
# Out-of-Pocket Spending Caps Protect Families in Oregon

Families USA

# Worry Less, Spend Less:
# Out-of-Pocket Spending Caps Protect Families in Oregon



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# Introduction

Paying for health care has become increasingly burdensome for Oregon families. As the cost of health care services has mounted, more and more health care costs have been shifted to consumers, who must cope with rising deductibles and higher copayments and co-insurance.

To relieve consumers of some of this financial burden, the Patient Protection and Affordable Care Act (Affordable Care Act) places caps on how much money insured people will have to spend out of their own pockets for health care services that are covered in the new law's essential benefits package. These caps on out-of-pocket health care spending will go into effect in 2014, when millions of Americans begin to purchase coverage in the new health insurance exchanges. The out-of-pocket spending caps will follow a sliding scale: Those with lower and middle incomes will pay less out of pocket than those with higher incomes. The new caps guarantee that consumers will not have to pay more than a set amount annually in out-of-pocket expenses for these covered services.

These new protections will obviously help those who are fighting expensive chronic illnesses, but they will benefit many others as well. While family health care spending remains low when people are healthy, every year, thousands of Americans receive new diagnoses for expensive conditions, such as heart disease, cancer, diabetes, and asthma. And every year, thousands of others suffer serious, unexpected injuries and illnesses. Such unpredictable events can drive up family health care costs dramatically. As a result, over time, many American families will benefit from these new caps.

Families USA commissioned The Lewin Group to analyze health care spending and determine how many Oregonians are in families that will have out-of-pocket spending that exceeds these new caps, and by how much. We asked The Lewin Group to base their estimate on expected patterns of health care spending for 2011.

We estimate that, *in 2011 alone*, 243,300 Oregonians are in families that will spend more out of pocket than these new caps for services that are included in the Affordable Care Act's essential benefits package. The total amount by which this out-of-pocket spending is estimated to exceed the caps is nearly $424.4 million. These new out-of-pocket caps will protect families from catastrophic medical costs when illness or accident strikes.

# Key Findings

## Oregon Families Will Benefit from Out-of-Pocket Caps

- In 2011, 243,300 Oregonians under the age of 65 are in families that will spend more than the out-of-pocket caps for covered services in the Affordable Care Act's essential benefits package (see Table 1).
- Spending by these families will exceed the caps by $424.4 million in one year alone.

Table 1.
Oregonians in Families Spending More than the Out-of-Pocket Caps

| Number of People | Spending > Caps |
|---|---|
| 243,300 | $424,368,400 |

**Source:** Estimates prepared by The Lewin Group for Families USA.

## Working Families in Oregon Will Save with Out-of-Pocket Caps

- More than two-thirds (70.2 percent) of the Oregonians who will spend more than the out-of-pocket caps are in working families (see Table 2).
- An estimated 170,700 Oregonians who will spend more than the out-of-pocket caps are in families where at least one person is employed full- or part-time.

Table 2.
Oregonians in Families Spending More than the Out-of-Pocket Caps, by Family Employment Status

| Family Employment Status | Number of People | As a Percent of All With Spending > Caps | Spending > Caps |
|---|---|---|---|
| Employed Full- or Part-Time | 170,700 | 70.2% | $295,733,700 |
| Employed Full-Time | 137,400 | 56.5% | $253,443,700 |
| Employed Part-Time | 33,300 | 13.7% | $42,290,000 |
| Unemployed (seeking work) | 19,400 | 8.0% | $23,228,800 |
| Not in Labor Force | 53,200 | 21.9% | $105,405,800 |
| **Total*** | **243,300** | **100.0%** | **$424,368,400** |

* Numbers may not add due to rounding.

**Source:** Estimates prepared by The Lewin Group for Families USA.

## Help for Families of Oregon's Small Business Employees

- An estimated 107,600 Oregonians in families where the head of the household is employed by a small business (those with fewer than 100 employees) will spend more than the out-of-pocket caps (see Table 3).
- More than two in five Oregonians (44.2 percent) who will spend more than the out-of-pocket caps are in families where the head of the household works for a business with fewer than 100 employees.

Table 3.

