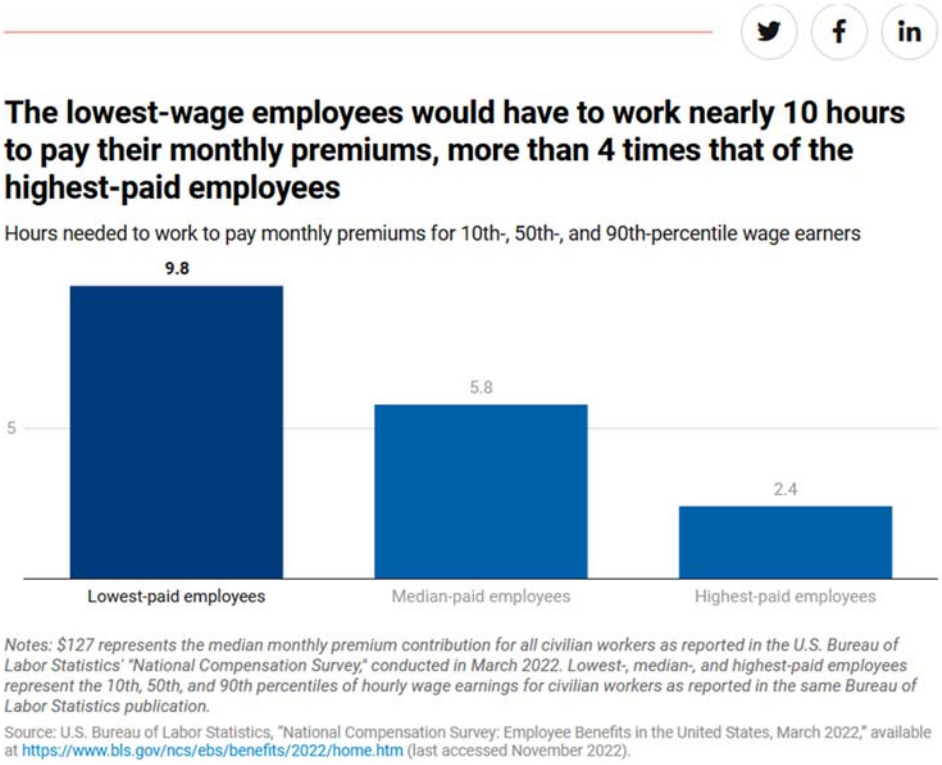
Because most employers do not adjust premiums or cost sharing based on employee wages or income, those who can least afford it often end up paying a higher portion of their wages toward coverage.[94] For both individual and family coverage, lower-wage workers not only contribute a greater share of their pay toward the employee contribution for premiums, but also pay more in absolute dollars than higher-wage employees. In 2022, the lowest-paid quartile of employees paid $6 more per month for individual coverage and $72 more per month for family coverage than the highest quartile of income earners, according to Bureau of Labor Statistics data.[95] (see Figure 5)

Figure 5



As simple illustration of the differences in the relative financial burden of ESI premiums among workers within a firm, imagine a firm that offered a health plan for single coverage for which the employee premium contribution is $127 per month—the all-worker median contribution as of March 2022, according to the Bureau of Labor Statistics.[96] At this hypothetical firm, the lowest-paid employee earns $13 per hour, which happens to be the 10th percentile of hourly wages nationally, and the highest-paid employee earns $54 per hour, equal to the 90th percentile.[97] For the lowest-paid employee, the monthly premium contribution is equivalent to 10 hours' worth of pretax wages. In contrast, the highest-paid worker can cover their premium contribution with 2 1/2 hours' wages. (see Figure 6)

Figure 6



In addition to the cost of premiums, cost sharing in ESI can pose a barrier to lower-income workers and their families. For lower-income individuals, the deductibles in ESI plans are higher than those they would face in ACA marketplace plans if subsidy eligible. Among marketplace enrollees in silver-tier coverage—for which those with family incomes under 250 percent of the federal poverty level (FPL) can receive cost-sharing reductions—the average deductible in 2010 was less than $1,000.[98] An analysis of 2018 data by the Urban Institute found "systematic and widespread gaps in access to affordable ESI" across the nation for low-income workers and the out-of-pocket maximum in ESI among private sector workers to be $4,416—four times the out-of-pocket maximum that an individual with an income at 100 percent of the FPL would face in marketplace coverage.[99]

For lower-income individuals, the deductibles in ESI plans are higher than those they would face in ACA marketplace plans.

