

# Sufficiency, Comprehensiveness of Health Care Coverage, and Cost-Sharing Arrangements in the Realpolitik of Health Policy

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## 1. Introduction

Sufficientarian approaches to distributive justice aim to ensure that everyone has “enough” of morally relevant goods or services.<sup>1</sup> One aspect of determining what constitutes “enough” in the health care arena involves deciding which interventions comprise a decent minimum basket of preventative, curative, or rehabilitative health care benefits—that is, a basket that enables the realization of normative conceptions of sufficiency that may be based on notions of a minimally decent life, a life of dignity, or a life of genuine political equality in a democracy.<sup>2</sup> In practice, some countries have more comprehensive benefit packages than others.<sup>3</sup> Theoretical accounts can provide an independent “moral yardstick” that helps determine the extent to which international variation, rather than convergence, is acceptable.

In this chapter, we focus on a different aspect of sufficiency—namely what price individuals can be asked to pay for an otherwise sufficient basket of benefits.

1. Harry Frankfurt, “Equality as a Moral Ideal,” *Ethics* 98, no. 1 (1987): 21–43.

2. Dean T. Jamison et al., “Global Health 2035: A World Converging Within a Generation,” *Lancet* 382, no. 9908 (2013): 1898–1955; Carina Fourie, Chapter 1 in this volume.

3. Dimitra Panteli and Ewout van Ginneken, Chapter 13 in this volume.

A well-designed minimum package is useless if accessing it entails exorbitant costs to potential beneficiaries.<sup>4</sup> Out-of-pocket costs (OOPCs), such as user fees, point-of-service charges, copayments, or co-insurance, represent one category of such costs and are part of many health care systems. Policymakers are increasingly interested in directing users to effective services, which can involve raising OOPCs for less effective interventions. Insurance premiums represent another type of cost to beneficiaries. To ensure affordability, the use of an income-related cost ceiling—or sometimes several thresholds—that demarcates acceptable from unacceptable cost-sharing typically represents a cornerstone of any sufficientarian approach, regardless of how that approach is anchored in normative terms and even though approaches differ regarding where exactly the threshold should be set. As such, health care costs pose two questions: What should be the threshold for the costs individuals are asked to bear? and What should be the relationship between costs and benefits (because benefits might be designed more generously if costs are higher, and, conversely, costs might be reduced if benefits are less comprehensive)?<sup>5</sup>

Broader movement toward universal health coverage (UHC) has recently brought the cost of health care into sharper focus.<sup>6</sup> The World Health Organization (WHO) first formally endorsed UHC in 2005, calling on states to provide “access to [necessary] promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost.”<sup>7</sup> In 2015, the United Nations’ General Assembly adopted the Sustainable Development Goals (SDGs) successors to the Millennium Development Goals. SDG Goal 3 is concerned with health, and it includes as a target “universal health coverage . . . including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.”<sup>8</sup>

4. Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost* (Washington, DC: National Academies Press, 2012), 12.

5. A third question is, of course, Who is to be covered? In principle, reducing (or not increasing) the number of people eligible for health care can allow for more generous benefit packages and/or lower OOPCs. Although the eligibility of noncitizens and others for health care is the topic of substantial debate, we bypass this issue in the following and make the simplifying assumption that policymakers seek to enable access to the widest group of people.

6. Thomas O’Connell, Kumanan Rasanathan, and Mickey Chopra, “What Does Universal Health Coverage Mean?” *Lancet* 383, no. 9913 (2014): 277–279.

7. World Health Organization, *World Health Assembly 58, Resolution 33, Sustainable Health Financing, Universal Coverage and Social Health Insurance*, [http://apps.who.int/iris/bitstream/10665/20383/1/WHA58\\_33-en.pdf](http://apps.who.int/iris/bitstream/10665/20383/1/WHA58_33-en.pdf)

8. Jamison et al., “Global Health 2035,” 1898–1955.

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Both the 2005 and the 2014 characterizations of UHC refer explicitly to cost. However, the relationship between “financial risk protection,” which has become the primary yardstick for assessing the financial aspects of UHC, and thresholds for costs to individuals is complex. Levels of financial risk protection are typically measured using two indicators: the incidence of so-called “catastrophic” health expenditures (where OOPCs exceed some percentage of household resources) and the incidence of impoverishment due to out-of-pocket health payments (where OOPCs push households below the poverty line).<sup>9</sup> The health economists Adam Wagstaff and Eddy van Doorslaer define catastrophic expenditures as those exceeding 40% of income after accounting for expenditures on food.<sup>10</sup>

