

***Assessing the Federal Basic Health Option:  
Recent Lessons from Washington's Basic Health Program***

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States are currently deciding whether or not they want to adopt the Federal Basic Health Plan (FBHP), an option offered under the Patient Protection and Affordable Care Act (ACA). The FBHP would cover individuals and families with incomes between 138%<sup>1</sup> and 200% of the federal poverty level (FPL). If a state adopts the FBHP, eligible individuals would participate in this plan instead of the Exchange. They would not receive premium tax credits or cost-sharing assistance from the federal government. Instead, the state would receive 95% of what the federal government would have spent on tax credits and subsidies for eligible individuals. States would negotiate for health plan coverage and use available funds that remain to reduce premiums and cost-sharing and provide additional benefits. FBHP-eligible individuals will not be eligible to receive subsidies in the Exchange. However, their FBHP premiums must be equal to or lower than the subsidized Exchange premiums for their income level.

In the Exchange, people with incomes between 138% and 200% FPL will pay premiums ranging from 3% to 6.3% of family income. Under the FBHP option, a state may offer premiums lower than this, thus making it more affordable for low- to moderate-income families. Proponents of the FBHP expect that the state will be able to achieve greater cost efficiencies through this option compared to the private market and, as a result, be able to offer enrollees more affordable premiums.

In determining premium levels for the 138-200% FPL group, policymakers should recognize that lower-income families are more price-sensitive than higher-income families, and they have little discretionary income. Paying for health insurance may require cutting back on other necessities. What appears to be a small difference in premiums can have a significant impact on whether low-income families can enroll in health insurance coverage and continue to pay for it.

Therefore, a key issue in determining the value of the FBHP is the affordability of premiums for consumers. The price of premiums will affect the number of people who would be expected to take up coverage. This paper analyzes premium affordability for people in the FBHP income bracket, through both a review of existing studies and an evaluation of recent data from Washington State's own Basic Health program (BH). These data reveal the impact of the program's premiums and premium increases on member disenrollment for premium-related reasons. Because the existing BH program is similar in structure to the FBHP, this analysis is instructive in determining whether the FBHP presents a more affordable alternative to the Exchange.

### **Brief Literature Review**

#### ***Insurance Affordability Studies***

Using the Survey of Income and Program Participation, the Congressional Budget Office conducted a study of 1,718 individuals whose primary access to health insurance was through the nongroup health

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<sup>1</sup> The ACA provides the option for individuals and families with incomes between 133% and 200% of the federal poverty level. However, Medicaid disregards the first 5% of income in determining eligibility. Therefore, families with incomes starting at 138% FPL would be eligible for the FBHP.

insurance market (i.e., they were not offered employer-sponsored insurance).<sup>2</sup> Some had health insurance, but a large majority of the sample population was uninsured. The researchers determined a price elasticity of -0.57 for the entire sample, which means that a 10% decrease in nongroup premiums would lead to a 5.7% increase in the rate of nongroup coverage.<sup>3</sup> Roughly half of the sample population had incomes below 200% FPL, and the price elasticity for this group was -0.84 – meaning a 10% decrease in premiums would, for this lower-income group, lead to an 8.4% increase in the rate of nongroup coverage.<sup>4</sup> This study illustrates that lower-income individuals are more price-sensitive: **The same percentage decrease in premiums induces greater participation among those with lower income, compared to those with higher income.**

Conversely, when premiums increase, participation in health insurance programs decreases. When researchers looked at data from several state insurance programs for low-income residents that utilized sliding-scale premiums, they found a consistent pattern: enrollment declines as premiums consume an increasing share of household income.<sup>5</sup> Together, the summary curve of three programs estimates that raising premiums from 1% to 3% of family income will reduce enrollment rates among the uninsured from 57% to 35%.<sup>6</sup> At 5% of family income, the rate of enrollment is estimated to be only 18%.<sup>7</sup>

