Washington State: Pioneer and Innovator in Covering Low-Income Workers

State Report

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EXECUTIVE SUMMARY

Washington State began the nation's first state-based health coverage program for low-income, uninsured workers – including childless adults – more than 15 years ago. Passed in 1987 as a pilot project in two counties, the Basic Health Program (BHP) expanded to 12 counties by 1990 and went statewide in 1993. BHP is entirely funded and controlled by the state. It covers uninsured workers and their dependents with incomes up to 200 percent of the Federal Poverty Level (FPL), without any distinction based on the presence or absence of children in the home. Children in these households typically receive Medicaid coverage, but can be enrolled in the same BHP health plans that serve their parents.

BHP has provided private HMO insurance with benefits and point-of-service cost sharing generally modeled after employer-sponsored coverage, albeit with strict limits on prescription drugs and mental health services that are not typical of employer-based insurance. Consumers have typically been required to pay a minimum of $10 a month in premiums, with additional amounts often required, depending on income, choice of health plan, and age.

There is no entitlement to BHP. When increased enrollment is projected to generate costs that would exceed appropriated funding, the Health Care Authority (HCA), which administers BHP, closes enrollment and puts new applicants on a waiting list.

As of December 2002, BHP covered 189,000 people, including 51,000 childless adults. Premium payments to health plans, which are age-rated, averaged $188 per month in December 2002. For childless adults under age 65, the state's per member per month costs averaged less than $223. As the following sections of this summary make clear, BHP has achieved tremendous success and garnered strong, bipartisan support. Program refinements and experiments over the years and the state's experiences during ever-changing economic and political conditions have yielded a rich harvest of lessons learned that could inform policy design nationally and in other states.

With Washington State experiencing the same fiscal problems that have faced most states, it was no surprise that, at the start of the 2003 Legislative Session, Governor Locke proposed significant cuts to BHP spending. He recommended eliminating all coverage of childless adults. State legislators across the political spectrum quickly rejected this approach, which was widely characterized as arbitrarily singling out childless workers who need and deserve coverage no less than their neighbors who happen to have dependent children living at home. Ultimately, the Legislature reduced BHP spending through across-the-board increases in consumer costs. In addition, new enrollment has been stopped (except for limited categories, like family members of current beneficiaries), with the goal of reducing the caseload, through attrition, to 100,000. While these cuts may have serious consequences, the Legislature's bipartisan rejection of the proposed singling out of childless adults for termination underscored the appeal and potential sustainability of BHP's approach, which covers low-income, uninsured workers without any distinction based on the presence or absence of children in the home.

Unless otherwise noted, this report describes the state's experience with BHP under the program as administered before the 2003 budget cuts, most of which did not go into effect until 2004. This executive summary and background paper provide an overview of Washington's history of covering low-income childless adults. It is based interviews with key stakeholders and document reviews, which took place as part of a larger multi-state examination of coverage available to low-income childless adults.

CHARACTERISICS OF BHP ENROLLEES

THE RELATIONSHIP BETWEEN BHP ENROLLEES AND EMPLOYMENT

As with the uninsured in general, most (59 percent) of BHP enrollees work, more often than not full-time. Only 28 percent of BHP-covered workers have an employer who offers health insurance. The average cost for workers to enroll in such employer coverage is nearly twice the average premium payment from BHP consumers.

CHILDLESS ADULTS RECEIVING BHP: DISPROPORTIONATELY OLDER AND POOR

Childless adults and parents covered by BHP have distinctly different age profiles. Only 3 percent of BHP parents are age 55-64. By contrast, fully 29 percent of BHP's childless adults are age 55-64, more than three times the prevalence of this age group among the uninsured in general. This pattern may result from the inclusion among so-called "childless adults" of older parents whose children have grown. Nearly all older, low-income adults who are ineligible for Medicaid – parents and non-parents alike – are thus classified as "childless adults." This analysis suggests that programs like BHP that cover childless adults may be an important policy option to consider for older, uninsured Americans.

Childless adults enrolled in BHP are also disproportionately likely to be quite poor. Individuals with incomes below 65 percent FPL, for example, comprise 45 percent of BHP's childless adult population but only 27 percent of BHP parents.[*] In fact, childless adults are more than twice as likely (46 percent vs. 24 percent) to be simultaneously (a) middle-aged or older (age 40+) and (b) poor (125 percent FPL or lower). This is precisely the group that faces the highest premiums in the individual market but has the least capacity to pay premiums of any amount. Put differently, among BHP adults, those without children are far more likely to be uninsured if not for BHP or comparable subsidies.

BHP'S IMPACT ON HEALTH CARE IN WASHINGTON STATE

Several published studies suggest that BHP coverage may have shifted health care utilization from hospital emergency rooms to physician offices, potentially improving health and creating some offsetting cost savings. Before the program began, a baseline study of consumers eligible for BHP found that those without health insurance were more than twice as likely to lack a usual source of care, to use hospital emergency rooms as their usual source of care, and to limit their use of health care because of cost. A much more recent study came to similar conclusions, finding that, compared to similar individuals who were uninsured, BHP enrollees were twice as likely to have a usual source of care and to have at least one physician visit a year.

Although many other aspects of the state's healthcare system were in motion at the same time, the period during which BHP expanded saw the following positive developments, in which BHP almost certainly played a part:

- The proportion of uninsured state residents fell by almost a third, from 12.2 percent in 1993 to 8.4 percent in 2000.
- The proportion of state residents who could not see a doctor because of cost dropped from 11.2 percent in 1995 to 8.7 percent in the year 2000.
- Uncompensated hospital charity care fell by more than a third.

[*] The Federal Poverty Level (FPL) was $15,260 for a family of three in 2003.

- The percentage of state residents with income under $15,000 a year who use hospital emergency rooms ("ERs") as their main source of care fell from approximately 3 percent in 1996 to 0.9 percent in 2000. This may signal a broader reduction in ER use among low-income state residents.

BHP'S POPULARITY AND LONGEVITY

The program's longevity despite many shifts between Democratic and Republican control of the Legislature, and BHP's continuation and expansion notwithstanding the elimination of most other Washington State reforms enacted in the early 1990s, attest to BHP's popularity among state policymakers. The program's popularity with the general public was dramatized in November 2001, when Initiative 773 ("I-773") raised state tobacco taxes by 73 percent, devoting 90 percent of the proceeds exclusively to funding increased BHP enrollment. Despite the absence of any well-funded campaign in favor of the initiative, it passed by a 2 to 1 margin.

There is general agreement on the reasons for this broad, bipartisan support:

- BHP covers low-income, working people, a group widely seen as deserving help.
- BHP is not an entitlement program, which allows more control over caseload and costs.
- BHP requires enrollees to help pay for their insurance and medical care, which is seen as contributing to financial responsibility.
- BHP is a public-private partnership that uses private insurance and strictly managed care through HMOs.
- BHP benefits generally resemble typical employer-based coverage.
- Without federal oversight and direction, state officials have broad freedom to manage and restructure the program.
- Many state legislators know personally people who have benefited from BHP.

PROS AND CONS OF NON-ENTITLEMENT APPROACH

As indicated above, the absence of an entitlement to coverage and the resulting enhanced control over caseload and spending have played a crucial role in generating broad, bipartisan support for BHP, according to observers across the political spectrum.

On the other hand, the absence of an entitlement has greatly reduced the number of uninsured workers who benefit from BHP. In the year 2000, for example, when HCA was putting eligible applicants on waiting lists instead of enrolling them into BHP, 71 percent of uninsured adults in Washington State had no access to either public coverage or employer-based insurance. If BHP instead had been an entitlement and any eligible adult could have enrolled, only 26 percent of uninsured adults would have lacked access to coverage, according to a consortium of analysts from the University of Washington, RAND, William Mercer, Inc., and other research institutions.

At a less fundamental level, BHP's waiting lists can greatly increase the impact of preexisting condition exclusions, which last for nine months after initial enrollment into BHP. Time spent on the waiting list can cut up to three months off the exclusion period. For example, a worker enrolling into BHP after waiting on the list for ten months would still have a six-month exclusion. That worker would wait a total of 16 months between first applying for BHP and receiving health coverage for preexisting health problems. Such delays can cause grim results for workers and their families with chronic health problems.

THE RELATIONSHIP BETWEEN CONSUMER PREMIUM COSTS AND ENROLLMENT

BHP has changed its minimum premium payment requirements several times. Each change was accompanied by major shifts in enrollment:

- From 1995 to 1996, the average BHP enrollee's monthly premium share dropped from $23.06 (21 percent of premiums) to $17.41 (16 percent of premiums). Enrollment rose by 146 percent, from 57,700 standard subsidized enrollees in December 1995 to 143,200 in December 1996.
- Policymakers later reversed direction, increasing average premium payments from $17.73 (16 percent of premiums) in December 1997 to $23.90 (19 percent of premiums) in December 1998. Demand for BHP coverage, measured by the number of enrolled individuals plus those on BHP waiting lists, fell by 45 percent, from 230,000 in December 1997 to 127,000 in December 1998. After policymakers later returned minimum premium payments to 1997 levels for enrollees with incomes above 125 percent FPL, demand for BHP rose by 27 percent to reach 161,000 enrollees plus individuals on the waiting list in June 2002.