Should efforts to ensure that individual health care costs fall below a manageable threshold focus on protecting individuals against the costs of expensive, one-time interventions? A report by the Lancet Commission on investing in health succinctly set out some of the principal problems with such an approach:

The most obvious administrative difficulty with the use of public funds for catastrophic coverage is that the definition of catastrophic for individual patients depends on their income. Therefore, means testing at all income levels must be enforced or, more typically, catastrophic coverage is defined at such a high level that many expenses that are catastrophic for poor people remain uncovered. As the health economist Austin Frakt has argued, “almost any cost is catastrophic if you are poor.” A second difficulty is that the natural response of providers and patients will be to avoid less costly interventions in favour of more costly ones in order to receive coverage. Third, and most important, . . . evidence suggests that coverage of only high-cost procedures might be an inefficient way to buy financial protection.<sup>11</sup>

Instead, the commission advocated an alternative approach termed “progressive universalism,” which can be realized in two subforms: by subsidizing interventions frequently used by poor people, or by exempting poor people from insurance premiums and copayments.<sup>12</sup>

9. Jennifer Prah Ruger, “An Alternative Framework for Analyzing Financial Protection in Health,” *PLoS Medicine* 9, no. 8 (2012), accessed June 4, 2015, doi:10.1371/journal.pmed.1001294.

10. Adam Wagstaff and Eddy van Doorslaer, “Catastrophe and Impoverishment in Paying for Health Care: With Applications to Vietnam 1993–1998,” *Health Economics* 12, no. 11 (2003): 921–934.

11. Jamison et al., “Global Health 2035,” 1936.

12. Jamison et al., “Global Health 2035,” 1898–1955.

In this chapter, we illustrate how individual health care costs pose the issue of a fair threshold for medical costs by reviewing the introduction of essential health benefits (EHBs) as part of the Affordable Care Act (ACA),<sup>13</sup> the major health reform measure recently adopted in the United States. Among the questions debated as part of this reform were which services should be covered and what cost-sharing arrangements are appropriate. We argue that many health insurance plans, particularly those with significant copayments, may not protect individuals from health care costs that threaten their access to a decent minimum of care, and that individuals may be encouraged to purchase insurance at levels that are inadequate if they become ill, leading to insufficient access to otherwise sufficient care. In particular, because financial burdens that impoverish people are incompatible with a minimally decent life, ensuring that people remain above a decent minimum, however defined, after paying for health care is a desideratum for health system design, including cost-sharing.

## 2. Essential Health Benefits in the Affordable Care Act

Currently, as has been the case historically, the United States lacks uniform national standards for EHBs. In part, the absence of national standards reflects the complex mix of private and public providers through which health care is organized:

1. Private, employer-sponsored health insurance covers 48% of the population, with larger employers offering their own programs and smaller ones purchasing in groups from insurers.
2. Medicare (covering 16%) and Medicaid and the Children's Health Insurance program (covering 14%) are financed by federal and state governments. These organizations provide services for people older than age 65 years, the least well-off, and individuals who meet special criteria, such as patients with end-stage renal disease.
3. Tricare provides services for active military personnel, and the Veterans Health Administration provides services for former servicemen and -women (3% are covered in this way).
4. Four percent of the population purchases insurance privately on the market.<sup>14</sup>

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13. Patient Protection and Affordable Care Act, 42 U.S.C. §18001 et seq.

14. Kenneth Finegold, *New Census Estimates Show 3 Million More Americans Had Health Insurance Coverage in 2012 (ASPE Issue Brief)* (Washington, DC: US Department of Health

Until recently, the United States had no universal medical coverage, and in 2010, when the Patient Protection and Affordable Care Act (ACA) was passed, approximately 60 million people completely lacked health insurance.<sup>15</sup> ACA implemented an individual mandate that required people to either purchase insurance or incur a tax penalty.<sup>16</sup> ACA also introduced insurance exchanges to enable purchasers to select policies from providers that have undergone quality screening and offer a set of EHBs, which all providers participating in the exchanges (as well as outside of them) were required to cover from 2014 onward.