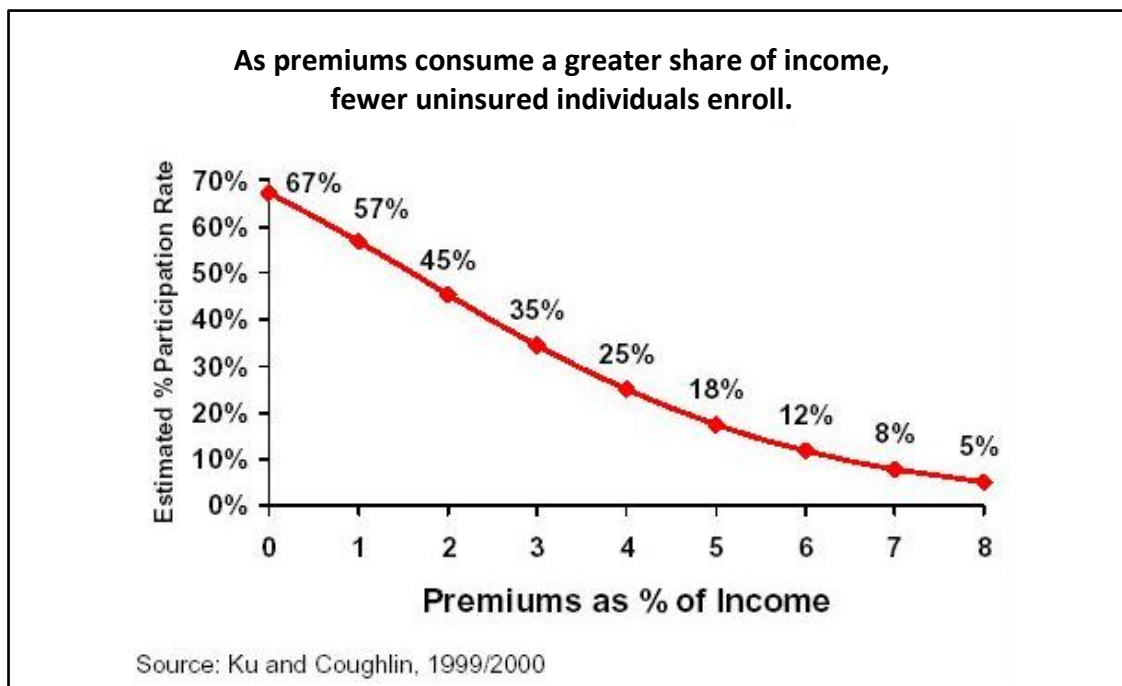


Figure 1. Estimated level of participation based on premium levels in three state insurance programs, 1995.<sup>8</sup>

<sup>2</sup> Auerbach, D., & Ohri, S. (2005). The Price Sensitivity of Demand for Nongroup Health Insurance. Congressional Budget Office Background Paper. Retrieved from <http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf>

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> Ku, L., & Coughlin, T. (1999). Slide-Scale Premium Health Insurance Programs: Four States' Experiences. *Inquiry*, 36, 4, 471-80.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

Therefore, it is expected that if the FBHP can offer lower premiums than the Exchange, then enrollment will increase substantially and the size of the uninsured population will decrease.

### **Previous Washington Basic Health Program Studies**

The history of Washington State’s Basic Health program illustrates the impact of rising premiums on participation and attrition rates. There have been a number of studies demonstrating this phenomenon:

- In the early years of BH, researchers conducted a telephone survey of families who enrolled in BH in order to determine what factors influenced the decision to enroll.<sup>9</sup> The researchers found that cost of coverage played a significant role: among those who enrolled, a \$10 premium increase (from an average of \$34 to \$44 per month) would have reduced the odds of enrolling to 0.87.<sup>10</sup>
- Further research in 1997 found that 14% of eligible adults would enroll in the BH if the monthly premium were \$10.<sup>11</sup> If the monthly premium increased to \$25, only 11% of eligible adults would enroll.<sup>12</sup> If increased again to \$50 per month, only 7% of eligible adults would enroll.<sup>13</sup>