Premium adjustments were not the only policy changes taking place at these junctures, of course. In particular, the 1996 drop in premium requirements was accompanied by significant outreach. But the causal relationship between premium charges and enrollment is confirmed by two, much more rigorous analyses of BHP enrollment published in peer-reviewed journals. One study found that each $5 increase in family premium costs triggered a 6 percent decline in overall enrollment. Another concluded that reducing monthly premiums from $50 to $25 would increase BHP enrollment by 62 percent; and cutting premiums from $50 to $10 would more than double BHP participation.

The sensitivity of low-income workers to small changes in premium requirements was explained by household budget studies published by researchers at the University of Washington and Mercer, Inc. By developing 576 minimum household budgets in eight diverse Washington counties, these analysts found that, to pay BHP costs while meeting other basic needs (like shelter, food, utilities, child care, etc.), households typically needed income above 150 percent FPL. Given the resulting absence of significant discretionary income for most BHP consumers, it is not surprising that relatively small changes to BHP premium requirements have caused large shifts in enrollment.

FINANCIAL INCENTIVES FOR CONSUMERS TO SELECT INEXPENSIVE PLANS

Most BHP consumers (78 percent) have a choice between health plans that charge different premiums. BHP consumers selecting any plan but the least expensive are required to pay the full difference in premium, plus their minimum premium payment. As of February 2003, 75 percent of BHP enrollees who were offered a choice between health plans picked the least expensive plan, which suggests that BHP's financial incentives strongly influence behavior and limit resulting health insurance costs.

SIGNIFICANT DECREASES IN COVERAGE FOR VERY POOR MEDICAID BENEFICIARIES WHO WERE TRANSFERRED INTO BHP

To take full advantage of I-773, which requires a certain baseline level of BHP enrollment for the state to access new tobacco revenues, policymakers shifted 27,000 very low-income immigrants formerly covered by Medicaid into BHP. This change was phased in from July through October 2002. Despite extensive education and outreach aimed at these identified beneficiaries, the number who remained enrolled in BHP by February 2003 was only 11,400.

A recent study of this change found that many of those who did not enroll in or retain BHP coverage became uninsured. Problems understanding the BHP application process, increased documentation requirements, and difficulty paying premiums created barriers to enrollment.[1]

LITTLE OR NO ADVERSE SELECTION INTO SUBSIDIZED BHP COVERAGE

Several careful studies in peer-reviewed journals have found that significant adverse selection did not take place, either in the pilot phase of BHP or after statewide implementation. During both periods, BHP enrollees (compared to individuals who qualified for BHP but did not enroll) tended to be healthier, better educated, more recently insured, and less costly users of health coverage.

BHP's December 2002 average per-member-per-month cost of $188 compares favorably to the $212 average premium in Western states for HMO employee-only coverage that typically is somewhat more generous than BHP's 2002 benefits package. Even among childless adults in BHP, average monthly costs to the state were less than $223, despite the disproportionate representation of individuals over age 55.

FINANCIAL SPONSORSHIP

As of February 2003, 19 percent of BHP enrollees subject to premiums were "financially sponsored." With financial sponsorship, a non-profit, community-based organization ("CBO") pays sponsored consumers' premiums, helps them complete enrollment and renewal forms, and educates them about how to use care. Typically, the community-based health plans and providers likely to benefit financially from such activities donate funds to the CBO. However, to serve as a financial sponsor, a CBO must be completely autonomous in its governance and use of donated funds and must inform consumers about all available BHP health plans, not just those affiliated with contributing providers.

Financially-sponsored enrollees have a very different demographic profile than do other BHP consumers. For example:

- 81.2 percent of financially sponsored enrollees have income below 100 percent FPL, compared to 53.8 percent of individuals enrolling on their own.
- 59.7 percent of financially-sponsored consumers are non-white, and 19.4 percent speak Spanish, compared to 15.5 percent non-white consumers and 1.6 percent Spanish speakers among individual enrollees.
- 32.3 percent of financially-sponsored enrollees have less than a high-school education, compared to 7.4 percent of individual enrollees.
- 34.4 percent of financially-sponsored enrollees report that they have fair or poor health, compared to 16.5 percent of individual enrollees.
- 75.1 percent of financially-sponsored enrollees lacked health insurance before enrolling in BHP, compared to 52.3 percent of individual enrollees.

This suggests that financial sponsors have been able to overcome hurdles to enrollment among less educated, lower-income households that may have posed problems for similar consumers trying to enroll on their own.

THE FAILURE OF EMPLOYER-SPONSORED ENROLLMENT

When BHP expanded into a statewide program in the early 1990s, officials expected that half of enrollees would be sponsored by their employers. Under employer sponsorship, firms pay special fees to the state to enroll their income-eligible workers in BHP. However, employer sponsorship

never approached expected levels. For example, in February 2003, employer sponsorship accounted for less than one-half of one percent of BHP enrollment. In part, this resulted from cumbersome program structure. To illustrate, firms typically must spend more to become employer sponsors than to simply pay their low-income workers slightly higher wages sufficient to cover the full cost of individual enrollment into BHP. Another factor responsible for minimal use of this enrollment mechanism may be employer resistance to government programs like BHP.

UNSUBSIDIZED COVERAGE FOR INDIVIDUALS WITH INCOMES TOO HIGH FOR BHP

When BHP began operation as a statewide program, individuals with incomes above 200 percent FPL were permitted to buy coverage from BHP plans by paying full premiums, which were capped at 106 percent of the amount the state paid for subsidized BHP coverage. Tremendous adverse selection resulted from guaranteeing enrollment into comprehensive insurance with premiums capped based on BHP's cost of serving relatively healthy workers and their families. By 1997, 24,000 individuals received unsubsidized BHP. Many were pregnant women ineligible for Medicaid. Even without considering maternity care costs, inpatient hospital expenses for unsubsidized BHP enrollees were nearly two and one-half times the level among subsidized BHP consumers. Responding to insurers' resulting losses, the state eliminated caps on premiums for unsubsidized BHP in 1998.

Insurers accordingly increased premiums by an average of more than 70 percent. Enrollment declined by 43 percent, to 14,000. For 1999, unsubsidized premiums rose again, this time by another 62 percent. Fewer than 8,000 consumers enrolled for that year. As premiums continued to rise, the number of unsubsidized enrollees dwindled further, to 1,800 in December 2000 and 1,100 in December 2001, and plans discontinued coverage. New enrollment ended in 2002, and HCA terminated remaining unsubsidized coverage in 2003.

WASHINGTON STATE: PIONEER AND INNOVATOR IN COVERING LOW-INCOME WORKERS

INTRODUCTION

Based on site visits, interviews with a range of stakeholders, and a broad review of relevant documents, this report focuses on Washington State's Basic Health Program ("BHP"), the country's oldest state-based, health insurance subsidy program for low-income workers, including those without dependent children living at home. During the more than 15 years of the program's existence, state policymakers have made many changes while preserving the program's basic structure. Wholly state-funded, BHP covers households with low or moderate incomes, without any distinction based on the presence or absence of children in the home. It provides private insurance that is somewhat more restrictive than typical employer coverage, with beneficiary cost-sharing and without any legal entitlement.

In response to serious state fiscal problems, state policymakers made significant program changes in 2003 to reduce state costs, most of which went into effect in calendar year 2004. This analysis focuses on BHP before the policy changes made in 2003, drawing on BHP's long and rich history to highlight salient policy questions of potential interest to state and national policymakers throughout the country.

PROGRAM HISTORY

INITIAL PROGRAM CREATION AND STATEWIDE EXPANSION

After several failed attempts to create a non-Medicaid health insurance program for low-income, uninsured workers, in 1987, the Legislature created BHP as a pilot project starting the following year in King County (which contains Seattle) and Spokane County. According to several observers, the public in a number of counties outside the initial pilot project (and their representatives in the Legislature) felt excluded from a useful and important program and demanded that their counties be added. As a result, by 1990, BHP had expanded to 12 counties. BHP moved from a pilot to a statewide program as part of a broad set of health care reforms in 1993, which also included mandates on employers and individuals. In 1995, a new and very different Legislature repealed most of the 1993 reforms. One element that remained in place was statewide BHP.

With the Washington Health Care Authority (HCA) overseeing the program, enrollment grew rapidly, from 22,000 in 1991, to 50,928 in December 1994, to 195,517 in December 1996. The following section describes BHP's major programmatic changes after going statewide.

SUBSEQUENT PROGRAM CHANGES

Following are some of the most important changes to BHP after it began operating throughout Washington State but before cutbacks made in 2003:

- ***Enrollee premium share***. Policymakers greatly reduced required premium payments in 1996. From 1995 to 1996, the average BHP enrollee's monthly premium share dropped from $23.06 (21 percent of premiums) to $17.41 (16 percent).[2] Another set of premium changes took place in the late 1990s, this time in the opposite direction. Effective in 1998, minimum required premium payments increased for all enrollees above 65 percent of the Federal Poverty Level ("FPL"). In addition, for the first time, beneficiaries with incomes below 125 percent FPL were required to pay increased premium amounts when choosing more expensive plans; before

1998, such financial incentives were limited to individuals with higher incomes. Enrollees' average share of monthly premiums rose from $17.73 (16 percent of premiums) in December 1997 to $23.90 (19 percent) in December 1998.[3] Resulting cuts in program demand led the 1999 Legislature to reinstate 1997 premium payments for households with incomes above 125 percent FPL, while keeping the increased premium shares and financial incentives for consumers with incomes below that level. As of February 2003, enrollees paid an average of $26.74 a month (14 percent of the total premium).[4]

- ***Benefits***. When the program began, benefits did not include certain services typically covered by employer insurance, including prescription drugs and mental health care. Benefits later expanded to include some coverage of the following: prescription drugs in 1994; mental health care, substance abuse treatment, and organ transplants in 1995; and chiropractic services and physical therapy in 2002.