### 3. The Affordable Care Act's Benefit Package

US legislators first addressed the question of what levels of benefits should be covered when Congress established Medicaid in 1965. Congress required that Medicaid participants have access to “medically necessary care,” but did not define what this meant.<sup>17</sup> Although some private plans developed working definitions and the subject became the matter of lawsuits, it was not until the 2010 health reform that it was revisited on a broader scale.

ACA's provisions regarding EHBs are relatively brief and apply to health plans sold in the individual and small-group markets, as well as to Medicaid coverage. They do not apply to self-insured health plans, those in the large-group market (typically companies with more than 100 employees), or grandfathered health plans (those in existence when ACA was passed). Section 1302 of ACA requires that plans provide services in at least 10 categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. Within these categories, benefits must be equal to the scope of benefits covered in “a typical employer plan.”<sup>18</sup> The content of EHBs became the subject of intense

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and Human Services, 2013); See also Thomas Rice et al., “United States of America: Health System Review,” *Health Systems in Transition* 15, no. 3 (2013): 1–431.

15. Jacob Molyneux, “The Top Health Care News Story of 2010: Health Insurance Dominated the Year,” *American Journal of Nursing* 111, no. 1 (2011): 14–15.

16. Elenora E. Connors and Lawrence O. Gostin, “Health Care Reform—A Historic Moment in US Social Policy,” *JAMA* 303, no. 24 (2010): 2521–2522.

17. Daniel Callahan, “Medical Futility, Medical Necessity. The-Problem-Without-a-Name,” *Hastings Center Report* 21, no. 4 (1991): 30–35.

18. Patient Protection and Affordable Care Act, 42 U.S.C. §18002(b)(2)(A).

lobbying from numerous interest groups, including patient groups, large employers, and health plans, during ACA's passage through Congress and in subsequent stages.<sup>19</sup>

ACA required the US Department of Health and Human Services (DHHS) to commission a report from the Institute of Medicine (IOM) that would recommend a process for defining and updating EHBs. Addressing the definition of "typical employer," the report noted difficulties in narrowing down the concept: If a "typical employer" should be representative of most employers, then the term refers to a small employer because 98% of all employer firms are classified as small. By contrast, if the term refers, then the "typical employer" is large, since large employers cover 65% of all employees.<sup>20</sup> Reviewing the scope of benefits and premiums offered by small and large employers, the report found them to be broadly similar. However, benefit design differed frequently, with smaller employers more frequently having higher deductibles. Ultimately, the report suggested a focus on the health plans of small employers because most growth was expected in this sector.

The report considered two approaches to formulating a list of benefits. One strategy would specify a set of benefits first and consider cost later; another would establish a cost threshold first and then decide which benefits to include. IOM was unequivocal that the latter approach was superior. It proposed to take as a point of departure the national average premium (approximately \$6,000) that small employers would have paid in 2014 for a mid-level single-person plan, had ACA not been enacted.

IOM's recommended method for defining EHBs was pragmatic and process driven, and the institute did not set out a "shopping list" of "best buy" items. Its report focused on specifying criteria for determining the content of the aggregate EHB package and criteria for specific components (Table 14.1). It recommended starting with a typical small employer plan, developing a preliminary service list, and then applying the criteria to adjust the list as appropriate. Overall cost would be incorporated from the outset. It then proposed using public deliberation processes and other public participatory processes to provide further guidance, before issuing final guidance on inclusions and permissible exclusions of services.

IOM's proposal received a cold response. Its bold attempt to tackle rising health care costs by starting with a cost target smacked too much of unacceptable

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19. Ezekiel J. Emanuel, *Reinventing American Health Care: How the Affordable Care Act Will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone System* (New York: PublicAffairs, 2014).

20. Institute of Medicine, *Essential Health Benefits*.

**Table 14.1** Criteria for Determining EHBs

In the aggregate, the EHB package must

- Be affordable for consumers, employers, and taxpayers.
- Maximize the number of people with insurance coverage.
- Protect the most vulnerable by addressing their needs.
- Encourage better care practices by promoting the right care to the right patient in the right setting at the right time.
- Advance stewardship of resources: maximize high-value services, minimize low-value services. Value is defined as outcomes relative to cost.
- Address the medical concerns of greatest importance to enrollees in EHB-related plans, as identified through a public deliberative process.
- Protect against the greatest financial risks due to catastrophic events or illnesses.