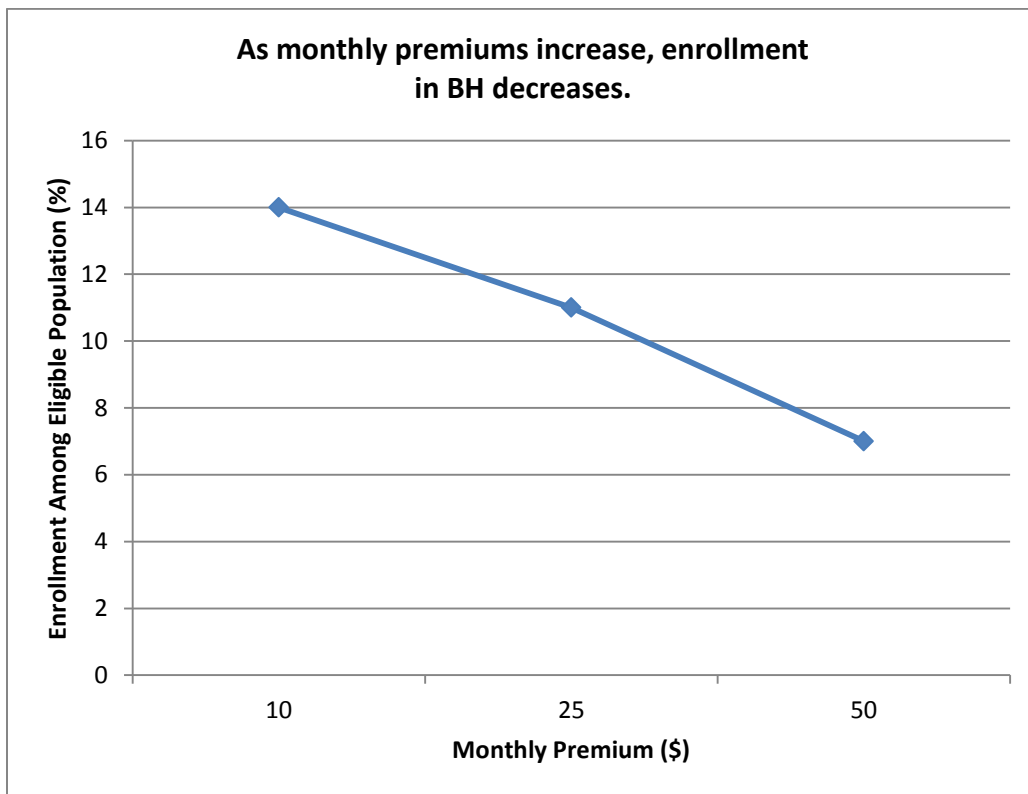


Figure 2. BH enrollment rates based on dollar amount of monthly premiums.

<sup>9</sup> Madden, C., Cheadle, A., Diehr, P., Martin, D., Patrick, D., & Skillman, S. (1995). Voluntary Public Health Insurance for Low-Income Families: The Decision to Enroll. *Journal of Health Politics, Policy and Law*, 20, 4, 955-72.

<sup>10</sup> *Id.*

<sup>11</sup> Long, S., & Marquis, M. S. (2002). Participation in a Public Insurance Program: Subsidies, Crowd-Out, and Adverse Selection. *Inquiry*, 39:243-57.

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

- The premium history of BH during 1995-1999 reveals a similar lesson: changes in BH premium levels over this period were accompanied by fluctuations in BH enrollment, reflecting the high price sensitivity of low-income enrollees. During this period, the state adjusted premium amounts in order to reach specified enrollment goals. From 1995 to 1996, when the average monthly premium went from \$23 to \$17, enrollment increased by 146%.<sup>14</sup> From 1997 to 1998, when the average monthly premium increased from \$18 to \$24, demand for BH (measured by the number of enrollees and number of individuals on the waiting list) decreased by 45%.<sup>15</sup> Demand rose by 27% the following year when premiums were reduced for enrollees with incomes greater than 125% FPL.<sup>16</sup>

Considering the price sensitivity demonstrated by these BH studies, any new program aimed at a similar low-income population must make premiums affordable enough so that sufficient numbers enroll in and retain coverage. If Exchange subsidies are insufficient to achieve this goal, the FBHP offers states the flexibility to do so.

### **Lessons from Recent BH Disenrollment Data**

The recent change in BH premiums provides an opportunity to build on previous affordability research, capturing the current response of low-income individuals to increasing costs of health care insurance.

In January 2010, Basic Health premiums increased due to budgetary constraints. We reviewed data on adults under 40 years of age with incomes between 140% and 200% FPL at the time of the increase. In December 2009, these premiums consumed about 4-6% of enrollees' household income. In January 2010, premiums increased to about 6-9% of household income. As a result, the average member in this subgroup had to pay an additional \$42 per month to maintain coverage in 2010.