Oregonians in Families Spending More than the Out-of-Pocket Caps, by Size of Firm Employing The Head of Household

| Size of Firm Employing Head of Household | Number of People | As a Percent of All With Spending > Caps | Spending > Caps |
|---|---|---|---|
| Fewer than 100 Workers | 107,600 | 44.2% | $183,432,100 |
| Fewer than 25 | 91,900 | 37.8% | $151,304,400 |
| 25-99 | 15,700 | 6.5% | $32,127,700 |
| 100-999 | 18,400 | 7.6% | $26,882,600 |
| 1,000-4,999 | 20,100 | 8.3% | $24,345,100 |
| 5,000+ | 15,700 | 6.5% | $43,374,400 |
| Government* | 18,000 | 7.4% | $25,501,200 |
| Non-Worker | 63,600 | 26.1% | $120,832,800 |
| **Total**** | **243,300** | **100.0%** | **$424,368,400** |

* The Medical Expenditure Panel Survey (MEPS) collects data for private- and public-sector employees separately.
** Numbers may not add due to rounding.
**Source:** Estimates prepared by The Lewin Group for Families USA.

- Of those Oregonians in families of small business workers, more than four out of five (85.4 percent) have a head of household who works for a business with fewer than 25 employees (see Table 4 on page 4).
- Families of Oregon's small business employees will spend $183.4 million more than the out-of-pocket caps.

Table 4.
Oregonians in Families of Small Business Employees Spending More than the Out-of-Pocket Caps

| Size of Firm Employing Head Of Household | Number Of People | As a Percent Of Families of Small Business Workers | As a Percent Of All with Spending > Caps | Spending > Caps |
|---|---|---|---|---|
| Fewer than 25 Workers | 91,900 | 85.4% | 37.8% | $151,304,400 |
| 25-99 Workers | 15,700 | 14.6% | 6.5% | $32,127,700 |
| **Total*** | **107,600** | **100.0%** | **44.2%** | **$183,432,100** |

* Numbers may not add due to rounding.
**Source:** Estimates prepared by The Lewin Group for Families USA.

# Discussion

Over the last two decades, health care spending has risen rapidly, driving an increase in insurance premiums. And as medical costs and premiums rose year after year, insurance plans covered fewer benefits and paid a smaller share of the benefits that they did cover. As a result, millions of American families were forced into the ranks of the underinsured, and still more were priced out of coverage entirely. Families have reached a breaking point—they simply can't continue to absorb an ever larger share of out-of-pocket health care costs.

People who have a chronic condition, such as diabetes or heart disease, have likely already felt the effects of these rising out-of-pocket costs. But even those who are healthy today may be at risk for high medical costs tomorrow—illness and injury happen suddenly and unexpectedly. For example, an estimated 1.5 million Americans will receive a diagnosis of cancer this year.[1] In addition, the latest data show that more than 340,000 Americans require emergency appendectomies each year, and at least 670,000 people need surgery to repair broken bones.[2]

When consumers are faced with expensive medical care, bills can pile up quickly, even for people with health coverage. Because illness and injury can't be predicted, it is imperative that families have insurance that provides true financial protection.

The Affordable Care Act will help protect Oregon families from high medical costs by establishing caps on out-of-pocket spending for health services that are included in the Act's essential benefits package. (For more on the benefits of these caps, see "Painting the Full Picture: How Capping Out-of-Pocket Spending Helps Us All" on page 6.) All health insurance plans that are sold in the exchanges and all new plans that are sold in the individual and small group insurance markets must provide this package of benefits. The package includes all acute health care services except vision and dental care for adults and restorative and orthodontic services for children.

The Affordable Care Act initially sets the level of these new caps by referencing an existing definition—the annual out-of-pocket spending limits for high-deductible health plans that are associated with Health Savings Accounts (HSAs). If these caps went into effect in 2011, they would be $5,950 for individuals and $11,900 for families.