Specific components (individual services, devices, or drugs) must

- Be safe—expected benefits should be greater than expected harms.
- Be medically effective, supported by a sufficient evidence base, or in the absence of evidence on effectiveness, a credible standard of care is used.
- Demonstrate meaningful improvement over current services/treatments.
- Be a medical service, not serving primarily a social or educational function.
- Be cost-effective so that the health gain for individuals and the population is sufficient to justify the additional cost to taxpayers and consumers.

Caveats

- Failure to meet any of the criteria should result in exclusion/significant limits on coverage.
- Each component is still subject to the aggregate EHB package criteria.

EHBs, essential health benefits.

Source: Adapted from IOM (2010); Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost* (Washington, DC: National Academies Press, 2012), 55.

rationing for both consumer and provider groups.<sup>21</sup> Due to concerns about political pressure, DHHS also did not go along with the key elements. Instead, in what has been described as “passing the buck,”<sup>22</sup> DHHS announced that there would be no national set of benefits but that states individually would need to identify

21. David Himmelstein, “Response to the Institute of Medicine’s Recommendation That Cost Determine Insurance Policies’ ‘Essential Benefits,’” *International Journal of Health Services* 42, no. 3 (2012): 571–573.

22. Noam N. Levey, “Passing the Buck—Or Empowering States? Who Will Define Essential Health Benefits?” *Health Affairs (Millwood)* 31, no. 4 (2012): 663–666.

EHBs, working from a benchmark plan. The benchmark could be (1) one of the three largest small-group plans in the state by enrollment, (2) one of the three largest state employee health plans by enrollment, (3) one of the three largest federal employee health plans by enrollment, or (4) the largest health maintenance organization plan offered in the state's commercial market by enrollment.<sup>23</sup>

ACA gave IOM no space to propose a way forward regarding the financial impact on users, which was set out clearly in Section 1302 of ACA. Coverage was to be provided under four “metal” tiers. Plans in different tiers do not differ in content—all cover the same interventions—but they differ in cost-sharing. ACA stipulates that a bronze-level health plan will cover 60% of health care costs, with 40% to be met by the user. Plans cover 70% of health care costs in the silver level, 80% in gold, and 90% in platinum, with users responsible for the respective remainder. In addition, insurers may offer a plan with lower actuarial value than that of the bronze plan to individuals under 30 years of age and to those who are otherwise exempt from the insurance mandate because available coverage is unaffordable or enrolment would constitute a hardship. Insurers selling plans on the exchanges are not obliged to cover all four levels, but they must offer one silver and one gold plan.

ACA also adopted several measures to reduce the financial impact on insured individuals. For all tiers, ACA caps the extent of cost-sharing achieved through OOPCs, requiring health plans to cover OOPCs that exceed the cap amount. In 2014, the OOPC cap was approximately \$6,000 for an individual and \$12,000 for a family. Where insurance is purchased through an exchange, people with incomes below 400% of the federal poverty level (FPL)—defined as \$11,490 for a single-person household and \$23,550 for a four-person household in 2014—can further reduce the OOPC cap to as low as approximately \$2,000 (Table 14.2). All preventive care is exempt from OOPCs. In addition, ACA provided refundable tax credits to individuals below 400% of the FPL, which aimed to offset the financial burdens of premiums on lower-income households by reducing their tax burden or even making their tax burden negative.<sup>24</sup>

For example, an individual with an income of \$17,235 (150% of FPL in 2014) would be expected to pay no more than 6.3% (\$1,086) of her income per year for the second-lowest-cost silver plan. The remainder of the plan's cost would be covered by tax credits. In addition, her OOPCs could not exceed \$2,167 (the OOPC cap of \$6,350 minus her two-thirds subsidy of \$4,233). In the period of October 1, 2013—March 1, 2014, 18% of those who selected a marketplace plan opted for

23. Levy, “Passing the Buck—Or Empowering States?” 665.

24. For a useful overview of these credits, see Center for Budget and Policy Priorities, “Premium Tax Credits: Answers to Frequently Asked Questions,” accessed January 24, 2015, <http://www.cbpp.org/sites/default/files/atoms/files/QA-on-Premium-Credits.pdf>.