**In 2010, for members with incomes between 140% and 200% FPL, premiums consumed 6.4% to 9.4% of income.**

Income Band	Income Range		Premium Amount		Percent of Income
	Annual	Monthly	Annual	Monthly	
<b>140-154%</b>	\$15,162-\$16,678	\$1,264-\$1,390	\$1,060	\$88	7.0-6.4%
<b>155-169%</b>	\$16,787-\$18,303	\$1,399-\$1,525	\$1,299	\$108	7.7-7.1%
<b>170-184%</b>	\$18,411-\$19,927	\$1,534-\$1,661	\$1,575	\$131	8.6-7.9%
<b>185-200%</b>	\$20,036-\$21,660	\$1,670-\$1,805	\$1,878	\$156	9.4-8.7%

Table 1. 2010 BH premium amounts, 0-39 Age Band.<sup>17</sup>

<sup>14</sup> Dorn, S., Varon, J., & Pervez, F. (2005). Limited take-up of health coverage tax credits and the design of future tax credits for the uninsured. Economic and Social Research Institute. Retrieved from [http://www.esresearch.org/documents\\_1-05/HCTC\\_TakeUp.pdf](http://www.esresearch.org/documents_1-05/HCTC_TakeUp.pdf)

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> Data obtained from the Washington State Health Care Authority.

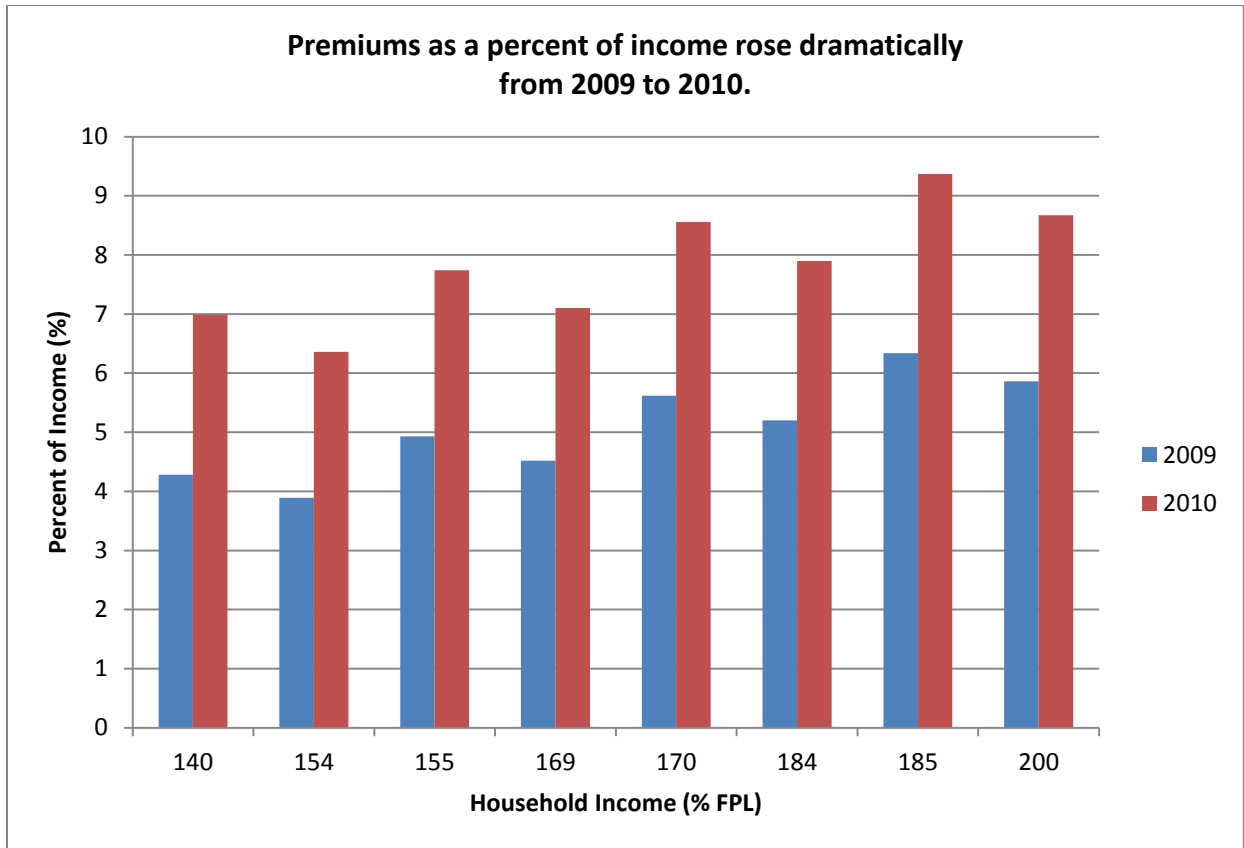


Figure 3. 2009 and 2010 BH premiums as a percent of household income.