The Affordable Care Act will further reduce these out-of-pocket caps for families with incomes below 400 percent of the federal poverty level (about $90,000 for a family of four[3]) who purchase coverage in the exchanges. The caps will be reduced on a sliding scale as follows:

- to one-third of the HSA limit for families with incomes between 100 and 200 percent of poverty (caps of $1,983/individual and $3,967/family in 2011);
- to one-half of the HSA limit for families with incomes between 200 and 300 percent of poverty ($2,975/individual and $5,950/family); and
- to two-thirds of the HSA limit for families with incomes between 300 and 400 percent of poverty ($3,967/individual and $7,933/family).

In this report, we examine the number of people who are in families that have out-of-pocket spending on essential benefits that exceeds the new caps, and by how much. Many families are liable for medical bills that are above the amounts of the caps and that they simply cannot afford to pay. However, our analysis looks solely at the amount of money that families actually spend out of pocket. We found that, in 2011, an estimated 243,300 Oregonians are in families that will have out-of-pocket spending for essential benefits that exceeds the caps. The total amount by which this spending will exceed the new caps is nearly $424.4 million.

## Painting the Full Picture: How Capping Out-of-Pocket Spending Helps Us All

This analysis focuses on the most direct way that the new out-of-pocket caps will help Oregon families: It quantifies the number of people in families who will have health care spending that exceeds the caps in 2011, as well as the dollar amount of that spending. Limiting the amount of money that families must pay out of their own pockets for care, however, is only part of the picture. The full benefit of the caps will be much broader.

In our current system, thousands of Oregon families are uninsured or underinsured, and many cannot afford to pay for the cost of the care that insurance doesn't cover. Private charities and government programs pay for some of the care that families can't afford, but the remaining amount is eventually written off by doctors, hospitals, and other providers as "uncompensated care." Unfortunately, this often creates a vicious circle: Providers attempt to recoup some of these losses by raising the prices that they charge for services. Insurers, faced with these higher prices, charge people with insurance (and their employers) higher premiums. As premiums rise, individuals and employers are forced to buy thinner coverage that includes fewer benefits. And when families have thinner coverage, they are more likely to be unable to pay all of their out-of-pocket medical costs.

The inability to pay a medical bill in full can have catastrophic consequences: It can result in long-term damage to a family's credit rating and harm their ability to meet financial needs now and in the future. However, as just described, we all pay the price for uncompensated care. Through the new out-of-pocket caps, health reform will help ease this burden for everyone by limiting the amount that families have to pay out of pocket for care. And by vastly increasing the number of people with comprehensive health coverage, health reform will also reduce the amount of uncompensated care that is provided.

What would our numbers have looked like if we had counted total medical bills above the out-of-pocket caps rather than families' actual spending? Approximately 296,100 Oregonians are in families with total medical bills that would exceed the out-of-pocket caps in 2011 (meaning that an additional 52,800 Oregonians would hit the caps if we had included the value of uncompensated care above the caps). The dollar value of these medical bills would be more than $864.6 million in 2011 (meaning that the value of uncompensated care that exceeds the caps would be $440.3 million in 2011).

## Eroding Coverage: How Insurance Plans Have Changed

Across all types of plans, both group and individual, health coverage now offers less protection than it did in the past. We have seen a significant change in health plans over the past decade, with a substantial shift toward consumers paying more out of pocket for health care in the form of higher deductibles, copayments, and co-insurance. This has resulted in an erosion of the quality of health coverage and an increased financial burden on American families.

### Employer Coverage

Between 2000 and 2010, the average premium for job-based family coverage grew from $6,438 to $13,770, an increase of 114 percent.[4] As premiums have risen, employers have been put in a difficult position: Years of compounding premium increases have left them with little choice but to reevaluate the coverage that they offer and explore options for controlling costs. Employers have three options when it comes to providing health insurance: Allow health benefits to consume more of their bottom line, pass along a greater share of costs to employees, or drop coverage entirely.

