



Center for Health Law and Economics
University of Massachusetts Medical School
The Schrafft Center
529 Main Street, 3rd Floor
Charlestown, MA 02129-1120

MEMORANDUM

To: Basic Health Program Working Group

From: Katharine London and Robert Seifert
Center for Health Law and Economics

Subject: Outstanding issues from November 19, 2012 meeting

Date: December 14, 2012

During its meeting on November 19, the working group identified a number of issues for which it requested our follow-up. The issues are:

- The possible impact of different levels of cost sharing on take-up in the Exchange;
- An assessment of the possible fiscal impact of a Basic Health Program (BHP) on health care providers; and
- Updated information about “churning” between programs as incomes fluctuate.

We address each of these in turn in what follows, briefly summarizing highlights drawn from existing literature. In a separate document, we also update the vignettes of hypothetical Connecticut residents, comparing their potential experiences in a BHP and the Exchange, using data from the recently completed Milliman projections.

1. Impact of cost sharing on take-up

The March 2003 Kaiser Commission on Medicaid and the Uninsured publication, “Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations,” by Hudman and O’Malley, presents a thorough review of the literature on this topic. The overall consensus of the research is that

- premiums can discourage enrollment of the uninsured in publicly funded programs, and
- cost sharing disproportionately affects low-income people by reducing the use of beneficial, cost-effective services, which can result in worse health outcomes.

The paper cites specific findings, for example from the RAND Health Insurance Experiments, which found a greater reduction in service use as a result of cost sharing for low-income people (defined as income below 200% of FPL) than for others, and that low-income adults in plans with cost sharing had a likelihood of receiving “highly effective” care that was 59 percent of the likelihood for those in plans with no cost sharing.

The Kaiser paper also cites a study by Ku and Coughlin, which estimated the sensitivity of participation rates to premium levels using data from three public health insurance programs (with no individual mandate) that used income-related premiums. The study found that participation rates declined from 57 percent when premiums were 1 percent of family income, to 18 percent at 5 percent of family income.

2. Fiscal impact of BHP on providers

We estimate that approximately 74,000 individuals meet the eligibility requirements for a BHP. Of these, 80% are currently uninsured. Most of this population cannot afford to pay for their care out of pocket and likely rely on charity care to cover their health care costs.

If a BHP paid providers at Medicaid rates, providers would receive more revenue than they currently receive for the care of this population, but perhaps less than their costs.

If individuals 133-200% FPL enrolled in commercial insurance plans through the Exchange, providers would be paid higher commercial rates for their care. However, fewer low-income individuals are likely to purchase coverage through the Exchange than enroll in a BHP because of the higher premium cost in the Exchange. That is, a higher number of low-income individuals will remain uninsured and continue to rely on charity care to cover their health care costs.

3. Churning

A justification for a BHP, particularly if it is well integrated with a state’s Medicaid program, can be that it reduces the disruption in coverage and care that can result when an individual’s income moves above or below the Medicaid eligibility threshold (133% of FPL). A study by Sommers and Rosenbaum in *Health Affairs* found that many low-income people regularly move across the Medicaid threshold in one direction or the other; over a three year period, nearly three-quarters did, many multiple times. A subsequent study by Graves and colleagues in the *New England Journal of Medicine*, however, concluded that a BHP might have the effect of simply moving the churning point further up the income scale, and that the frequency of churning would be similar at a threshold of 200% FPL, which would be the transition point between a BHP and an Exchange. An April 2012 study by the New York State Health Foundation on ensuring continuity of coverage for low income residents supports this finding, and suggests that fluctuations may even be more prevalent at the 200% level depending on economic conditions. In contrast, a Health Affairs/Robert Wood Johnson policy brief on the BHP from November 2012 reviews two studies that find a small reduction in churning with a BHP: an estimated 1.1 to 1.8 million fewer people per year would not experience an income-related eligibility change if all states had a BHP.