In order to understand the impact of this change on enrollment rates, we reviewed 2009 and 2010 data from the Health Care Authority. We analyzed members who disenrolled for premium-related reasons, seeking to answer two questions:

- (1) To what extent did disenrollment rates change in response to the premium increases? and
- (2) Do the attrition rates in Basic Health during 2009-10 have implications for enrollment and retention of coverage in the Exchange or FBHP?

This data set may be instructive as Washington State weighs the Exchange versus the FBHP, as the data closely represents the population eligible for the FBHP in two key ways. First, we only included data from the 0-39 age band.<sup>18</sup> Younger adults between age 19 and 34 are much more likely to be uninsured than older adults, so those are the individuals who would likely purchase insurance if new affordable options are offered in 2014.<sup>19</sup> In fact, in Washington, young adults age 18 to 24 make up almost half of the uninsured population.<sup>20</sup> Second, we analyzed non-sponsored members in the income bands

<sup>18</sup> A separate 0-22 “child-rated” age band exists in the complete data set, so presumably the 0-39 age band does not include children.

<sup>19</sup> Graves, J., & Long, S. (2006). Why Do People Lack Health Insurance? Urban Institute. Retrieved from [http://www.urban.org/UploadedPDF/411317\\_lack\\_health\\_ins.pdf](http://www.urban.org/UploadedPDF/411317_lack_health_ins.pdf)

<sup>20</sup> Kreidler, M. (2011). State of the uninsured, Health coverage in Washington state: Costs, trends and projections 2008 to 2014. Retrieved from <http://oic.wa.gov/legislative/reports/2011-uninsured-report.pdf>

between 140% and 200% FPL, as the FBHP would only be offered to individuals and families with incomes between 138% and 200% FPL.<sup>21</sup>

**(1) To what extent did disenrollment rates change in response to the premium increases?**

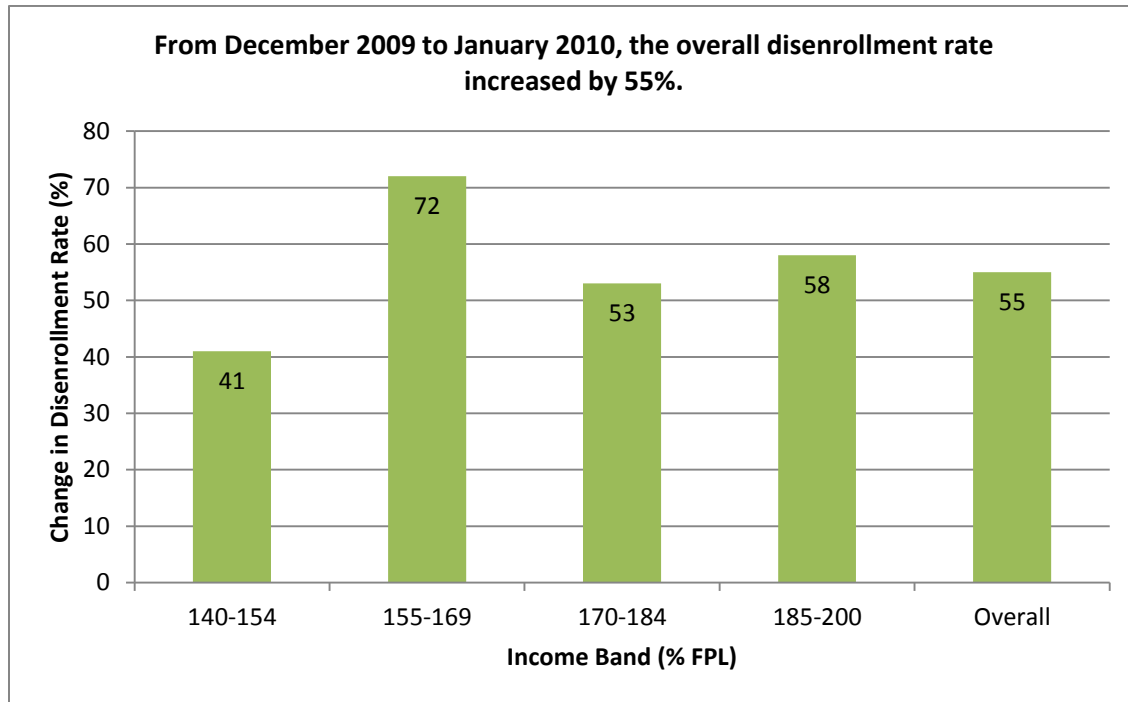


Figure 4. Change in BH disenrollment rates by income band from December 2009 to January 2010.