Most employers have opted to pass along a greater share of out-of-pocket costs to employees, generally in the form of higher deductibles, copayments, and co-insurance. In addition, insurance companies have introduced new types of cost-sharing aimed at controlling high spending, such as hospital-specific deductibles and tiered prescription drug plans that charge consumers more for higher-cost, brand-name drugs than for generics.[5] These changes mean that employer plans cover a lower percentage of total health care costs now than they did in the past.[6]

In spite of changes in plan design aimed at controlling premiums, many employers are deciding that they simply cannot afford to offer health coverage any longer. As a result, the share of Americans who get their coverage through the workplace has fallen substantially in recent years. In 2000, 64.2 percent of Americans were covered through their job or the job of a loved one. In 2009, only 55.8 percent had job-based coverage.[7]

Those who work for small businesses are especially at risk. Because small businesses have less buying power and face proportionately greater administrative burdens than their larger counterparts, small business owners pay up to 18 percent more than large businesses for a comparable health insurance plan.[8] These high and growing premiums have forced small business owners to make tough decisions regarding health benefits. Small employers are less likely to offer coverage, and when they do offer coverage,

they are more likely to place limits on which workers are eligible. As a result, small business workers are significantly less likely to have coverage through their employer than those who work for large businesses (25 percent versus 74 percent).[9] In addition, small business workers who do have coverage are less likely to have *quality* coverage. For example, those who receive their coverage through a small business are more likely to have plans with a deductible, and those small business employees who have plans with a deductible typically have higher deductibles than those who work for larger businesses.[10]

## Individual Market Coverage

Workers who don't receive coverage through their employer, either because they aren't offered coverage or because their employer has dropped coverage, must seek it on their own in the individual market (or go without). Generally, the individual market offers less comprehensive coverage that comes with higher cost-sharing. Policies sold through the individual market are more likely to have a sizeable deductible and other out-of-pocket expenses. For example, policies sold through the individual market are nearly four times as likely as employer plans to have a deductible of more than $1,000 (39 percent versus 11 percent).[11] In addition, one recent study found that overall out-of-pocket spending was 71 percent higher, on average, for people with individual policies than for people with employer coverage.[12]

Not only are policies sold through the individual market more likely to require high out-of-pocket spending for covered services, but they are also less likely to provide coverage for entire categories of essential services, such as prescription drug coverage and maternity care. For example, plans sold in the individual market are four times as likely as employer plans to exclude prescription drug coverage (20 percent versus 5 percent).[13] The disparity in maternity coverage is even greater: While nearly all employer plans cover maternity care, 57 percent of basic individual plans do not cover any maternity care.[14]

Because of the high cost and low quality of plans sold in the individual market, many people who seek coverage in the individual market cannot find a plan that meets their needs. According to a 2009 report, well over half (57 percent) of nonelderly adults who sought insurance in the individual market "found it very difficult or impossible to find affordable coverage." The same report noted that nearly three-quarters (73 percent) of nonelderly adults who sought insurance in the individual market never bought a plan because they could not find affordable, appropriate coverage, or they were denied coverage.[15]

## What Eroding Coverage Means for American Families

Eroding coverage puts American families at risk, both physically and financially. For example, eroding coverage leads to rising numbers of underinsured Americans. In 2003, 12.3 million Americans were underinsured. By 2007, that number had more than doubled to 25.2 million.[16] As more Americans become underinsured, more find themselves facing medical debt. Nearly half (45 percent) of underinsured adults had medical bill problems in 2007.[17] Medical debt can lead to credit troubles, bankruptcy, and foreclosure. In 2007, nearly one-third (30 percent) of adults who were struggling with medical bills took on credit card debt in order to pay their bills[18] (see "Health Care Credit Cards: Buyer Beware" on page 10). That same year, nearly two-thirds (62.1 percent) of all bankruptcies in America were due, at least in part, to illness and medical bills.[19] And a recent study of foreclosures in four states found that approximately half (49 percent) of foreclosures are due, in part, to medical problems.[20]

In addition to being financially burdensome, eroding coverage has also led to a dramatic increase in the number of people who delay getting necessary health care or forgo it entirely. In 2001, 29 percent of nonelderly adults had problems obtaining necessary medical care due to cost. By 2007, that number had risen to 45 percent, up by 16 percentage points.[21] Also in 2007, three in five (60 percent of) underinsured adults and nearly three-quarters (71 percent) of uninsured adults went without necessary health care because of cost.[22] Those who forgo necessary medical care are sicker when they eventually do seek care, and they require more intensive—and expensive—care.

