Research

To Buy or Not to Buy: Uninsured Young Adults and the Perverse Economic Incentives of the ACA

CONOR RYAN, CHRISTOPHER HOLT | JANUARY 22, 2014

Executive Summary

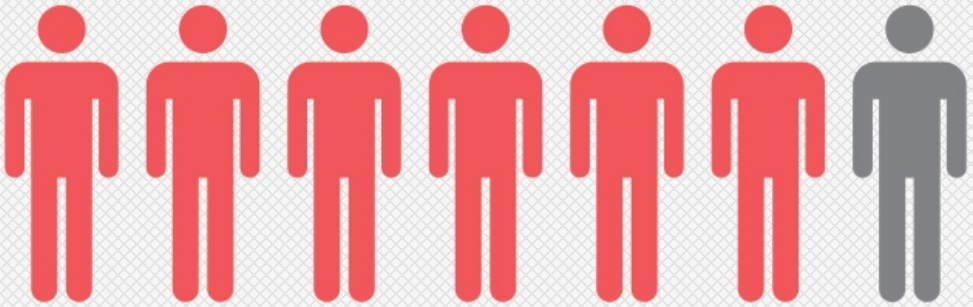
The Affordable Care Act's (ACA) state-based health insurance exchanges, now in the fourth month of open enrollment, are relying on the participation of young adults—defined as 18 to 35 year olds—to create a balanced risk pool. Whether that participation materializes will be a key factor in the law's ultimate success or failure.[1] Recently released data from the Department of Health and Human Services on the breakdown of enrollee age shows young adults make up only 24 percent of total enrollment through December 28, 2013—well below the administration's target level of 39 percent.[2] The ACA's perverse economic incentives are well documented. The law makes health insurance more expensive for many young adults, while at the same time making the decision to go without health coverage exponentially less risky than it previously was. It is impossible to predict how many young adults will ultimately enroll in coverage, but it is clear that many young adult enrollees will be worse off financially if they decide to purchase health insurance.

American Action Forum (AAF) experts previously reported in two October 2013 studies that a 30 year old male can expect premiums for his least costly insurance option to increase on average 260 percent in 2014,[3] while a 30 year old female will see an average increase of 193 percent.[4] In this study we seek to determine whether uninsured young adult households will find purchasing insurance coverage through the exchanges to be a financially advantageous decision when compared to remaining uninsured, and paying health care costs out of pocket.

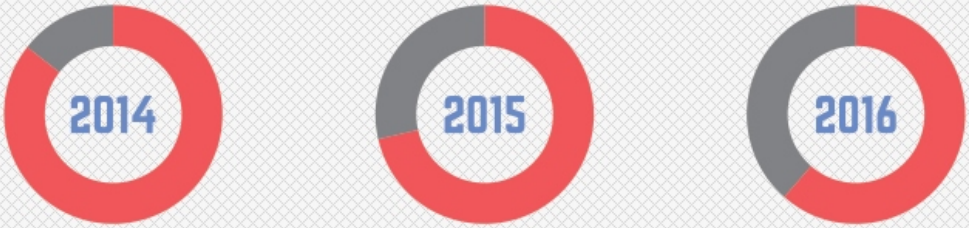
We find that after accounting for subsidies and cost-sharing, 6 out of 7 uninsured, young adult households will find it financially advantageous to forego health coverage, and instead pay the mandate penalty and cover their own health care costs. As the penalty increases, that number will drop from 86 percent in 2014 to 71 percent in 2015 and 62 percent in 2016, before ticking back up to 66 percent in 2019. In two additional analyses, using alternate assumptions explained in further detail below, the exact percentages vary, but the overall finding is constant; the majority of uninsured young adults will benefit financially from opting out of coverage in 2014.

TO BUY OR NOT TO BUY?

2014: 6 OUT OF 7 UNINSURED YOUNG ADULTS WILL SAVE MONEY BY FOREGOING INSURANCE AND PAYING THEIR HEALTH CARE COSTS OUT OF POCKET.