- ***Point-of-service cost-sharing*** rose in 1998 for office visits ($8 copays increased to $10), hospital care (the previous $50 deductible rose to $100), hospital outpatient visits ($0 to $25), and emergency care at network hospitals ($25 to $50). In 2002, the two lowest tier copays for prescription drugs rose from $1 to $3 and from $5 to $7. The 50 percent coinsurance amount for the highest-tier (name-brand drugs on health plan formularies) has been unchanged since coverage of prescription drugs began.

- ***Preexisting condition exclusions*** started at 12 months, dropped to 3 months in 1995, and rose to 9 months in 2001.

RECENT DEVELOPMENTS

The past few years have included several important developments, described in approximate chronological order below.

BHP AUDIT

In 1997 and again in 2001 and 2002, the Washington State Auditor's office reviewed HCA's management of BHP subscriber accounts. The Auditor raised a number of concerns, suggesting that, for a significant number of beneficiaries, the income consumers claimed did not appear to match their incomes as reported in various electronic databases. While contending that federal law bars access to such databases for some program applicants and that the information in such databases is not determinative of BHP eligibility under state law, HCA agreed to institute and has since put in place numerous measures to increase verification of eligibility for applicants and enrollees.[5]

INITIATIVE 773

In November 2001, Initiative 773 ("I-773") raised state tobacco taxes by 73 percent, devoting 90 percent of the proceeds exclusively to increased BHP enrollment.[6] Despite the absence of any well-funded campaign in favor of the initiative, and despite strong anti-tax sentiments in the Pacific Northwest, I-773 passed by a 2 to 1 margin, with 66 percent of voters in favor.[7] I-773 provided that, for the state to use these new tobacco tax dollars, BHP's base enrollment, without using new funds, could not drop below 125,000. The apparent purpose of this provision was to ensure that the new tax dollars would add to, rather than replace, previous state spending on BHP. Under state law, this provision can be overridden by a two-thirds vote of both houses of the Legislature.

SHIFT OF ELIGIBILITY FOR IMMIGRANTS FROM STATE-FUNDED MEDICAID TO BHP

Effective October 1, 2002, the State terminated coverage under Medical Assistance (entirely state-funded Medicaid) for 27,000 immigrants who were ineligible for federal matching funds. Most of these immigrants were children. All were offered BHP as a substitute for terminated Medical Assistance. This change was phased in from July through September 2002, with significant outreach and education efforts targeted at this group of identified beneficiaries.

Policymakers expected that these immigrants could be used to meet I-773 enrollment requirements for accessing tobacco tax funds, without increasing total state spending. However, despite efforts to educate these beneficiaries and help them make this transition, most of the immigrants who lost Medicaid never enrolled into BHP. By February 2003, only 11,426 were covered by BHP.[8] Many who did not enroll became uninsured.

ADDRESSING BUDGET SHORTFALLS

Starting in December 2002, new enrollment into BHP was limited to children and certain parents. In January 2003, Governor Locke presented his 2003-2005 budget, which recommended significant cuts to a number of social programs, including Basic Health. The governor proposed eliminating $150 million from the program's operating budget by making all childless adults ineligible, including those already on the program.

The Governor proposal was first advanced when, because of a general economic slowdown that reduced state revenues and increased state costs across the country, Washington State officials projected a $1.2 million budget deficit in the General Fund for the 2003-2005 biennium.[9] The state likewise anticipated a $542 million deficit in the "core" Health Services Account. Not part of the State General Fund, the Health Services Account funds Basic Health, the state's SCHIP program, and certain county public health programs. Its revenue comes from taxes on insurance premiums, taxes on tobacco and alcohol, tobacco settlement proceeds, hospital taxes, and Medicaid Upper Payment Limit dollars, known inside the state as "Proshare." The Health Services Account shortfall stemmed, most significantly, from the federal government's failure to provide Proshare dollars consistent with state expectations. Other factors included reduced tobacco settlement proceeds because of state "securitization" and program expenditures increasing more rapidly than flat to declining revenue from cigarette and liquor taxes.[10]

In developing his budget, the governor held "Priorities of Government" meetings to determine how and where cuts would be made, "building a health budget from the bottom up." The Governor and his staff decided to prioritize services that benefit children (including family coverage that includes both children and parents).[11] However, virtually every informant queried about this process believed that a factor of at least equal if not greater importance was the absence of federal matching funds for childless adults. A dollar cut from entirely state-funded BHP services saves a dollar in the state budget; but with federally matched coverage (like Medicaid), cutting one dollar of services saves only 50 cents in state funds while costing the state 50 cents in federal revenue.

Across the political spectrum, state policymakers and stakeholders rejected the proposed singling out of childless adults for termination as unfair and unreasonable. Instead, the Legislature reduced projected BHP costs by directing the Administration to lower per-beneficiary costs 18 percent, which was accomplished by increasing required premium payments and beneficiary out-of-pocket costs. These measures applied to BHP beneficiaries as a whole and did not single out childless adults. In addition, intake into BHP remained largely closed. Until attrition reduced enrollment to 100,000, the only new eligibles allowed into the program were children and pregnant women enrolling in federally-matched coverage, new family members of current BHP enrollees, certain

target groups with special BHP eligibility (personal care workers, foster parents, etc.), and a few other categories.[12] In addition, state officials made significant cutbacks to Washington's Medicaid program.[13]

PROGRAM STRUCTURE

The primary focus of this case study is BHP as it existed before the debate on the State's operating budget for 2003-2005. As of December 2002, BHP covered 189,000 residents of Washington State, including 51,000 childless adults. State costs per member per month averaged $188 for regular, subsidized BHP consumers. Such costs were less than $223 for childless adults.[14] However, several other state programs have also provided health care services to specific groups of childless adults who are ineligible for Medicaid. This section of the report begins with these other programs and then focuses on BHP.

PROGRAMS OTHER THAN BHP

Three other programs have served uninsured, childless adults in Washington State:

- ***The General Assistance - Unemployables (GAU) program***, which furnishes cash assistance and health care to 6,700 adults with incomes at or below 45 percent of the Federal Poverty Level (FPL).[15] To receive such coverage, individuals must suffer from incapacitation precluding employment that lasts more than 30 days but less than the 12 months required for disability-based Medicaid coverage. GAU covers most Medicaid services. Individuals do not pay premiums or point-of-service cost-sharing.

- ***The Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) program***, which furnishes time-limited, inpatient and outpatient substance abuse treatment, a broad range of other health care services, housing, nutrition, and other support to 3,400 adults with substance abuse problems that preclude employment.[16] To qualify, adults must have income at or below 45 percent FPL.

- ***The Medically Indigent (MI) program,*** which pays catastrophic hospital costs for 3,900 adults who experience medical emergencies.[17] To qualify, adults' income must be less than 50 percent FPL, after taking hospital costs into account. Note: the MI program was repealed as part of the year 2003 budget deliberations, replaced to some degree by limited subsidies to hospitals.

The above enrollment numbers are for December 2002.

BHP

The following sections describe key features of BHP, starting with eligibility and the absence of any individual entitlement to coverage.

ELIGIBILITY AND THE ABSENCE OF ENTITLEMENT

Funded primarily by taxes on tobacco and alcohol, BHP provides health coverage to adults and children with family incomes up to 200 percent FPL who are Washington State residents ineligible for Medicare and not institutionalized at the time of enrollment. Children have the option to enter "Basic Health Plus," which receives matching federal dollars from Medicaid and provides additional services. As Medicaid beneficiaries enrolled in BHP plans, such children are exempt from family premium payments and point-of-service cost sharing (deductibles, copayments, etc.) Pregnant

women can be shifted to Medicaid during their pregnancy, receive enhanced services with lower costs, and then returned to BHP after the conclusion of post-partum care.

Except for such pregnant women and for children in Basic Health Plus, BHP enrollment is capped based on appropriated funds. As a result, the program has frequently experienced periods in which applicants are placed on waiting lists for coverage. This is occurring now.

BENEFITS

Using a fully capitated, HMO model, BHP covers a broad but basic set of benefits. The program covers many fewer services than Medicaid, with cost sharing required at the point of service. BHP's benefits are somewhat less comprehensive than average American employer-sponsored insurance provided through HMOs, particularly for dental care, prescription drugs, and mental health services, as shown in the following table.

Table 1: Covered services in 2003: BHP versus Average Employer Coverage through HMOs

Benefit category	Average employer coverage	BHP
Adult physicals	Covered for 98 percent of all insured workers in HMOs.	Covered.
Prescription drugs	Covered for 99 percent of all insured workers in HMOs.	Covered.
Copays for: Generic drugs Formulary name-brand drugs Other name-brand drugs	 $9* $17* 29 percent average HMO coinsurance.	 $3/$7, depending on drug. 50 percent patient share. No coverage.
Outpatient mental health	Covered for 98 percent of all insured workers in HMOs.	Covered.
Limits:	Median HMO: 21 to 30 visits per year.	12 visits per year.
Inpatient mental health	Covered for 97 percent of all insured workers in HMOs.	Covered
Limits:	Median HMO: 21 to 30 days per year.	10 days per year.
Annual OB/GYN visit	Covered for 99 percent of all insured workers in HMOs.	Covered.
Prenatal care	Covered for 99 percent of all insured workers in HMOs.	Covered.
Oral contraceptives	Covered for 85 percent of all insured workers in HMOs.	Covered.
Chiropractic	Covered for 72 percent of all insured workers in HMOs.	Covered, for up to 6 post-operative visits.
Dental care	Covered for 56 percent of all insured workers.*	Not covered.
Preexisting condition limit	Imposed on 12 percent of insured workers in HMOs.	9 month preexisting condition exclusion.
Office visit copays	Median HMO: $10	$10

Sources: HCA 2003 (Member Handbook); Kaiser Family Foundation/HRET 2002 survey of employer coverage (all benefit categories except dental care); Bureau of Labor Statistics, July 2002 report on year 2000 survey of employer coverage (source for information about dental care only). Notes: (1) Employer coverage numbers with asterisks are for all workers, regardless of type of health plan. Employer numbers without asterisks are for workers in HMOs only. (2) The percentage of insured workers with dental care coverage among employers was determined by comparing the incidence of workers with dental coverage to the incidence of workers with medical care coverage. (3) Out-of-pocket cost-sharing for BHP is slated to increase significantly in 2004.