Eroding coverage is particularly burdensome for people with chronic conditions such as cancer, for example. According to a recent study, nearly one-quarter (23 percent) of insured cancer patients found that their health plan paid less than they expected toward their health care costs. In addition, one in 10 insured cancer patients (10 percent) reached the limit for what their health plan would pay for cancer treatment.[23] This meant that, if they needed treatment beyond their plan's limit, they had to pay for it entirely out of their own pocket. Making matters worse, people with chronic conditions and high medical bills are likely to find themselves in a vicious circle: Those with high medical bills in one year are more likely to have high medical bills the next year as well.[24]

## Health Care Credit Cards: Buyer Beware

With health care costs rising year after year, Americans have turned to credit cards to cover their medical expenses. A recent study found that, in one year alone, consumers charged $45 billion in out-of-pocket health care expenses to their credit cards.[a] In addition, banks and credit card companies now offer special "health care credit cards" to pay for medical services that may not be covered by health insurance. And because they result in fast payments, health care providers often promote the use of these health care credit cards. However, consumers should be wary of such cards. While these cards frequently feature 0 percent introductory interest rates (as shown below), the terms and conditions of these promotional rates often trip up consumers. For example, when a consumer misses a payment or fails to pay off the balance in full by the end of the promotional period, high interest rates and/or fees may apply. This can accelerate the slide into medical debt.

The table below shows the terms and conditions of three medical-specific credit cards.[b]

| Credit Card Company And Plan Name | Promotional Interest Rate | Interest Rate (APR*) | Penalty Interest Rate |
|---|---|---|---|
| Chase Health Advance | No Interest for 12, 18, or 24 Months | 24.75%-27.99% | 29.99% |
| Citi Health Card | No Interest for 6 or 12 Months | 26.99% | 26.99% |
| GE Money's Care Credit | No Interest for 6, 12, 18, or 24 Months | 26.99% | 29.99% |

* The APR, or the annual percentage rate, is the amount paid in interest on a credit card per year.

Consumers should be aware of the terms and conditions associated with their credit cards—they should read the fine print and other contract information that pertains to their cards, especially if they are using them to pay for medical care. Savvy consumers can avoid excessive fees, but only if they are vigilant.

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[a] Nick A. LeCuyer and Shubham Singhal, "Overhauling the U.S. Health Care Payment System," *The McKinsey Quarterly* Web Exclusive (June 2007): 1-11.

[b] "GE Money Bank Credit Card Agreement," *CareCredit* (July 1, 2010): 1-11; "Financing," *Chase Health Advance*, available online at http://www.chasehealthadvance.com/patient-financing/financing.asp, accessed on September 20, 2010; personal communication between Credit Card representative, Citi Bank, and Elisabeth Rodman, Families USA, on September 20, 2010. The Credit Card Accountability Responsibility and Disclosure Act of 2009 (Credit CARD Act of 2009) includes some provisions that went into effect in 2009 and 2010 that limit credit card fees and require credit card companies to disclose more information to consumers. More information is available online at http://www.defendyourdollars.org/CC%20summary_1.25.2010.pdf.

# Conclusion

With the rising number of underinsured Oregon families facing medical debt, it is clear that the trend of eroding coverage is unsustainable. Health reform will help halt this trend: It creates new out-of-pocket caps that will protect Oregon families from catastrophic health care costs. These new caps guarantee that consumers will not have to pay more out of pocket for covered services than a set amount each year, thereby limiting deductibles, copayments, and co-insurance. This means that once consumers reach their out-of-pocket spending cap, their health plan must pay the full cost of any other covered services. These new caps will ensure that Oregon families have access to quality health coverage that provides the financial protection and peace of mind that they need.

# Endnotes

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[2] Carol J. DeFrances, Christine A. Lucas, Verita C. Buie, and Aleksandr Golosinskiy, "2006 National Hospital Discharge Survey," *U.S. Centers for Disease Control and Prevention National Health Statistics Reports* no. 5 (July 30, 2008): 1-20.

[3] Federal poverty levels are available online at http://aspe.hhs.gov/poverty/.