**Table 14.2** Premium Tax Credits and OOPC Subsidies for EHBs

Household Income (% FPL) <sup>a</sup>	Expected Contribution (% of Household Income)	OOPC Subsidies (Reduction of Maximum OOPC)
Up to 133	2	Two-thirds
133–150	3–4	
150–200	4–6.3	
200–250	6.3–8.05	One-half
250–300	8.05–9.5	
300–400	9.5	One-third

<sup>a</sup>FPL in 2014 was \$11,490 for a single-person household and \$23,550 for a four-person household.

EHBs, essential health benefits; FPL, federal poverty level; OOPC, out-of-pocket costs.

Source: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “2014 Poverty Guidelines,” accessed January 24, 2015. <https://aspe.hhs.gov/poverty/14poverty.cfm>.

the bronze level, with 63% opting for silver, 11% for gold, and 6% for platinum.<sup>25</sup> Eighty-three percent of those selecting a plan on an exchange chose one for which they received financial assistance; 93% of those selecting a silver plan are eligible for federal premium assistance.

ACA’s subsidy provisions function, although never explicitly, as protection against costs that exceed a threshold. The OOPC limits and premium subsidies serve to protect households against excessive medical costs incurred after they have purchased a plan that, at least in principle, secures access to sufficient medical care. In so doing, they reduce the number of households that fall below the poverty line as a result of seeking care.

#### 4. Financial Thresholds and Health Care Costs

Health care costs—including insurance premiums and OOPCs—can worsen households’ financial positions. Ill health can have similar effects, whereas good health can improve financial position. Although policymakers frequently set thresholds at levels different from the theoretical literature, both policymakers and sufficientarian philosophers share a commitment to thresholds. Some policy

25. US Department of Health and Human Services, “Health Insurance Marketplace: March Enrollment Report; For the Period: October 1, 2013–March 1, 2014,” accessed January 24, 2015, [https://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/mar2014/ib\\_2014mar\\_enrollment.pdf](https://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/mar2014/ib_2014mar_enrollment.pdf).

proposals employ an *absolute* threshold of resources below which no individual should fall—for instance, the \$1.25/day global poverty line adopted by the World Bank. Others employ a *societally relative* threshold, such as the European Union’s definition of poor households as those falling below 60% of the median income in their society. Adopting a societally relative threshold means that a household whose income is above the threshold in a less-developed country might fall below the threshold if it emigrates to a wealthier nation. It also entails that any society with substantial inequality, no matter how high the median income, is likely to have members who fall below the threshold. Still others use a *individually relative* threshold: As economists Olivia Mitchell and Gary Fields state, “A standard of relative adequacy might be adopted where adequacy could be judged relative to one’s level of consumption prior to the event precipitating economic insecurity.”<sup>26</sup> Adopting this approach entails that two households in the same society could have the same income or same net worth but fall on different sides of the threshold depending on their prior income.

We suggest that the individually relative threshold is least defensible. Although wealthier households may privately prefer to insure their current level of consumption, insuring such consumption is not a high-priority use of public funds. Nor is it morally appealing to ignore the plight of households experiencing chronic medical costs that are small in individually relative terms but, over time, lead to growing disadvantage and social exclusion. In contrast, protecting households against the detrimental effects of expenses that threaten to exclude them from participation in society is widely agreed, not only by sufficientarians but also by theorists ranging from egalitarians to classical liberals, to be a public priority.<sup>27</sup> This provides support both for the societally relative threshold and for the absolute threshold.

Different approaches to health care financing can affect not only households’ physical health but also their financial health. An entirely publicly funded health care system that does not require individuals to devote income toward premiums or significant OOPCs, such as the UK’s National Health Service, will not drop households below a threshold because of excessive health care costs. However, if a publicly funded system can offer only a limited package of benefits, households may fall below a threshold because of ill health that prevents work.

26. Gary S. Fields and Olivia S. Mitchell, “Reforming Social Security and Social Safety Net Programs in Developing Countries,” in *Development Issues: Presentations to the 47th Meeting of the Development Committee*, ed. P. Mountfield (Washington, DC: The World Bank, 1993), 116.

27. See Rawls, *Justice as Fairness* (Cambridge: Belknap Press, 2001), 132; Matt Zwolinski, “Libertarianism and the Welfare State,” forthcoming in *The Routledge Handbook of Libertarianism*, eds. Jason Brennan, Bas van der Vossen, and David Schmidtz (forthcoming 2016).