In one important respect, BHP coverage exceeds average employer benefits nationally. Under Washington's "any willing provider law," health plans must offers services, such as acupuncture and massage therapy, that are not covered for most insured individuals in other states. Health plans have the option to supplement these benefits. None have exercised that option, however. Instead, plans try to attract enrollees through more generous prescription drug formularies and broader provider networks.

As noted in the above table, BHP plans may exclude coverage of preexisting conditions for up to nine months, depending on the individual's coverage history before applying for BHP. However, up to three months spent on the BHP waiting list counts against this exclusion. For example, an individual on the waiting list for two months before enrollment can be subject to seven months of subsequent exclusion.

By contrast, preexisting condition limitations, of any length, apply to only 12 percent of workers with employer-sponsored HMO coverage. However this difference is understandable. Employer insurance typically involves semi-automatic enrollment into health coverage by an employment group that includes a range of health risks. The employment group is defined by factors other than a willingness to make premium payments for health coverage. BHP coverage, on the other hand, depends on individuals choosing voluntarily to enroll and to pay partial premiums. This increases the odds that less-healthy individuals who foresee high health costs will disproportionately enroll. Preexisting condition exclusions are intended to address the risk of such adverse selection. However, as noted below, BHP has changed the permitted length of such exclusions from time to time, and careful research suggests that adverse selection has not been a serious problem for subsidized BHP, despite such changes. Moreover, the state's policy of disregarding only three months spent on the BHP waiting list does not seem narrowly tailored to preventing adverse selection.

PREMIUM COSTS TO ENROLLEES

In general, BHP enrollees must make minimum monthly premium payments that vary with income. For enrollees with family income at or above 125 percent FPL, minimum payment amounts are a percentage of the full insurance premium paid by the state, which is higher for older enrollees. Accordingly, for such near-poor enrollees, minimum monthly premium payments depend not just on earnings but on age as well. The following table shows percentages and amounts for 2003.

Table 2: Minimum Premium Payments for BHP, by Income: 2003

Income			Minimum enrollee premium payment per person per month
FPL	Maximum monthly dollars by household size, childless adults		
	1 person	2 people	
Under 65 percent	$480	$647	$10
65 – 99 percent	$738	$995	$14
100 – 124 percent	$923	$1,244	$17.50
125 – 139 percent	$1,034	$1,393	15 percent of premium ($17.50 to $52, depending on age)
140 – 154 percent	$1,144	$1,542	23 percent of premium ($18 to $79, depending on age)
155 – 169 percent	$1,255	$1,691	30 percent of premium ($24 to $103, depending on age)
170 – 184 percent	$1,366	$1,841	38 percent of premium ($30 to $131, depending on age)
185 – 200 percent	$1,477	$1,990	46 percent of premium ($36 to $158, depending on age)

Source: HCA 2003*, How Much Will Basic Coverage Cost?* Note: premium payments increased in 2004.

BHP enrollees pay minimum amounts if they select a "benchmark" plan (typically the lowest-priced plan in the area). Consumers may enroll in more expensive plans by paying, not just the minimum premium contribution, but also the full premium amount above the benchmark level. For example, a beneficiary with income at 110 percent FPL who enrolls in a benchmark plan paid $17.50 a month in 2003; if that beneficiary picked a different plan with a monthly premium that was $10 higher than the benchmark, the beneficiary paid $27.50 a month.

Consumers enrolled in BHP may change plans during annual open enrollment periods. Individuals who fail to make a premium payment or who make two late premium payments within a year receive an initial program suspension followed by a brief opportunity to pay past-due premiums. Consumers who do not pay their overdue premiums during this window are disenrolled and barred from rejoining the program for twelve months.

ALTERNATIVE ROUTES INTO BHP

BHP has several different avenues for enrollment, with some corresponding program variations. The following table shows the number of individuals covered through each such avenue, including Basic Health Plus, in February 2003.

Table 3. Categories of BHP enrollment, February 2003

Enrollment group	Number of covered individuals	Proportion of BHP enrollment
BH Individual Enrollees	93,971	50.9%
BH Plus	50,702	27.5%
Financially-Sponsored Enrollees	25,278	13.7%
Medicaid Transfer	11,426	6.2%
Home Care Workers	1,346	0.7%
Employer-Sponsored Enrollees	638	0.3%
Other	1,275	0.7%
Total	184,636	**100.0%**

Source: HCA unpublished data. (ESRI calculations, March 2003)

As this table shows, the largest enrollment category besides individual enrollment and Basic Health Plus involves "financial sponsorship." Excluding BH Plus children, who are not charged premiums, financially sponsored enrollees comprise 18.9 percent of enrollees. With the financially sponsored enrollment group, a non-profit entity pays premiums on behalf of enrollees, helps applicants complete forms, educates enrollees on appropriate use of health services (including how to obtain care from network outpatient providers rather than hospital care from emergency rooms and other non-network care), and helps beneficiaries complete the periodic forms required to retain BHP coverage.

Most financial sponsors have informal affiliations with community health care providers, such as clinics or public hospitals, but are formally distinct from such providers. The motivation for financial sponsors to commit to consumer assistance, without direct state reimbursement, stems largely from community-based health plans' desire for market share and appropriate health care utilization by their BHP enrollees. However, provider sponsors must pay a fee for each enrollee. Since such fees were first imposed in 1997, most financial sponsors have been non-provider sponsors, exempt from fees. While they may receive contributions and donations from health plans and providers, non-provider sponsors must be non-profit entities that are organizationally distinct from their donors and completely autonomous in their governance and use of donated funds. They must inform consumers about all available BHP health plans, not just those affiliated with contributing providers.[18]

The next-largest group of enrollees, individuals covered via Medicaid transfer, is the group of immigrants (primarily children) whose Medicaid coverage was ended in the hope that they would shift to BHP, as described above in the section describing recent developments.

Certain home care workers became eligible in 1996 for subsidized enrollment. In 2002, the Legislature voted to create a separate enrollment category for these home health workers, distinguishing them from regular subsidized enrollees. The apparent goal was to help trigger access to I-773 funds by building up BHP's baseline population. The Department of Social and Health Services, rather than HCA, funds this coverage for home care workers.

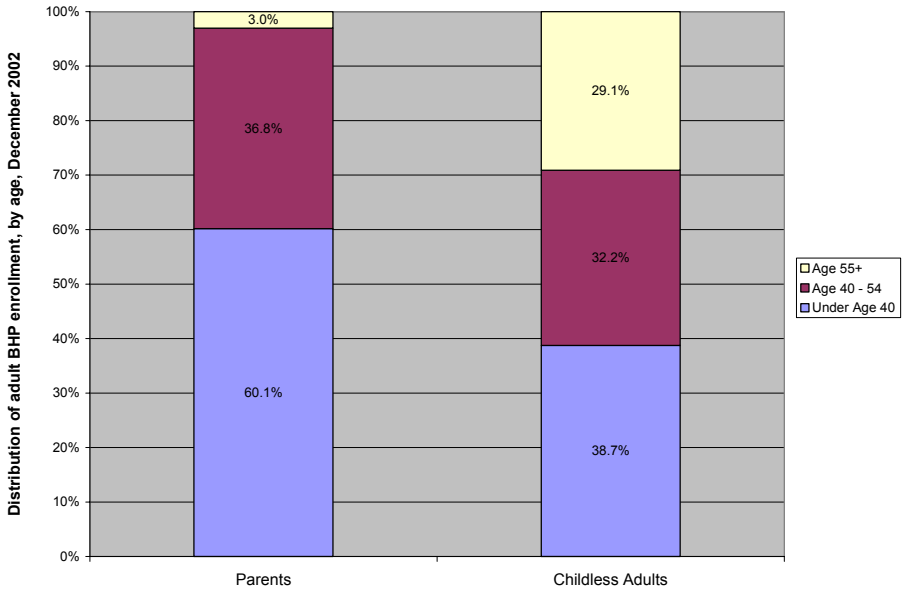
Finally, a small number of enrollees have employer sponsorship, through which qualifying employers may enroll their workers with incomes sufficiently low to qualify for BHP. To participate, employers must pay a sponsorship fee (in 2003, a minimum of $45 and $25 a month for full-time and part-time workers, respectively), limit BHP to income-eligible employees, offer no coverage but BHP to workers eligible for BHP, and ensure that 75 percent of income-eligible workers within the applicable employment classification (e.g., full-time employees) in fact enroll in BHP.[19]

CHARACTERISTICS OF BHP CONSUMERS, INCLUDING CHILDLESS ADULTS

Much published information describes the characteristics of BHP enrollees as a whole. For example, a survey of BHP enrollees in May and June 2001 found that 59 percent of them worked, most often full-time. Among working BHP enrollees, only 28 percent had an employer who offered health insurance. The median monthly premium cost of accepting such employer coverage would have been $55, compared to an average of $31 in monthly BHP premium costs. The median period of residence in Washington State was 23 years. Nearly half (48 percent) of BHP enrollees had been on the program for one to three years.[20]

Historically, neither the state nor outside researchers have distinguished, in their analyses of BHP data, childless adults from other adults. Not surprisingly, since Governor Locke proposed eliminating coverage of childless adults, some data have become available that distinguish between these consumers and other adults enrolled in BHP. Compared with BHP parents, childless adults are much more likely to be over age 55, as the following chart shows.