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[6] Jon R. Gabel, Roland McDevitt, Ryan Lore, Jeremy Pickreign, Heidi Whitmore, and Tina Ding, "Trends in Underinsurance and the Affordability of Employer Coverage, 2004-2007," *Health Affairs* Web Exclusive (June 2, 2009): W595-W606.

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[10] Kaiser Family Foundation and Health Research and Educational Trust, op. cit.

[11] Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* (New York: The Commonwealth Fund, July 2009).

[12] Roland McDevitt, Jon Gabel, Ryan Lore, Jeremy Pickreign, Heidi Whitmore, and Tina Brust, "Group Insurance: A Better Deal for Most People than Individual Plans," *Health Affairs* 29, no. 1 (January 2010): 156-164.

[13] Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, op. cit.

[14] Roland McDevitt, Jon Gabel, Ryan Lore, Jeremy Pickreign, Heidi Whitmore, and Tina Brust, op. cit.

[15] Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, op. cit.

[16] Cathy Schoen, Sara R. Collins, Jennifer L. Kriss, and Michelle M. Doty, "How Many Are Underinsured? Trends among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive (June 10, 2008): w298-w209. "Underinsured" is defined as spending 10 percent or more of annual family income on out-of-pocket medical expenses, or spending 5 percent or more of annual income on medical expenses in low-income families, or having deductibles equal to 5 percent or more of annual income.

[17] Cathy Schoen, Sara R. Collins, Jennifer L. Kriss, and Michelle M. Doty, op. cit.

[18] Sara R. Collins, Jennifer L. Kriss, Michelle M. Doty, and Sheila D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families* (New York: The Commonwealth Fund, August 2008).

[19] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine* 122, no. 8 (August 2009): 741-746.

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[21] Sara R. Collins, Jennifer L. Kriss, Michelle M. Doty, and Sheila D. Rustgi, op. cit.

[22] Ibid.

[23] *USA Today,* Kaiser Family Foundation, and Harvard School of Public Health, *National Survey of Households Affected by Cancer* (Washington: Kaiser Family Foundation, November 2006).

[24] Peter J. Cunningham, *Chronic Burdens: The Persistently High Out-of-Pocket Health Care Expenses Faced by Many Americans with Chronic Conditions* (New York: The Commonwealth Fund, July 2009).

# Methodology

Families USA commissioned The Lewin Group to provide an analysis of the estimated number of people in families with out-of-pocket spending in 2011 that would exceed the out-of-pocket spending caps that are defined in the Patient Protection and Affordable Care Act (the Affordable Care Act) if they were in effect in 2011. In addition, Families USA asked The Lewin Group to estimate the aggregate dollar amount by which the out-of-pocket spending of those individuals and families would exceed these caps.

To undertake this analysis, The Lewin Group used their Health Benefits Simulation Model (HBSM) to determine how many individuals and families would spend money out of pocket on the health care services that are specified in the essential benefits package that is defined in the Affordable Care Act if the out-of-pocket caps were to take effect in 2011. (It therefore excluded spending on certain health care services. For example, spending on dental services for adults was not counted because these services are not included in the Affordable Care Act's list of required essential benefits.)

The Lewin Group then looked at how many of these people would have out-of-pocket spending for covered services that exceeds the caps specified in the Affordable Care Act. Finally, they looked at the level of spending for each individual or family that would exceed the cap defined for their family income level and aggregated these amounts to come up with an estimate of the total amount of out-of-pocket spending in 2011 that exceeds the caps.

## Out-of-Pocket Protections in the Affordable Care Act

Under the Affordable Care Act, all health insurance plans sold through the exchanges and all new individual and small group plans will be required to cover a package of essential benefits that is outlined in the law. New health insurance plans will also be required to have caps on how much an individual or family must pay out-of-pocket for covered services. These caps will limit the amount that an individual or family must pay in deductibles, copayments, and co-insurance for essential benefits.