We analyzed the impact of the 2010 premium increases on rates of disenrollment, looking at those members who disenrolled for one of two reasons: (1) “non-payment of premium” and (2) “voluntary – cannot afford premium.”<sup>22</sup> There was a notable increase in the rate of disenrollment due to premium-related reasons from December to January. Across all income bands, the disenrollment rate increased by 55%, from 2.9% to 4.4%. In January 2010, 195 out of the 367 members in this subgroup who disenrolled did so for “non-payment of premium” or “voluntary – cannot afford premium” reasons. This increase in disenrollment from one month to the next, when the main change in the program was a premium increase, strongly suggests that most people who disenrolled did so due to unaffordability of the new premium amounts.

<sup>21</sup> BH members can be sponsored or non-sponsored. Sponsored members have their monthly premiums paid for by individuals or organizations, while non-sponsored members pay their monthly premiums themselves. In order to understand price sensitivity of those who pay for premiums, we only included data for non-sponsored members in our analysis.

<sup>22</sup> We calculated disenrollment rates by dividing the number of people disenrolled by the number of people enrolled in the previous month. Enrollment and disenrollment are determined on the first of the month. A person who is considered disenrolled on January 1<sup>st</sup> lost coverage on that date.

**(2) Do the attrition rates in Basic Health during 2009-10 have implications for enrollment and retention of coverage in the Exchange or FBHP?**