Figure 1. Compared to other BHP adults, more childless adults are older



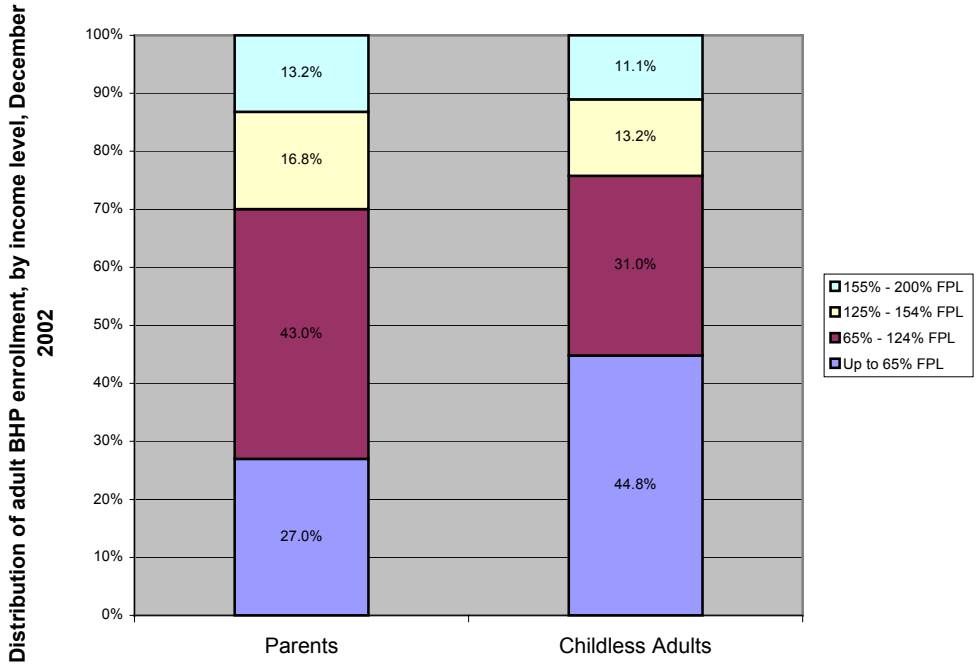
Source: HCA unpublished data (ESRI calculations, March 2003).

The difference in age distribution may result from the definition of "childless adults." That is, so-called "childless adults" include older parents whose children have grown. Nearly all older adults who are ineligible for Medicaid -- parents and non-parents alike -- are thus classified as "childless adults."

The prevalence of older adults among BHP's childless beneficiaries contrasts to the overall national demographics of uninsurance. While only 8.1 percent of all low-income, uninsured adults in the country are ages 55-64,[21] adults in this age range comprise fully 29.1 percent of all BHP's childless adults, or nearly three times their proportion among uninsured adults in general.

Another striking characteristic of BHP's childless adults is that, compared to parents, they are more likely to have very low incomes, as the following chart illustrates.

Figure 2: Compared to other BHP adults, more childless adults are very poor

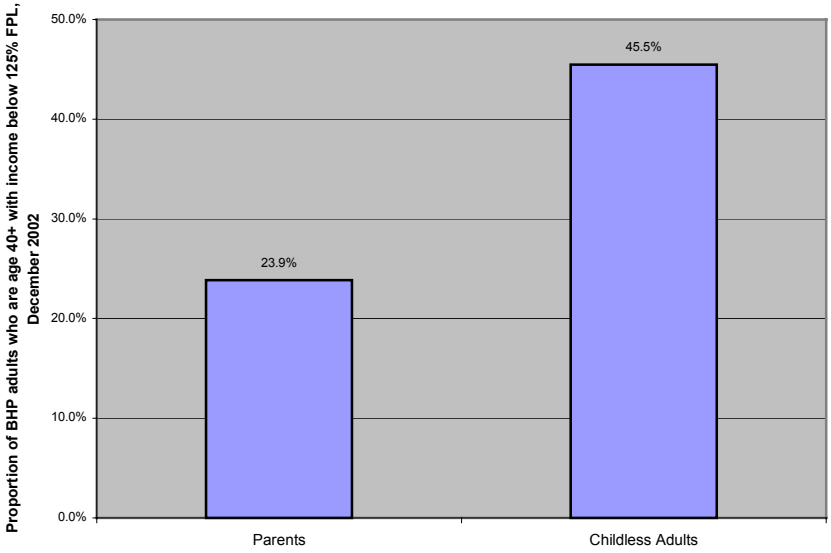


Source: HCA unpublished data (ESRI calculations, March 2003).

This difference in income distribution may result from Medicaid's exclusion of childless adults. Parents with incomes up to 45 percent FPL are covered by Medicaid.[22] By contrast, poor childless adults must generally turn to BHP, rather than Medicaid.

Figure 3 on the next page shows the combined impact of age and income on BHP's childless adults.

Figure 3. Compared to other BHP adults, childless adults are almost twice as likely to be simultaneously older and poor



Source: HCA unpublished data (ESRI calculations, March 2003).

Because they are older and poorer than BHP parents, childless adults receiving BHP are precisely the group least able to purchase health coverage on their own. Simultaneously, they face the highest premiums in the nongroup market and have the least ability to pay even modest premiums.

According to the study by researchers at the University of Washington and William M. Mercer, Inc., described in some detail below, even the healthiest adults without dependent children living at home must have an income above the following levels in order to meet their other basic needs and still afford either nongroup or WSHIP (high-risk pool) coverage:

- Between 168 and 202 percent FPL for one-adult households;
- Between 238 and 273 percent FPL for two-adult families.

Where a family falls on these spectra depends on their county of residence. Based on this analysis, very few childless adults now covered by BHP could purchase coverage on their own.

BHP'S IMPACT ON HEALTH CARE AND COVERAGE

Little published research analyzes the impact of BHP on receipt of health care. Of course, much research nationally makes the case that adults without health insurance are less likely to get essential care, less likely to have a medical home, and more likely to suffer serious harm, compared to the insured. Fairly recent reports by both the Institute of Medicine and the Kaiser Commission on Medicaid and the Uninsured analyze the extensive literature on this subject.[23] In addition, some published research specific to BHP and Washington State illustrates the impact of health coverage on BHP eligibles. Before the program began, a baseline study of Washington state residents eligible for BHP found that those without health insurance were more than twice as likely to lack a usual source of care, to use hospital emergency rooms as their usual source of care, and to limit their use of health care because of cost.[24]

A much more recent study came to similar conclusions after comparing BHP enrollees to low-income Washington state residents without coverage. Controlling for socioeconomic status and other factors, this later study found that BHP enrollees were twice as likely to have a usual source of care and to have at least one physician visit a year.[25] These studies indicate that, for many low-income households, BHP apparently shifts health care utilization from hospital emergency rooms to physician offices, potentially improving health and creating some offsetting cost savings.

Other, less rigorous evidence reaches similar conclusions. During the period BHP expanded, Washingtonians' access to health coverage and care improved. While other factors surely played a significant part, BHP may have contributed to some of these favorable trends. Following are some examples:[26]

- The proportion of uninsured state residents fell from 12.2 percent in 1993 to 8.4 percent in 2000. Since then, even as declines in employer coverage increased the state's overall uninsurance rate to 10.7 percent in 2002, health insurance coverage among state residents earning under $35,000 – the group most affected by BHP and other public programs – has remained stable, at 80.5 percent.
- The proportion of state residents who could not see a doctor because of cost dropped from 11.2 percent in 1995 to 8.7 percent in the year 2000.
- As shown by annual state surveys, the proportion of women age 40 and older who are did not receive a mammogram during the two years before the survey fell by more than a third, from 37.3 percent in 1995 to 24.2 percent in 2000.
- Uncompensated hospital charity care likewise fell more than a third, from 3.2 percent of adjusted hospital revenue in 1996 to 2.1 percent in 2000.[27]
- The percentage of state residents with income under $15,000 a year (in year 2000 dollars) who use hospital emergency rooms as their main source of care fell from approximately 3 percent in 1996 to 0.9 percent in 2000.[28] This may signal that other use of hospital ERs also declined among low-income people.

POLICY DESIGN ISSUES

The following sections of this report discuss a series of topics raised by the long and complex history of BHP.

LONG-TERM, BIPARTISAN SUPPORT AMONG POLICYMAKERS AND THE PUBLIC

One striking feature of BHP's history is the program's popularity among policymakers and the general public. As noted above, even while the Legislature repealed most other reforms of the early 1990s, BHP expanded, and the program has remained in place, despite many changes in the state's economy and shifts back and forth between Democratic and Republican control of the Legislature.