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ACA's approach to health care provision, particularly the cap on OOPCs and the subsidy for premiums, helps to limit health care costs. However, ACA's caps and subsidies still allow some individuals to fall below a poverty threshold due to health care costs. Even reaching the cap of approximately \$2,000 in OOPCs to which a family near the poverty line is exposed under ACA would almost certainly drop a household near the poverty line into poverty. The same is true, although to a lesser extent, for premium costs. Although households can be exempted from ACA's requirement to purchase insurance and pay premiums if the payments would cause hardship or exceed 8% of income,<sup>28</sup> exemption simply leaves a household uninsured, exposing it to potentially unlimited OOPCs. The same is true for the choice to make the fee payment for failing to purchase insurance.

By providing health care coverage without premiums and with limited OOPCs to households below 138% of the poverty line, ACA's initially intended expansion of Medicaid would have substantially reduced the danger of households near the poverty line becoming impoverished by OOPCs and premiums. However, the Supreme Court made the Medicaid expansion voluntary, and nearly half of US states have refused to expand Medicaid for adults without dependent children, with many of these states providing Medicaid only to adults with dependents who fall substantially below the poverty line.<sup>29</sup> Furthermore, even in those states that expanded Medicaid, households above the poverty line can be subjected to cost-sharing requirements up to 5% of yearly income, which means that households within Medicaid could still be impoverished by OOPCs.<sup>30</sup>

In addition, the design of the metal tiers, with the same coverage but different levels of cost-sharing, when combined with the choice to design the subsidies to cover a silver plan, raises the risk that poorer households will be exposed to high OOPCs. Households can receive the OOPC subsidies only if they choose silver plans,<sup>31</sup> and they receive tax credits toward premiums that are based on purchasing a silver plan. A silver plan provides the exact same benefits as a platinum plan, but it has lower premiums and is actuarially predicted to involve higher OOPCs.

28. US Department of Health and Human Services, "Exemptions from the Fee for Not Having Health Coverage," accessed January 24, 2015, <https://www.healthcare.gov/fees-exemptions/exemptions-from-the-fee>.

29. Kaiser Family Foundation, "Medicaid Income Eligibility Limits for Adults at Application, as of August 28, 2014 (Table)," accessed January 24, 2015, <http://kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits>.

30. Kaiser Commission on Medicaid and the Uninsured, *Premiums and Cost-Sharing in Medicaid (Policy Brief)* (Menlo Park, CA: Kaiser Family Foundation, 2013), 2.

31. Kaiser Family Foundation, *Focus Health Reform: Patient Cost-Sharing Under the Affordable Care Act* (Menlo Park, CA: Kaiser Family Foundation, 2012).

For many other goods, such as food, clothing, transportation, and housing, poorer households ensure that they preserve financial sufficiency by making functional but less luxurious purchases. The uniformity of the metal tiers excludes the possibility of purchasing insurance that covers fewer interventions. Although there may be good arguments for not differentiating coverage by tier, related to concerns about adverse selection and about underinsured households imposing costs on hospitals and physicians, the choice not to subsidize cost-sharing for plans at the gold or platinum level seems to assume that poorer households should accept the silver plan's comparatively higher level of cost-sharing. This is so even though poorer households are frequently less able to self-insure, making the purchase of gold or platinum insurance—which is actuarially predicted to cover a larger share of health care expenses—more rational for them.

Meanwhile, ACA provides subsidies even to households in little danger of falling below any morally significant threshold. OOPCs totaling \$9,000 for a four-person household at 400% of poverty—one making more than \$90,000 per year—would not drop that household below an absolute or a societally relative threshold. Indeed, even individually relative thresholds do not regard a household that incurs OOPCs amounting to 10% of income as in danger of financial insufficiency. Furthermore, preventing people from falling below a decent social minimum is a morally more urgent priority than providing subsidies that protect better-off households against income fluctuations. The US tax code does not permit taxpayers younger than age 65 to deduct OOPCs from their taxable income until the OOPCs exceed 10% of income.<sup>32</sup> Although middle-class and wealthy households may well wish to insure themselves against such OOPCs, such insurance is not a priority for public spending. Indeed, allowing households who can afford higher OOPCs without risk of poverty to choose higher OOPCs might help to encourage greater cost awareness in the market for medical services.