These differences in ESI availability and affordability for high- and low-income workers are reflected in enrollment rates. Among employers with a high proportion of high-wage employees (35 percent earning more than $70,000), 82 percent of employees chose to take up their employer's insurance in 2022, compared with 71 percent of employees at firms with a high proportion of low-wage employees (35 percent earning less than $30,000) that same year.[100] The lack of affordability of ESI also contributes to disparities in insurance rates by income.[101] In 2021, 4 percent of nonelderly adults with family incomes above 400 percent of the FPL were uninsured, in contrast to 17 percent of those at 100 percent to 399 percent of the FPL and 24 percent of those under 100 percent of the FPL.[102] Workers who are offered job-based coverage generally do not qualify for

income-based financial assistance to purchase ACA marketplace plans on their own, unless their ESI contribution exceeds a certain share of their income (9.12 percent in 2023).[103]

Some employers do offer reduced ESI premiums or cost sharing based on wage and salary levels. Large firms are more likely to offer wage-tiered premiums;[104] among those that have done so are General Electric Co., Pitney Bowes, Synchrony, News Corp., and JPMorgan Chase & Co.[105] About 10 percent of large firms (200 or more employees) currently have a program to lower premiums for lower-wage workers, and 5 percent have programs to reduce cost sharing for lower-wage workers.[106] The Bureau of Labor Statistics reports that in 2017, nearly one-quarter of civilian employees covered by an ESI—24 percent of those with single coverage and 23 percent of those with family coverage—were enrolled in a plan with tiered premiums based on salary.[107] Of those plans with premium tiers, 68 percent included three or more tiers for both single and family coverage.[108] An August 2022 survey by Willis Towers Watson showed a similar portion (28 percent) of employers tiering premiums based on employee salary and an additional 13 percent of employers reporting they considered implementing a tiered structure in the next two years.[109]

Rising costs are unsustainable for workers and employers

Employers have attempted to contain health care costs in a variety of ways, including increasing the share of employee premium contributions, raising deductibles, and using HDHPs, as well as other tactics, such as offering a narrower network of providers or joining with other employers in provider negotiations. However, these strategies have limited impact on a key underlying cause of rising ESI costs: high prices for care. While some employers have successfully improved their bargaining position vis-a-vis providers by collaborating with other purchasers and advocating for greater price transparency, until employers can negotiate meaningfully lower prices across the board, ESI costs will continue to rise for employers and employees.[110]

These strategies have limited impact on a key underlying cause of rising ESI costs: high prices for care.

In a 2021 poll by the Kaiser Family Foundation and Purchaser Business Group on Health, only 4 percent of business leaders disagreed with the statement “employer costs for health benefits are excessive.”[111] Nearly 9 in 10 (87 percent) respondents said they believed that in the next five to 10 years, the cost of providing health benefits would be “unsustainable,” and 85 percent believed that a “greater government role in coverage and costs” would be needed.[112]

Some recent health reform proposals take aim at the cost of health care for those privately insured. Several states have established cost commissions, which are tasked with benchmarking health care cost growth and conducting market analysis that can be used in enforcement actions.[113] Additionally, reforms to the insurance system, such as an employer public option or default contract, could provide insurers and purchasers with leverage to secure lower prices or introduce a degree of provider rate regulation.[114] Other interventions that could help lower the price of care include robust state and federal enforcement of existing antitrust laws and outlawing anti-competitive contracting practices—such as anti-steering, anti-tiering, or all-or-nothing clauses—that hamper insurance plans’ ability to tailor networks of higher-quality, lower-cost providers.[115] Lastly, while the prescription drug price negotiation and drug price hike rebates included in the Inflation Reduction Act apply only to Medicare, earlier versions of drug pricing legislation would have extended those features to the commercial market, potentially saving employers and ESI enrollees $256 billion between 2023 and 2029.[116]

Conclusion

The financial burden of employer-sponsored coverage has grown for both employers and employees over the past decade. While employees continue to value health coverage as a highly desirable benefit and most employers see it as a crucial tool for recruitment and retention, costs are rising—and firms have dealt with this over the past decade by shifting costs through plan design changes and increasing deductibles.

Employers are worried about the long-term sustainability of ESI,[117] and there is reason to believe that ESI cost growth is approaching a tipping point. Without policies to keep in check health care prices for private insurance, high ESI premiums and cost sharing; affordability problems; and income-based inequities among workers will continue to worsen.

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Endnotes

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