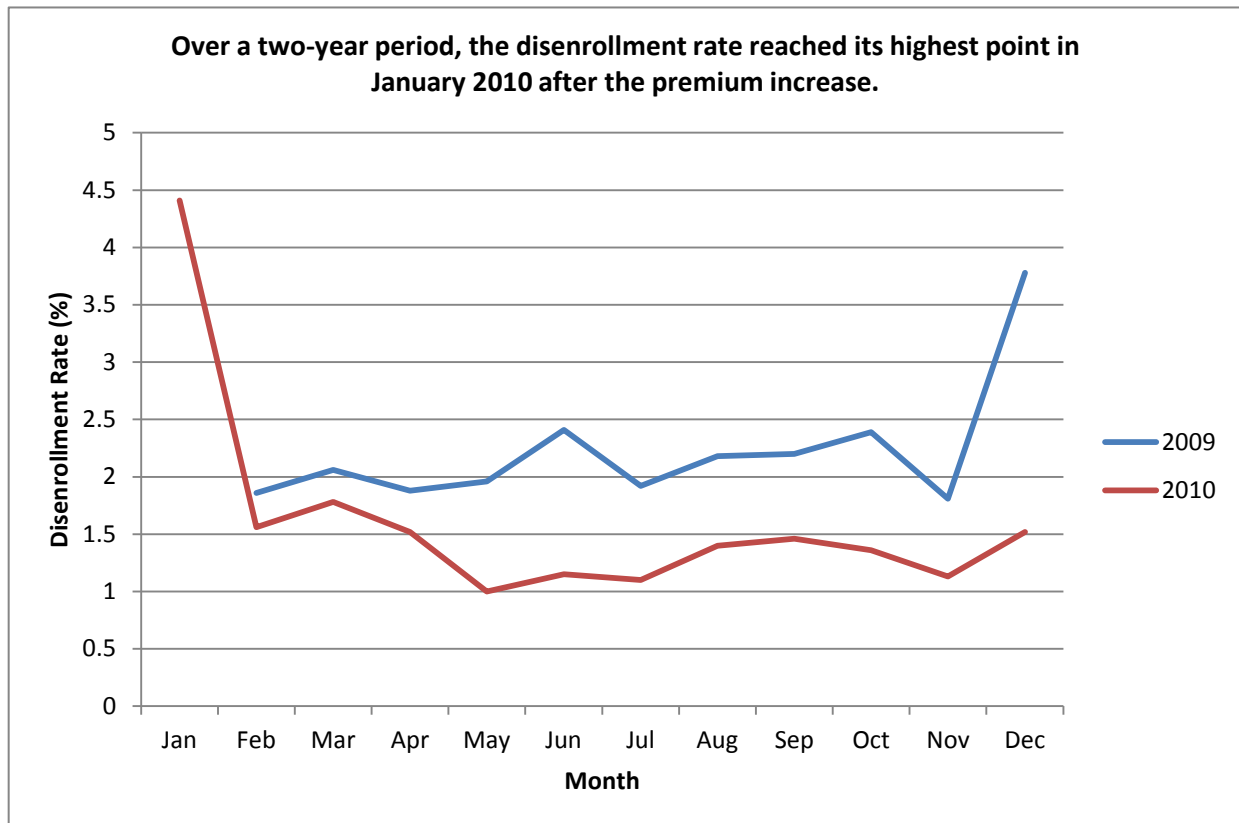


Figure 5. 2009 and 2010 BH monthly disenrollment rates.

In a 23-month timeframe, the disenrollment rate based on premium-related reasons was highest in January 2010 when premiums increased. This spike clearly demonstrates that people with low-income responded to the price increases, and many could not afford to continue coverage.

The month-to-month attrition rates in the year preceding the January 2010 spike offer an important perspective on potential attrition levels in 2014. The attrition rate due to nonpayment and unaffordability in 2009 was approximately 2% of the population each month. Thus, over the course of a year, about 20% of the population disenrolled for premium-related reasons.<sup>23, 24</sup> Most who disenrolled likely became uninsured.

This data suggests a “best case” scenario for attrition among lower-income populations beginning in 2014, unless premiums are further subsidized beyond minimum federal requirements. In 2009, the BH 140-200% FPL group’s premiums consumed 3.9% to 6.3% of household income, which is roughly comparable to the subsidized premium levels allowed in the Exchange and FBHP (3% to 6.3% of income).

<sup>23</sup> Over a 10-month period, from February through November 2009, with an average monthly disenrollment rate of 2% and assuming no new enrollees during this period, the annual disenrollment due to nonpayment/unaffordability would be 18.3% (1-.98<sup>10</sup>).

<sup>24</sup> It is possible that some of these individuals became eligible for Medicaid or other insurance, but did not report this. This number is likely to be small, considering the higher cost of commercial plans compared to a state-subsidized plan.

Therefore, we can expect that in the Exchange or FBHP, there would also be similar attrition due to nonpayment and unaffordability of premiums at these premium rates.

This projected attrition is likely to be exacerbated by two key differences between BH enrollees and those in the same income bracket eligible for the Exchange or FBHP. First, BH members chose to enroll without a mandate, unlike currently uninsured people who may not prioritize health insurance coverage to the same degree. Second, many BH members in 2009 had been enrolled for several years without a break in coverage, and there were very few new enrollees due to budget cuts. This made for a relatively stable enrollment pool – members who had continually paid their monthly premiums and complied with recertification requirements. By contrast, previously uninsured new enrollees in the Exchange or FBHP may not value health insurance in the same way, may have less disposable income, or may prioritize spending for other needs over health insurance. As a result, take-up and retention may be even lower than in 2009 BH if premiums are at similar levels. Premiums lower than those charged to BH enrollees in 2009 may be necessary to attract and retain high numbers of enrollees. Since FBHP offers the chance to lower premiums beyond Exchange rates, states could potentially lower attrition by opting for the FBHP.

**In order to maximize enrollment of the uninsured population, the state must set premiums in accordance with the financial realities of low- to moderate-income families.**

A vast majority of the uninsured population have incomes below 200% FPL.<sup>25</sup> In Washington State, a substantial proportion of low-income people between the ages of 20 and 59 are uninsured. Washington residents with income between 100% and 200% FPL had the following rates of uninsurance in 2010: 31% of residents aged 20-29, 38% of residents aged 30-39, 33% of residents aged 40-49, and 26% of residents aged 50-59.<sup>26</sup>

These households struggle to meet basic needs and often do not have room in their budgets for health insurance. Housing dominates the budgets of low and middle-income families.<sup>27</sup> In a recent qualitative study, Kaiser Family Foundation found that housing typically consumes about a third of the household budget. Monthly take-home pay often falls short of expenses, and families find themselves racking up credit card debt, prioritizing and skipping the payment of bills, and borrowing money.<sup>28</sup> These families do not make enough to cover monthly expenses; it is not surprising that many are unable to save and do not have savings.<sup>29</sup>