AS THE INDIVIDUAL MANDATE PENALTY INCREASES, THE OUTCOME STAYS THE SAME – MOST YOUNG ADULTS STILL BENEFIT FROM OPTING OUT OF COVERAGE.



AMERICAN ACTION FORUM

Data

Our analysis uses the 2011 Medical Expenditure Panel Survey Household Component (MEPS)—a large-scale, nationally-representative, household survey collected by the Agency for Healthcare Research and Quality. MEPS contains comprehensive information on Americans' utilization of medical care as well as the costs, and how medical care is financed. We focus on uninsured health insurance eligibility units (HIEU) which are defined more narrowly than a traditional family unit and denote a group of people that may purchase insurance as a unit. In this report, HIEU and household are used interchangeably. An HIEU is included in our sample if all members of the household were without health insurance for the entire year and the head of household is an exchange-eligible adult aged 18 to 35. For the purposes of this study, the head of household is defined as the oldest member of the HIEU, and the highest earner in the case of two persons of the same age.[5]

A household is considered exchange-eligible if it is not covered by the expansion of Medicaid. All households earning less than the federal poverty level (FPL) and some households earning between 100 and 138 percent of FPL are considered ineligible. Since Medicaid expansion beyond the poverty level is a state-by-state characteristic and MEPS data is a national sample, we accommodate the reduction of this population by manipulating household weights. Using state-level data from the American Community Survey, we find that 51 percent of uninsured young adults earning 100 and 138 percent of FPL live in the 26 states expanding Medicaid (including the District of Columbia). Thus we reduce this population in our sample to 51 percent of the nationally representative population.

We remove from our sample any uninsured households that indicate they were unable to receive needed medical service or were delayed in doing so. If these respondents were included, the distribution of health spending by uninsured households would be biased towards low spending. In one variant of our analysis, we take a step further by including only households with non-zero health care spending. This is done to ensure that uninsured households who may be foregoing health care due to being uninsured do not skew the analysis. This assumption—further explained in the methodology section—provides a conservative way to account for general bias towards low spending caused by a lack of health insurance.

Methodology

The central comparison of this analysis is the cost of remaining uninsured versus the cost of premiums and out-of-pocket expenses for a Bronze or Silver plan on the newly implemented health insurance exchanges. An HIEU is considered to benefit from purchasing insurance if the predicted cost of doing so is lower than or equal to that of remaining uninsured.

For every HIEU in the sample, we calculate the cost of premiums and out-of-pocket expenses given the household's 2011 level of medical expenditure for both Silver and Bronze plans and allow the household to choose the cheapest option. The Bronze plan is cheaper for nearly all households; however, some income levels can take advantage of cost-sharing benefits for Silver plans which can reduce out-of-pocket spending enough to out-weigh the premium savings of a Bronze plan. The premium costs of Silver and Bronze plans are national averages based on age of the beneficiary.[6] The total premium cost for a household is the sum of the premiums for all of its members, with a maximum of 3 children adding to the cost. After 3 children, an additional child under 20 covered under an insurance plan incurs no additional premium cost.

Premium subsidies reduce the total cost of the health insurance coverage and are calculated separately for each household. The premium subsidy available to a household is equal to the cost of the second lowest cost Silver

plan available to the household less the portion of total household income the ACA prescribes will be paid for a Silver plan. Thus, the cost of that benchmark Silver plan will be exactly equal to the portion of household income prescribed by the law, and the cost of a Bronze plan will be that income portion less the difference between Silver plan cost and Bronze plan cost, to a minimum of zero—no household can be subsidized beyond the full premium cost of a Bronze plan.

