

## Defining Quality Coverage

The Cover Missouri project aims to increase the number of Missourians with affordable, quality health coverage. In the context of this goal, the term “quality” refers to the quality of a health insurance plan, as opposed to the quality of health care delivered to an individual. The term “quality coverage” or “high quality coverage” has been used in recent years as health plans incorporate higher levels of cost-sharing requirements (through deductibles, copayments, and/or restrictions on benefits covered). Health plans with prohibitive cost-sharing requirements are often referred to as “low quality” plans because they do not protect insured individuals from potential financial burden and medical debt. A health plan may also be considered low quality if the scope of benefits prohibits access to necessary health services. Policymakers, political candidates, advocacy organizations, and the insurance industry commonly use the term “quality coverage” to emphasize coverage that adequately or fully meets the health needs of the insured.

### A Definition of Quality Coverage

Defining and characterizing quality coverage is challenging because of the inherent subjectiveness of the concept. Individuals may value the benefits and/or the financial requirements of a health plan differently. Additionally, variations in economic and health status across a population make it difficult for policymakers and researchers to establish a benchmark for quality coverage. For example, a deductible of \$5,000 may be a financial burden to someone making \$30,000 but may seem reasonable to someone making \$100,000.

Given the challenge of specifying a standard, the Cover Missouri project has chosen to define “quality coverage” as health insurance that adequately covers medically necessary services. “Adequately” means that the health coverage protects the insured from financial hardship after receiving needed care, does not prevent the insured from accessing needed services due to limitations in the scope of benefits, and does not discourage the acquisition of needed preventive or acute care due to financial reasons. In other words, cost-sharing may, or may not, be incorporated into the health coverage package as long as the person can afford medically necessary services and is protected from medical debt. The scope of benefits may, or may not, be limited as long as the person is able to access necessary care and can afford to pay for care received.

### The Concept of Underinsurance

Although references to “quality coverage” abound in the political arena, the concept has not been clearly defined. However, various authors have attempted to conceptualize the term “underinsurance.” Cover Missouri’s definition of quality coverage parallels the concept of underinsurance.

Underinsurance has been described by several researchers on a continuum of adequacy.<sup>1</sup> Some agreement exists that a person can be deemed underinsured if they have “health insurance with a scope of benefits that is in some way inadequate.”<sup>2</sup> However, a precise definition of underinsurance is lacking due to the absence of consensus on the purpose of health insurance and on how to measure adequate versus inadequate coverage.<sup>3,4,5</sup>

Several authors have broken down the concept of underinsurance into definable parts. In one study, underinsurance was classified along three dimensions: structural (i.e., elements of the benefits package are insufficient to protect the needs of the insured); experiential (i.e., the consumer experiences excessive out-of-pocket costs); and attitudinal (i.e., the person believes that the coverage provided by the benefits package is somehow inadequate).<sup>6</sup> An additional study characterized the attitudinal dimension in two ways: the individual's perception of unmet health care needs and the individual's satisfaction with the coverage provided by his or her health insurance.<sup>7</sup>

Although researchers generally agree upon the concept of underinsurance, no benchmark health insurance benefits package has been established. Several studies and surveys have considered out-of-pocket costs relative to income as a way to measure underinsurance. The upper limit of appropriate out-of-pocket costs in most studies is set at 5 to 10 percent of income.<sup>8</sup> However, the criteria used to select these values is not well-documented and involves subjective determination of how much someone should pay out-of-pocket for health care services.

## Conclusion

The problem of subjectivity and the difficulty in adapting one benchmark to individual situations complicates the process of defining underinsurance and quality coverage. However, a framework for quality coverage, as opposed to a specific benchmark, can provide the basis for determining adequate cost-sharing levels and scopes of benefits for various populations. Policymakers could define a variety of benchmark packages for specific groups based on the concept that quality coverage adequately protects against financial hardship and does not prohibit access to needed care. Factors such as income level, age, and health status should be considerations when determining standard coverage packages for specific populations.

Policymakers at the state and federal levels have mandated that certain health benefits be covered by both private and public insurance plans. Allowing for further discussion between policymakers and a broad group of stakeholders (e.g., consumers, health professionals, business leaders, insurance companies, and advocates) may facilitate the creation of acceptable standard benefit packages and reasonable cost-sharing limits. Defining benchmark coverage packages through the legislative process may be an effective means of eliminating the issue of the underinsured.

## Endnotes

- 1 E Ziller, A Coburn, and A Yousefian, Out-Of-Pocket Health Spending and the Rural Underinsured, *Health Affairs* 25.6 (2006):1688-99.
- 2 L Blewett, A Ward, and T Beebe, How Much Health Insurance Is Enough? Revisiting the Concept of Underinsurance, *Medical Care Research and Review*, 63.6 (2006): 663-700.
- 3 L Blewett, A Ward, and T Beebe, 2006.
- 4 R Bashshur, D Smith, and R Stiles, Defining underinsurance: a conceptual framework for policy and empirical analysis, *Medical Care Review* 50.2 (1993):199-218.
- 5 A Ward, The Concept of Underinsurance: A General Typology, *Journal of Medicine and Philosophy*, 31 (2006):499-531.
- 6 R Bashshur, D Smith, and R Stiles, 1993.
- 7 L Blewett, A Ward, and T Beebe, 2006.
- 8 A Ward, 2006.