The high cost of health insurance is the single most reported reason for being uninsured.<sup>30</sup> Being uninsured is associated with poorer health than those with private insurance – for example, nearly half of all uninsured adults have a chronic health condition.<sup>31</sup> Over a quarter of the uninsured adult population report forgoing care in the past year because of cost.<sup>32</sup> Furthermore, those without

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<sup>25</sup> Kaiser Commission on Medicaid and the Uninsured (2011). *The Uninsured: A Primer – Key Facts About Americans Without Health Insurance*. Retrieved from <http://www.kff.org/uninsured/upload/7451-07.pdf>

<sup>26</sup> Kreidler, M. (2011). *State of the uninsured, Health coverage in Washington state*, *supra*, n. 20. Statewide, the rate of uninsurance is 14.1%, with children and seniors least likely to be uninsured.

<sup>27</sup> Perry, M., Cummings, J., Paradise, J., & Schwartz, T. (2009). *Snapshots from the Kitchen Table: Family Budgets and Health Care*. Kaiser Commission on Medicaid and the Uninsured. Retrieved from <http://www.kff.org/uninsured/upload/7849.pdf>

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> Graves, J., & Long, S. (2006). *Why Do People Lack Health Insurance?*, *supra*, n. 19.

<sup>31</sup> Kaiser Commission on Medicaid and the Uninsured (2011). *The Uninsured: A Primer*, *supra* n. 25.

<sup>32</sup> *Id.*

insurance are less likely to obtain timely preventive care than those with insurance.<sup>33</sup> When they do seek care, they are usually sicker. Concerned with high medical bills, the uninsured are less likely than the insured to follow through with recommended treatments.<sup>34</sup>

A recent survey study found that 32% of uninsured children and working-age adults reported problems paying medical bills compared to 20% of insured children and working-age adults.<sup>35</sup> Furthermore, the study found that 28% of uninsured respondents with medical bill problems reported unmet medical needs compared to 9% of insured respondents with medical bill problems.<sup>36</sup>

The uninsured pay for their health care costs to the best of their abilities – depleting their savings, taking out loans, working extra shifts, and cutting back on other family expenses, enabling them to pay an estimated 35% of their cost of care.<sup>37</sup> But their medical bills create difficulties; 66% of survey respondents with medical bill problems reported problems paying for other necessities and 50% reported borrowing money.<sup>38</sup> They are unable to repay the majority of these costs, resulting in a substantial cost-shift to other payors in the health care system. Of the remaining balance of the cost of care to the uninsured, one-third is reimbursed by government programs and two-thirds is recovered through higher premiums for insured individuals.<sup>39</sup> If these uninsured individual were to be able to afford premiums and purchase insurance, the burden of this cost-shift to the public would be reduced.

## **Conclusion**

Insurance affordability studies and the Washington Basic Health experience offer important lessons for states considering the adoption of the Federal Basic Health Plan as an alternative to including lower-income populations in the Exchange. Setting premiums at low levels is important for reducing the size of the uninsured population because it allows a state to offer realistic coverage options. Under the FBHP, states may consider setting premiums at levels even lower than the subsidized rates in the Exchange, thereby achieving a higher level of participation. Not only would more people enroll and retain coverage, but the cost-shift to the rest of the system caused by uncompensated care would be lower.

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<sup>34</sup> Hadley, J. (2007). Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition. *JAMA*, 284(16):2061-9.

<sup>35</sup> Sommers, A., & Cunningham, P. (2011). Medical Bill Problems Steady for U.S. Families, 2007-2010. Retrieved from <http://www.hschange.org/CONTENT/1268/1268.pdf>

<sup>36</sup> *Id.*

<sup>37</sup> Families USA. (2005). Paying a Premium: The Added Cost of Care for the Uninsured. Retrieved from [http://www.familiesusa.org/assets/pdfs/Paying\\_a\\_Premium\\_rev\\_July\\_13731e.pdf](http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf)

<sup>38</sup> Sommers, A., & Cunningham, P. (2011). Medical Bill Problems Steady for U.S. Families, *supra*, n. 35.

<sup>39</sup> Families USA. (2005). Paying a Premium: The Added Cost of Care for the Uninsured, *supra*, n. 37.