The out-of-pocket expenses are based on actuarial values mandated by the ACA for Bronze and Silver plans. Specifically, the average out-of-pocket expenses for a household enrolled in a Bronze plan are equal to 40 percent of the household's total health care expenditure and 30 percent for an HIEU enrolled in a Silver plan. Out-of-pocket expenses for those enrolled in a Silver plan are reduced to 6 percent, 13 percent, and 27 percent for enrollees that earn less than 150 percent, 200 percent, and 250 percent of FPL, respectively. All out-of-pocket expenses are capped at the ACA mandated annual maximum of $6,350 for single coverage and $12,700 for a family.

The appropriate measure for the cost of being uninsured is not immediately apparent. Even after accounting for households with poor access to health care, patients without insurance are frequently the beneficiaries of uncompensated care and discounted rates or simply do not pay their medical bills. Consequently, out-of-pocket spending for uninsured Americans is considerably lower than total expenditure on medical services for the uninsured. To avoid underestimating medical spending of the uninsured, we use total expenditures on medical services from all sources in 2011 as a measure of household medical spending—holding a household accountable for the total spending on the health care it receives, rather than what is actually paid for by the recipients of care. While this assumption risks overestimating the portion of households that benefit from purchasing insurance, as the cost of medical care for uninsured households may be much lower in reality, this higher measure of health care spending accounts for some of the hidden costs of choosing not to purchase insurance such as lower levels of personal wellbeing and lower health outcomes from care. The Institute of Medicine, in a 2009 study on the consequences of being uninsured, found that adults who suffered from illness or injury were more likely to experience poorer health outcomes, greater limitations in quality of life, and premature death if they did not have health insurance.[7]

The total cost of being uninsured is the sum of a household's total expenditure on medical services and the tax penalty for remaining uninsured. Beginning in 2014, the tax penalty defined by the Internal Revenue Service is equal to the greater of a flat fee per household member and a percentage of household income. The flat fee begins at $95 per uninsured person in 2014 and increases to $325 and $695 in 2015 and 2016, respectively. However, the fee is halved for children and cannot exceed three times the adult fee for a single household. The percentage of income applicable to the penalty begins at 1 percent of all income earned above the income tax filing threshold and increases to 2 percent and 2.5 percent in 2015 and 2016. By law, a household's tax penalty cannot exceed the national average cost of a Bronze plan for the household.

Alternative Analyses

We conduct two variants of our baseline analysis to provide alternative ways of analyzing the incentive for young adults to purchase insurance on the health exchanges. The first of these examines the subset of households that meet our baseline criteria but also had non-zero spending on medical services in 2011. Removing all households that do not use medical services is another potential method to account for a bias in spending that is caused by being uninsured. If uninsured households are not using medical services because they are uninsured, it will bias the results of the analyses towards underestimating the portion of households that will financially benefit from purchasing insurance. Households that do not have access to the market for medical services because of their uninsured status suffer an indirect cost equal to the medical services they cannot

receive. Our baseline analysis attempts to account for this by removing all households that identify being unable to receive medical care or delayed in doing so. Further removing all households that have no medical expenditures is a more exaggerated approach to account for this bias.

Our final variant makes an attempt to quantify the value of owning insurance for young adults. When evaluating the decision to purchase health insurance, it is not a perfect comparison to weigh the costs of being uninsured directly to the cost of purchasing insurance because health insurance has inherent value to a consumer beyond the payments it makes to medical service providers. If a person values a car at $10,000 and is able to buy it for $8,000, he or she has gained $2,000 in value. Similarly, a household benefits from paying an insurance company to spare them the risk of financial ruin. To approximate the average dollar value of this benefit to households in our sample, we use data from the employer-sponsored insurance market where information on offered insurance prices and employee take-up rates is more readily available.

Using the Kaiser Family Foundation's 2013 Employer Health Benefits survey, we find that an average employer-sponsored insurance offer to employees of businesses with a significant portion of young-adult workers (defined as having greater than 35 percent of employees aged 26 or younger) is $980 for single coverage and $4,830 for family coverage, and the take-up rate at those businesses is 70 percent.[8] By multiplying the average cost of coverage with the take up rate, we get an average value of health insurance to a young adult as $690 for single coverage and $3,380 for a family. We then account for the value of insurance in our comparison by subtracting the estimated average value from the total cost of purchasing insurance.