The public also supports BHP, as shown by the adoption of I-773. There is broad agreement among observers about the reasons for the program's ongoing popularity among the public and decision-makers:

- BHP provides health coverage to low-income, working people, a group widely seen as deserving help.
- BHP is not an entitlement, as discussed below, which allows more control over caseload and costs.

- BHP requires enrollees to help pay for their insurance and medical care, which many view as contributing to financial responsibility.
- BHP is a public-private partnership, using private insurance and strictly managed care through HMOs.
- BHP provides a somewhat less comprehensive benefit package than is covered by typical employer-sponsored insurance.
- As a purely state-run and state-funded program, BHP is exempt from federal Medicaid rules. Accordingly, the state has much more ability to manage the program.

In addition, many state Legislators know people who have directly benefited from BHP. They include constituents as well as some of their peers' sons and daughters, who have aged out of their parents' coverage but don't yet have a job with health coverage.

THE ABSENCE OF AN INDIVIDUAL ENTITLEMENT

The absence of an entitlement to coverage and the resulting enhanced control over caseload and spending have played an important part in generating broad, bipartisan support for BHP, according to observers across the political spectrum. These factors contributed to this program's growth from two pilot counties in 1988 to a statewide undertaking in the early 1990s and its subsequent continuation and expansion, despite numerous changes in the political and economic climate.

On the other hand, the absence of an entitlement and the resulting waiting lists and enrollment caps have greatly reduced the coverage provided by BHP. In the year 2000, 71 percent of uninsured adults in Washington State had no access to either public coverage or employer-based insurance. If BHP were an entitlement and any eligible adult could have enrolled, only 26 percent of uninsured adults in Washington would have lacked access to coverage.[29]

The contrast with children's coverage underlines the impact of enrollment caps. Through Basic Health Plus, Medicaid and the Children's Health Insurance Program,[†] children who apply for assistance automatically receive coverage, without any waiting list, so long as their family income is below 250 percent FPL. Between this higher eligibility level and the absence of waiting lists, only 17 percent of Washington's uninsured children in the year 2000 lacked access to any public or private coverage.[30]

At a less fundamental level, individuals on the waiting list can experience preexisting condition exclusions that, in effect, far exceed those specified in BHP program rules. That is because only three months spent on the waiting list can be used to meet the nine month preexisting condition period. Suppose, for example, a worker is on the waiting list for ten months before enrolling into BHP. At that point, the preexisting condition exclusion is shortened by three months, so a seven-month exclusion applies once the consumer enrolls in BHP. Altogether, such a worker would have to wait 16 months between first applying for BHP and receiving health coverage that addresses preexisting health problems. This can cause grim results for workers and their families with chronic health problems.

AFFORDABILITY OF CONSUMER PREMIUM COSTS

Several observers have concluded that, because required household premium contributions increase when income exceeds 125 percent FPL, the bulk of BHP enrollment is at lower income

[†] Although at a national level SCHIP is not an entitlement program, Washington's coverage of children in 2003 and earlier years did not impose any enrollment caps or waiting lists.

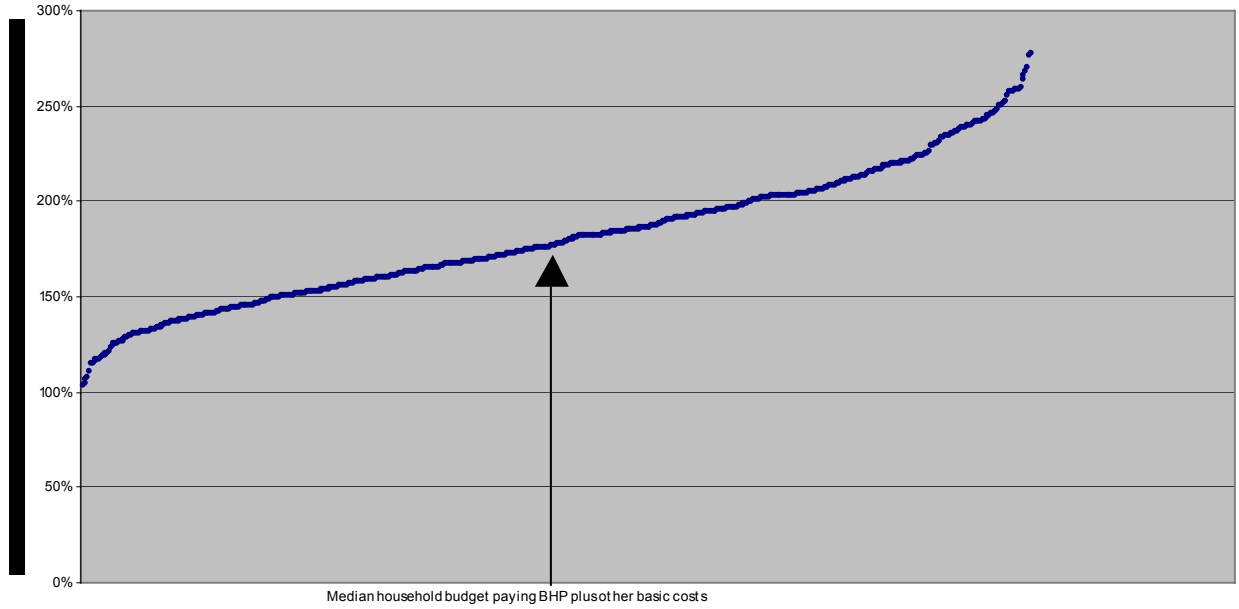
levels. For example, in February 2003, more than 72 percent of BHP regular subsidized enrollees had incomes below 125 percent FPL.[31]

Above that income threshold, even for relatively young BHP adults under age 40, minimum premium payments can consume between 2.2 percent and 6.9 percent of all household income.[32] While these proportions sound modest, their association with low enrollment is made understandable by a recent study of household budgets conducted by Carolyn Watts of the University of Washington and James Matthisen of William M. Mercer, Inc.

Watts and Matthisen estimated the minimum income needed, in eight diverse Washington counties, to make BHP payments and still meet other basic needs, such as shelter, food, utilities, transportation, child care, and clothing. In each county, researchers developed separate budgets for twelve family types, three health status categories, and possible receipt or non-receipt of certain public benefits (food stamps and child care subsidies). These analysts developed a total of 576 minimum household budgets, in eight counties, that included BHP costs.

Watts and Matthisen concluded that, for households to pay BHP premium contributions and average point-of-service cost-sharing and still meet their other basic needs, their income must exceed 104 percent FPL for the best-case household (a large, healthy family, living in Chelan County, receiving various kinds of public assistance) and 278 percent FPL for the worst-case household (a large family in poor health, living in King County, not receiving public assistance). Most minimum budgets easily exceeded 150 percent FPL. Figure 4 shows the results for all 576 household budgets in the eight analyzed counties.[33]

Figure 4: Most households in eight, diverse Washington counties need income well above 150 percent FPL to make BHP payments and still meet their other basic needs



Source: Watts and Matthisen, June 2002.34 Notes: (1) For 576 profiled households in eight counties (Whatcom, Jefferson, King, Pierce, Tacoma, Clark, Chelan, Spokane, Yakima), this chart shows the income required to pay BHP premiums and average point-of-service cost-sharing and still meet basic needs for housing, child care, food, taxes, transportation, and certain other costs (e.g., clothing). (2) The median household budget was determined in simple rank order, without any weighting.

Suggesting that many low-income households cannot afford even modest premium payments, this analysis of minimum required household budgets is consistent with a study of pilot BHP implementation finding that each $5 increase in family premium costs triggered a 6 percent decline in overall enrollment.[35] A later study of statewide BHP implementation came to similar conclusions, determining that reducing monthly premiums from $50 to $25 would increase BHP enrollment by 62 percent; and cutting premiums from $50 to $10 would more than double BHP participation.[36]

Throughout BHP's history, whenever consumer premium payments moved significantly in one direction, up or down, enrollment moved strongly in the other direction. As noted above, the first major change took place from 1995 to 1996, when the average BHP enrollee's monthly premium share dropped from $23.06 (21 percent of premiums) to $17.41 (16 percent of premiums). Total BHP enrollment rose rapidly from 57,700 in December 1995 to 143,200 in December 1996.[37] If Basic Health Plus children, home care workers, and enrollees in Health Access Spokane (a now defunct demonstration project) are subtracted, the increase is even more dramatic, from 51,592 enrollees in December 1995 to 126,663 in December 1996 – a 146 percent rise.[38] Although lower premium charges may have been the most important factor leading to this increase, other program adjustments also played a role, including increased outreach and what turned out to be short-term authorization of payments to insurance agents and brokers. (After enrollment rose, such authorization ended.)

As explained above, state policymakers reversed direction in 1998, increasing minimum premium payments for all enrollees above 65 percent FPL. Policymakers also asked consumers with incomes below 125 percent FPL to pay the increased cost of choosing plans more expensive than benchmark coverage, as illustrated by the following table.

Table 4: 1997 to 1998 change in enrollee premium contributions for one adult, age 40-45

Income	1997 monthly payments	1998 monthly payments
<65 percent FPL	$10	$10 - $40
65 – 99 percent	$10	$12 - $42
100 – 124 percent	$10	$15 - $45
125 – 139 percent	$10 - $20	$31 - $60
140 – 154 percent	$10 - $30	$42 - $72
155 – 169 percent	$10 - $40	$51 - $81
170 – 184 percent	$20 - $50	$62 - $92
185 – 200 percent	$29 - $60	$75 - $105

Source: HCA 1997 annual report. Note: the highest and lowest monthly payment levels depict the consumer premium costs of choosing benchmark coverage and the most expensive BHP plans.