Under the Affordable Care Act, the out-of-pocket caps will be linked to the spending maximums for high-deductible plans that are associated with Health Savings Accounts (HSAs) in 2014. The Act provides more protection for lower-income individuals and

families by reducing the out-of-pocket caps on a sliding scale for those who purchase coverage through the new exchanges. If the caps took effect in 2011, the out-of-pocket caps for individuals and families with incomes between 100 and 200 percent of the federal poverty level would be $1,983 for an individual and $3,967 for a family. For those with incomes between 200 and 300 percent of poverty, the caps would be $2,975 for an individual and $5,950 for a family. For those with incomes between 300 and 400 percent of poverty, the caps would be $3,967 for an individual and $7,933 for a family. For individuals and families with incomes above 400 percent of poverty, the caps would be $5,950 for an individual and $11,900 for a family.

The Affordable Care Act extends Medicaid eligibility to all U.S. citizens with incomes below 133 percent of the federal poverty level, as well as to legally present immigrants who have been in the country for a minimum of five years who meet the same income test. A standard income disregard of 5 percent effectively raises this income eligibility level to 138 percent of poverty. Medicaid cost-sharing requirements are nominal for enrollees with incomes below the federal poverty level and cannot exceed 10 to 20 percent of service costs for enrollees with incomes above the federal poverty level. In addition, no family with Medicaid coverage can be required to pay more than 5 percent of family income on premiums and any cost-sharing payments (deductibles, copayments, or co-insurance). Thus, for this analysis, The Lewin Group assumed that maximum out-of-pocket spending could not exceed 5 percent of family income for U.S. citizens and legally present immigrants who have been in the country for at least five years with incomes below 138 percent of poverty.

## The Health Benefits Simulation Model

For this analysis, The Lewin Group used their Health Benefits Simulation Model (HBSM). The HBSM baseline data are based on pooled Medical Expenditures Panel Survey (MEPS) data for 2002 through 2005. These data provide information on sources of coverage and health care expenditures by service categories for a representative sample of the population and are used to provide the underlying distribution of health care utilization and expenditures across individuals by age, sex, income, source of coverage, and employment status. These data are pooled to increase sample size, which is necessary to more accurately analyze expenditures for people with high levels of health spending, as they are a smaller proportion of the total population. The Lewin Group then re-weighted their health coverage and expenditures database to reflect the population control totals that were reported in the March 2009 Census Bureau Community Population Survey.

In addition, The Lewin Group "aged" the health expenditure data that were reported in the MEPS database to reflect expected changes in the characteristics of the population through 2011. These data were adjusted to reflect projections of the health spending by type of service and source of payment in 2011. Spending estimates are based on the National Health Expenditure Accounts data provided by the Centers for Medicare and Medicaid Services (CMS) and detailed projections of expenditures for people with different sources of coverage and across various Medicaid eligibility groups. The result is a database that is representative of the population by economic and demographic group and that also provides extensive information on the joint distribution of health expenditures and utilization across population groups for 2011. Because these spending estimates are coded to reflect categories of health care services, The Lewin Group can sort spending by categories to isolate spending for only the essential benefits that are required to be covered by new plans under the Affordable Care Act.

## Identifying Spending Above the Out-of-Pocket Caps

The Lewin Group used the underlying data in the HBSM to identify the number of people in families with out-of-pocket spending for covered health services that exceeds the maximum spending caps as defined in the Affordable Care Act. They looked solely at legal residents who are under the age of 65 and not enrolled in Medicare. For the purposes of this analysis, Lewin assumed that all eligible individuals and families will enroll in coverage. In addition, The Lewin Group limited the range of services for which direct spending was counted to those services that are specified in the essential benefits package in the Affordable Care Act. These covered services include all acute health care services (but not long-term care, home health care, and other personal care services) except for vision and dental care for adults and restorative dental and orthodontia services for children. The Lewin Group then analyzed spending above the caps under two sets of assumptions. First, it looked solely at direct out-of-pocket payments made by an individual or family to a health care provider for medical services. This report looks primarily at findings under this set of assumptions. Second, The Lewin Group looked at both direct out-of-pocket spending by individuals and families and the value of any unpaid medical bills that were eventually allocated by a hospital or other provider to the "free care" category. Findings under this set of assumptions can be found in "Painting the Full Picture: How Capping Out-of-Pocket Spending Helps Us All" on page 6.

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