Five Year Projection

We predict our three analyses from 2014 through 2016 in order to track the effect of increasing the tax penalty on the uninsured and then in 2019 for a glimpse of the 5 year outlook. In order to make predictions about future health care spending and premium costs, we assume 6 percent annual growth in exchange plan premiums and health care expenditures. Cost growth in the individual market has been cited at much higher rates in previous years; the Assistant Secretary for Planning and Evaluation (ASPE) found that premiums have been growing around 10 percent in recent years, but growth is slowing.[9] The Center for Medicare & Medicaid Services estimates that private health insurance spending will grow nearly 8 percent in 2014, falling to steady growth of just under 6 percent by 2016.[10] We use these estimates to inform our 6 percent annual growth rate assumption for medical expenditures of uninsured young adults.

Our projections also require assumptions on income growth in order to determine future subsidies. Based on historic median household income growth, we assume that household income growth will average 2 percent annually between 2014 and 2019, but households do not earn at higher levels of poverty.[11] However, the percent of income that households are expected to contribute towards their premiums will increase according to indexing provisions outlined in the law, based on the difference between premium and income growth.[12]

Results

In our baseline analysis, we find that 86 percent of uninsured, young adult households will be discouraged from purchasing health insurance through the newly implemented state health insurance exchanges in 2014. In 2015, 71 percent will find it financially advantageous to forgo coverage and when the penalty is fully implemented in 2016, 62 percent will save money by remaining uninsured. In 2019, 64 percent will save money by remaining uninsured.

When we reduce our sample to only those households with medical expenditures in 2011, we find that 72

percent of uninsured, young adult households will be discouraged from purchasing health insurance through the health insurance exchanges in 2014. In 2015, 64 percent will find it financially advantageous to forgo coverage, and when the penalty is fully implemented in 2016, 55 percent will save money by remaining uninsured. In 2019, 59 percent will save money by remaining uninsured.

If we account for the inherent value of health insurance, we find that 63 percent of uninsured, young adult households will be discouraged from purchasing health insurance through the health insurance exchanges in 2014. In 2015, 47 percent will find it financially advantageous to forgo coverage, and when the penalty is fully implemented in 2016, 36 percent will save money by remaining uninsured. In 2019, 41 percent will save money by remaining uninsured.

Percent of Uninsured, Young Adult Households Financially Discouraged from Purchasing Health Insurance

	2014	2015	2016	2019
Baseline Analysis	86%	71%	62%	64%
Including only Non-zero Household Spending	72%	64%	55%	59%
Including Value of Insurance	63%	47%	36%	41%

Conclusion

The purpose of this study is not to estimate how many young adults will ultimately enroll in coverage through the state health exchanges over the next several years. Instead we seek to quantify the economic benefit for young adults of enrolling in coverage versus paying the individual mandate penalty and covering one's health expenditures out of pocket.

We find under our baseline scenario that even after the mandate penalty is fully implemented, a majority of young adult households will find that it is financially advantageous for them to forego health insurance, pay the mandate penalty, and personally cover their own health care expenses. Even under our third, and most conservative, scenario we still find that in 2019, 41 percent of young adult households will be financially incentivized to forego health insurance.

Through its insurance market reforms and overly prescriptive benefit design, the ACA makes the decision to purchase health insurance more costly than it previously was for the vast majority of young adults, while at the same time significantly reducing the risks associated with the decision to go without coverage. Whether young adults make the decision to purchase health insurance will depend on many factors, but the perverse economics of the ACA discourages young adults from joining the health insurance system.

[1] The participation in of young adults in the exchange pool is a proxy for enrollees with low health care costs and utilization. Younger individuals tend to be healthier and can be easily tracked, while measuring health status of enrollees is difficult. However, reaching the 39 percent young adult goal does not guarantee that the pool will have enough healthy enrollees, and missing that mark does not guarantee the exchange's failure.