As a result, average premium payments rose from $17.73 in June 1997 (16 percent of premiums) to $23.90 in June 1998 (19 percent of premiums).[39] Before that increase, 130,000 subsidized individuals were enrolled in BHP,[40] and more than 100,000 individuals were on BHP's waiting list.[41] In 1998, enrollment dropped to 127,200, and the program accepted everyone on the waiting list who wanted to enroll.[42] In effect, the demand for subsidized BHP dropped by 45 percent, from 230,000 to 127,000 low-income individuals.

Enrollment remained stagnant in 1999, with 128,000 individuals in BHP and no waiting list. The Legislature then lowered premium costs to 1997 levels for households with incomes above 125 percent FPL, while keeping the increased premium shares for lower-income consumers. In 2000, enrollment rose slightly, to 132,000. By 2001, demand outpaced appropriations, and the waiting list was re-established. By June 2002, the waiting list had 23,000 people, and subsidized enrollment reached 138,000. As of February 2003, monthly premium payments from enrollees

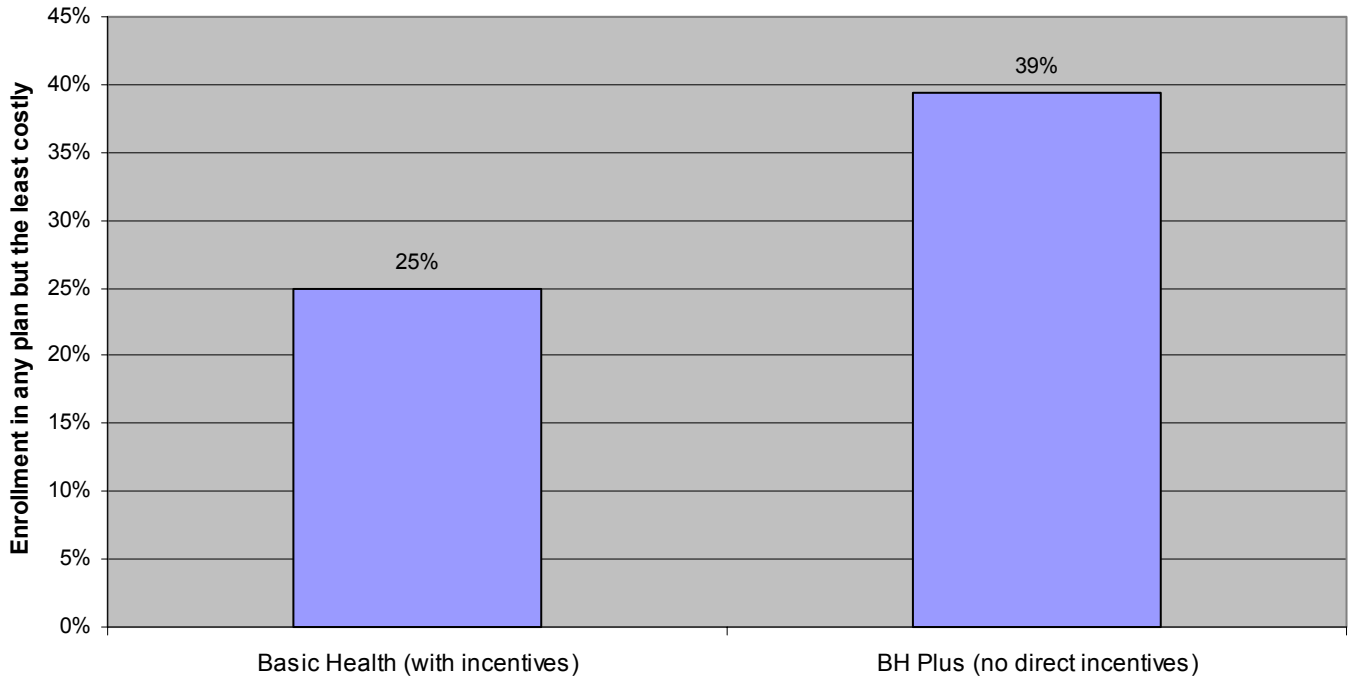
averaged $26.74 (14 percent of the total average premium).[43] As noted above, premium contributions are again slated to rise in 2004, in response to state budget shortfalls.

THE IMPACT OF FINANCIAL INCENTIVES FOR CONSUMERS TO CHOOSE LESS COSTLY PLANS

As explained above, BHP enrollees who choose coverage more expensive than the "benchmark" plans in their area pay, not just their minimum premium contributions based on age and income, but also the extra cost of non-benchmark coverage. These incentives have been effective in encouraging cost-consciousness among BHP enrollees. In 16 of 39 counties, containing 78 percent of enrollees, BHP consumers have a choice between benchmark and non-benchmark plans. As of February 2003, 75 percent of the BHP consumers in these counties had selected the least expensive plan, according to HCA data.

The contrast with enrollment patterns for children in Basic Health Plus is instructive. Covered by federal Medicaid law, Basic Health Plus requires no premium contribution, regardless of which plan is selected. Accordingly, a comparison of enrollment patterns in standard BHP with Basic Health Plus can suggest (albeit without the kind of controls or multivariate analysis that would be desirable) the general magnitude of financial incentives' impact on choice of plan. As the following Figure indicates, the enrollment patterns are quite different in the two programs.

Figure 5: Financial incentives favoring the least expensive plan appear effective



Source: HCA unpublished data for February 2003 (ESRI calculations, March 2003). Note: This depicts enrollment in counties where consumers have a choice of plans that include both benchmark and non-benchmark coverage.

The above chart shows that BH Plus children, who are not subject to direct financial incentives, are 56 percent more likely than are standard BHP consumers to be enrolled in costly plans, suggesting the power of the program's consumer financial incentives. However, this analysis understates the impact of these incentives. Despite the absence of premiums for BH Plus children, parents wishing

to have the entire family enrolled in a single plan still have a financial incentive (albeit somewhat reduced) to choose a benchmark plan. Such parents pay no premiums for their children, but they must make premium contributions for themselves, and they pay more for choosing non-benchmark coverage. If parents had, instead of a reduced financial incentive, absolutely no financial incentive to enroll BH Plus children in less costly coverage, the difference in enrollment patterns would be even starker.

However, these cost savings have an accompanying trade-off. Some observers have found that, when a health plan changes from benchmark to non-benchmark coverage, enrollees frequently do not understand until they start getting billed that the consumer premium costs for the same plan are changing. This often happens after the open enrollment period has ended and the consumer can no longer switch to a less expensive plan. In such cases, enrollees frequently do not make the required premium payments, are dropped from BHP, and cannot rejoin the program until 12 months have passed.

TERMINATION OF MEDICAID FOR CERTAIN IMMIGRANTS, EXPECTING BHP ENROLLMENT

As noted above, only 11,426 out of 27,000 immigrants (or 42 percent) terminated from state-funded Medicaid on October 1, 2002 wound up enrolling in BHP by February 2003. It is likely that many who did not enroll in or who retain BHP coverage became uninsured. According to a recent study, problems undertanding the BHP application process, increased documentation requirements, and difficulty paying premiums created barriers to enrollment.[44] Among immigrant families who enrolled in BHP, it appears that some may be experiencing problems accessing necessary care due to benefit limits and cost sharing requirements.[45]

FINANCIAL SPONSORSHIP AS A STRATEGY TO REACH HARD-TO-SERVE CONSUMERS

The demographic profile of financially sponsored enrollees is quite different than for individually enrolled BHP consumers, as shown by Table 5 on the next page.

Table 5: BHP consumers receiving help from financial sponsors tend to be more disadvantaged than individuals enrolling on their own

Characteristic	Proportion among individual enrollees	Proportion among financially-sponsored enrollees
Income below 100 percent FPL	53.8 percent	81.2 percent
Non-white ethnicity	15.5 percent	59.7 percent
Less than high school education	7.4 percent	32.3 percent
More than high school education	62.6 percent	43.4 percent
Spanish-speaking	1.6 percent	19.4 percent
Fair or poor health (self-reported)	16.5 percent	34.4 percent
Had health insurance before BHP	47.7 percent	24.9 percent

Source: 2001 survey of BHP enrollees conducted by HCA and Oregon Health Policy and Research, published in June 2002.[46]

These data suggest that financial sponsors have been able to overcome hurdles to enrollment among less educated, lower-income households that may have posed problems for similar consumers trying to enroll on their own.

THE FAILURE OF EMPLOYER SPONSORSHIP

A decade ago, when BHP first went statewide, policymakers harbored high hopes for employer sponsorship, anticipating that fully half of BHP enrollment would come through employers. However, as shown above, employer sponsorship wound up accounting for less than one-half of one percent of BHP enrollment. This limited use of employer sponsorship has multiple causes, according to a number of observers, including the following: it is usually less expensive for employers to give their BHP-eligible workers the extra income needed to cover BHP consumer premium costs than to pay employer sponsorship fees; many employers do not wish to offer BHP (and only BHP) to their low-income workers but other coverage to employees with higher incomes, as required under state rules for employer sponsorship; identifying the workers who qualify for BHP requires inquiries into spousal income, which triggers privacy concerns among firms and employees alike; and some employers are predisposed against public sector programs in general.

THE ABSENCE OF ADVERSE SELECTION

During the pilot project phase of BHP, both insurers and health policy analysts expressed serious concerns that adverse selection could harm, perhaps even doom the program. They feared that older and sicker individuals would disproportionately tend to enroll, driving up per capita program costs and premiums.