## 5. Limiting Costs Within the Affordable Care Act's Framework

How might ACA evolve to better promote the goal of keeping citizens above a threshold? Perhaps the most important evolution would be the broadening of access to Medicaid. The judicially imposed decision to give states discretion whether to expand Medicaid exposed many lower-income households to burdensome OOPCs and premiums. If more states expand Medicaid access, households near the poverty line will be insured while being protected against potentially

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32. 26 U.S.C. § 213(a), (f).

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impoverishing OOPCs and insurance premiums. States can and should also choose to further reduce the OOPCs within the Medicaid program. Although nominal OOPCs may serve an important gatekeeping function, they should not expose households to poverty. To the extent that financial incentives to choose cost-effective interventions are desirable, paying patients to choose those interventions, rather than imposing OOPCs, would prevent the risk of imposing excessive costs.<sup>33</sup>

Another evolution would be a shift in the OOPC subsidies. The current structure of the OOPC subsidies lacks a defensible foundation: They leave poorer households exposed to impoverishment despite being insured while arguably being too generous to better-off households. They also contain sharp “cliffs”—the transitions between different subsidies and out of the subsidy program—that are difficult to justify. A better design for the OOPC subsidies would cover all but nominal OOPCs for individuals up to 138% of the poverty line—the Medicaid access cutoff—and would phase OOPC subsidies out in a continuous, rather than stepwise, manner after that. Ending the subsidy before 400% of FPL could allow the increased coverage at lower incomes to be revenue-neutral. Another alternative to OOPC subsidies for wealthier households would be access to loans that enable them to spread the costs of one-time medical expenses over several years.

Extending OOPC subsidies to lower-income households receiving premium tax credits who choose to purchase gold or platinum plans instead of silver plans would also help to ensure financial sufficiency. Purchasing a gold or platinum plan—despite these metals’ evocations of luxury—simply involves making larger prepayments for the exact same package of interventions in exchange for a reduced actuarial probability of high OOPCs. It does not make sense to deny households who choose to minimize their downside risk an OOPC subsidy, particularly because such a subsidy will likely be less costly given the reduced OOPCs in gold and platinum plans.

Moving from OOPCs to premiums, the increased premiums permitted under ACA for subgroups of the population (tobacco users, overweight individuals, and older people) should be designed so that they do not threaten financial sufficiency.<sup>34</sup> Premiums should be such that no household, regardless of medical risk factors, risks being impoverished by purchasing insurance. The exemption that permits individuals whose insurance would exceed 8% of income to go uninsured

33. Harald Schmidt and Ezekiel J. Emanuel, “Lowering Medical Costs Through the Sharing of Savings by Physicians and Patients: Inclusive Shared Savings,” *JAMA Internal Medicine* 174, no. 12 (2014): 2009–2013.

34. Kristin Madison, Harald Schmidt, and Kevin G. Volpp, “Smoking, Obesity, Health Insurance, and Health Incentives in the Affordable Care Act,” *JAMA* 310, no. 2 (2013): 143–144.

without paying a penalty represents another major gap that allows health care costs to threaten financial sufficiency. It would be preferable to mandate that these individuals purchase a plan that protects them against health care costs that would leave them below a threshold while ensuring that they can access such a plan without impoverishment.

Finally, IOM's suggestion that EHBs protect against financial risks should be reconceived. Rather than subsidizing access to one-time, high-cost interventions such as high-cost chemotherapy that would be prohibitively expensive without insurance, EHB design should put the highest priority on ensuring access to interventions that help to sustain and improve households' ability to maintain financial sufficiency in the long term, particularly among lower-income households. ACA's subsidies for preventive care are congruent with this goal, but curative interventions can also help in achieving financial sufficiency. For example, interventions to help individuals quit smoking, overcome substance abuse, and deal with mental illnesses can ensure that earners stay in the workforce and continue earning income for their households. The same is true for interventions that address chronic childhood conditions such as learning disabilities and autism.

ACA represents an important step toward a health care system that ensures that every US citizen has access to a decent quantum of health care. However, whether it can do so while also ensuring that citizens receiving such care do not fall below a decent financial standard depends on how its financing structure evolves. A design that places greater emphasis on preventing impoverishment due to OOPCs and premiums, and that finances the achievement of that goal by reducing unnecessary subsidies to better-off households, would better accord with a sufficientarian approach to health care. Reducing impoverishment caused by ill health or lack of funds for health care helps to ensure that citizens can secure minimally decent lives.

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