In fact, significant adverse selection did not occur. A careful study of initial BHP enrollment found that, compared to individuals eligible for BHP who stayed outside the program, BHP enrollees tended to be healthier, better educated, more recently insured, and less costly users of health coverage. No “pent up demand” was observed among initial enrollees.[47]

At first, it appeared that several program design features may have had something to do with the absence of adverse selection: namely, 12 month preexisting condition exclusions; and no coverage

for prescription drugs, mental health, and substance abuse services. However, nearly a decade after the Legislature converted BHP into a statewide program, BHP benefits had grown to include some prescription drugs, mental health, and substance abuse services; the preexisting condition exclusion had shortened to three months; and premium subsidies had increased significantly. Despite these changes, researchers found the same enrollment patterns, with lower-risk eligibles disproportionately choosing to enroll.[48] (Since then, as noted above, the preexisting condition exclusion has grown from three to nine months.)

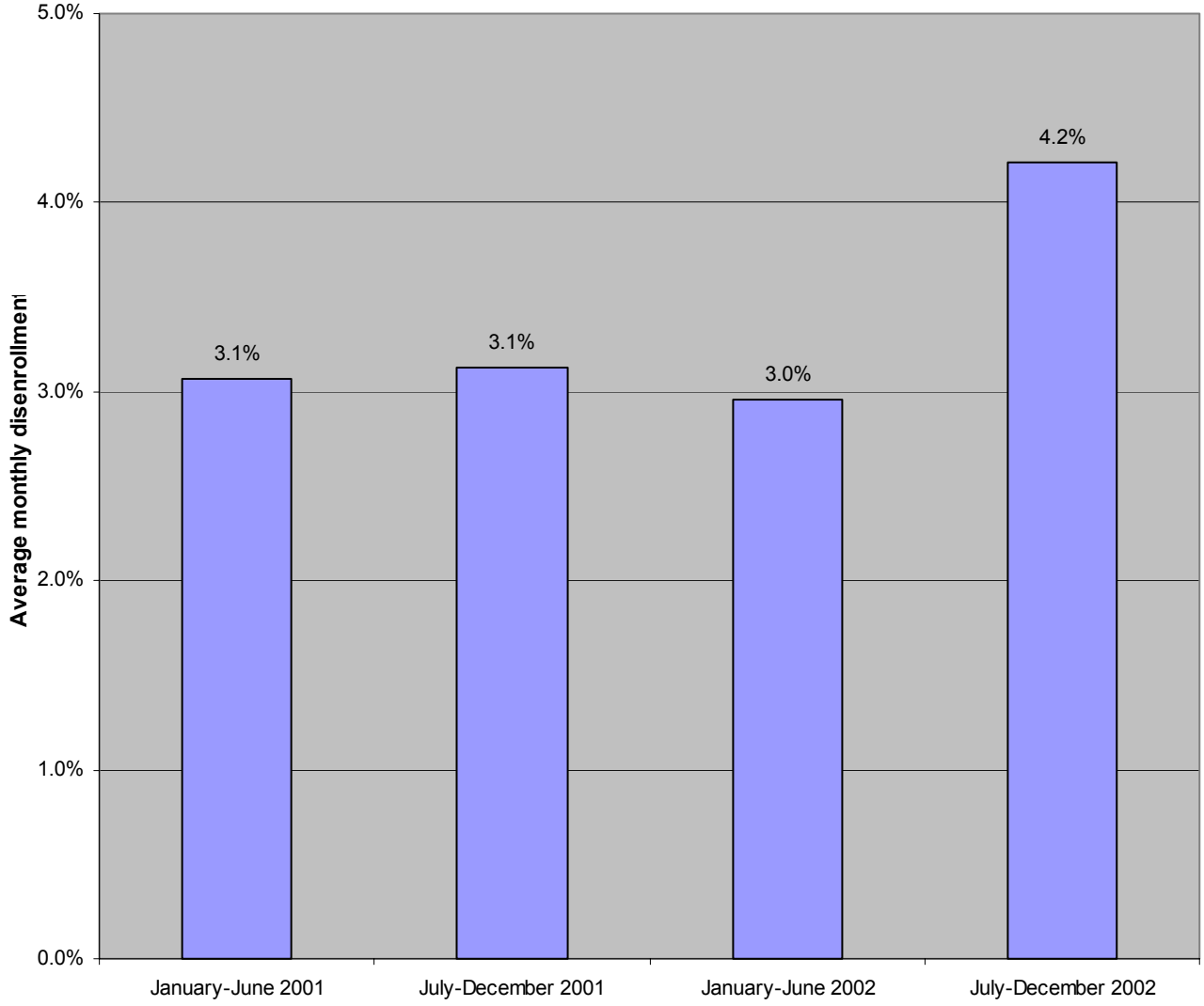
One explanation for the ongoing absence of adverse selection, despite various program changes that increased the usefulness of coverage to higher-risk individuals, is that generous premium subsidies made it possible for even young and healthy workers to enroll at costs they could afford. This is consistent with other recent studies suggesting that relatively generous health premium subsidies available to federal workers have largely prevented adverse selection in their health benefit program.[49] Another factor is that sicker, less educated individuals not benefiting from financial sponsorship may have had more difficulty completing forms and enrolling in available BHP subsidized coverage.

The combination of a relatively healthy population and limited benefits kept December 2002 average per member per month costs to $188. This principally reflects the costs of adults, as only 6 percent of regular subsidized BHP enrollees are children. Even among childless adults under age 65, the state's per member per month costs averaged less than $223, despite the disproportionate representation of individuals over age 55, and the state's resulting higher, age-rated premium costs.[50] By comparison, among Western employers generally, 2002 HMO premiums averaged $212 per month for worker-only coverage that typically is somewhat more generous than BHP.[51]

DISENROLLMENT RULES

As explained above, one missing premium payment or two late payments during the year cause disenrollment and a bar from rejoining BHP for twelve months. On the one hand, reserving coverage for those who pay in a timely fashion can be defended as allocating finite coverage slots on the basis of personal responsibility. On the other, the penalty is quite harsh. Disenrollment levels took a significant upward jump in the second half of 2002, as the Figure on the next page illustrates.

Figure 6: BHP disenrollment increased during the last half of 2002



Source: HCA unpublished data (ESRI calculations, May 2003). Note: To show the percentage of enrollees who leave the program in an average month within each six-month period, this chart depicts total net disenrollment levels for regular subsidized coverage, subtracting from gross disenrollment numbers consumers whose enrollment is temporarily suspended for non-payment or late payment but who bring their accounts current and are reenrolled into BHP, without any subsequent 12-month bar.

UNSUBSIDIZED COVERAGE FOR INDIVIDUALS WITH INCOMES TOO HIGH FOR BHP

When BHP began operation as a statewide program, individuals with income above 200 percent FPL were permitted to buy coverage from BHP plans. The state capped premiums for such unsubsidized coverage at 106 percent of the amount the state paid for subsidized BHP. Soon thereafter, insurers wishing to participate in any state-based health coverage (Medicaid, BHP, or public employee coverage) were required to issue such "unsubsidized" coverage to all applicants. This was intended to permit continuity of coverage and increase work incentives for low-income individuals who first enrolled into subsidized coverage but whose earnings later rose to exceed

eligibility for subsidies. Unsubsidized coverage also sought to provide comprehensive, affordable insurance options for uninsured workers with incomes above 200 percent FPL, leveraging the state's purchasing power to offer such individuals "good deals" on insurance.

Despite these worthy goals, the outcome was quite different for BHP's unsubsidized than for its subsidized coverage. For unsubsidized BHP, tremendous adverse selection resulted from guaranteeing enrollment into comprehensive benefits with a fixed premium based on the cost of serving a relatively healthy group of workers and their families through subsidized BHP. With the nongroup market rarely offering maternity care coverage, pregnant women ineligible for Medicaid were among those with high health costs who enrolled, frequently dropping coverage after delivering a child. Moreover, the closure of the state's high risk pool to new enrollees further contributed to enrollment of high-risk consumers into BHP. Even excluding maternity care costs, average inpatient utilization by unsubsidized BHP enrollees was nearly two and one-half times the level of subsidized BHP consumers.[52] By 1997, 24,000 individuals received unsubsidized BHP,[53] paying average monthly premiums of $108.[54] Insurers lost considerable sums, and some dropped all state-based coverage rather than continue to offer this one product.

As a result, the state eliminated the cap on premiums for unsubsidized coverage in 1998. From 1997 to 1998, premiums for such coverage rose by an average of more than 70 percent, and enrollment declined by 43 percent, to 13,641. For 1999, unsubsidized premiums again rose, this time by another 62 percent.[55] Fewer than 8,000 individuals sought unsubsidized coverage for 1999. Effective in 2000, plans with other state contracts were no longer required to offer unsubsidized BHP. Enrollment continued to dwindle, reaching 1,791 in December 2000 and 1,143 in December 2001. After various attempts to preserve the limited ability of unsubsidized coverage to provide ongoing insurance for individuals who formerly received subsidized coverage, new enrollment into unsubsidized coverage ended in 2002, and the program was completely eliminated in 2003.

CONCLUSION

For half a generation, Washington State's Basic Health Program has achieved significant, positive results providing health coverage to uninsured, low-income workers, including childless adults. Policymakers at both the state and national levels grappling with the potential redesign of current health insurance programs serving low-income households and the structure of future coverage expansions would be well-advised to consider carefully the numerous lessons taught by the long and varied history of this program.

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