Economic Opportunity Institute

Policy Memo

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Washington's Basic Health Plan: Fulfilling Its Mission or Creating Barriers for Working Families?

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Introduction: Birth and Growth of the Basic Health Plan

The Washington State Basic Health Plan (BHP) began in 1987 as a pilot project to provide health insurance for low-income and lower middle-class workers who do not receive health coverage through their employer. The BHP is intended to provide a no-frills package of health care benefits to Washington residents with incomes at or below 200% of the Federal Poverty Level.[1] State funds are used to help pay a portion of monthly premiums on a sliding scale basis, depending on family income.

The BHP was made a permanent statewide program in 1993 when the legislature mandated the implementation of universal health coverage. While the universal coverage mandate was repealed two years later, the legislature retained the BHP and set a statutory enrollment target of 200,000 adults. Enrollment grew rapidly from 57,264 in January 1996 to 128,858 in November 1996.[2] This increase in BHP enrollment during the mid-1990's offset decreases in employer coverage. The result was a stabilization of the proportion of uninsured at slightly more than 13% of people ages 19-64.

By the end of 1996, demand for Basic Health Plan coverage had already exceeded budgetary allocations. A cap was placed on enrollment, and a waiting list was created. By June 1997, over 100,000 people were on the waiting list. In 1998 the legislature imposed steep cost-sharing increases on BHP participants, and within six months, the waiting list disappeared.

The legislature had effectively succeeded in pricing the BHP out of the reach of the very people it was designed to serve: low-income and lower-income working families. In 1999, the legislature somewhat decreased premiums for participants but not enough to remove significant cost barriers for BHP participants.[3]

BHP enrollment hovered around 130,000 through 2000 and 2001. As the percentage of uninsured adults climbed to 11.5%,[4] it became clear that funding for the BHP was still insufficient to meet the need for health insurance. This need was popularly crystallized and legitimized in 2001 with the development of Initiative 773 (I-773). This measure, which voters approved by a 2:1 margin, expanded Basic Health Plan coverage. I-773 appropriated funding from a $0.60 increase in the tobacco tax to "enroll 20,000 additional persons (over a base of 125,000) in the two-year budget period beginning July 1, 2001, plus an additional 50,000 enrollees in the two-year budget period beginning July 1, 2003."[5] By December 2002, total subsidized enrollment had reached a peak of 135,229.[6]

De-funding the BHP and Its Impact on Participants

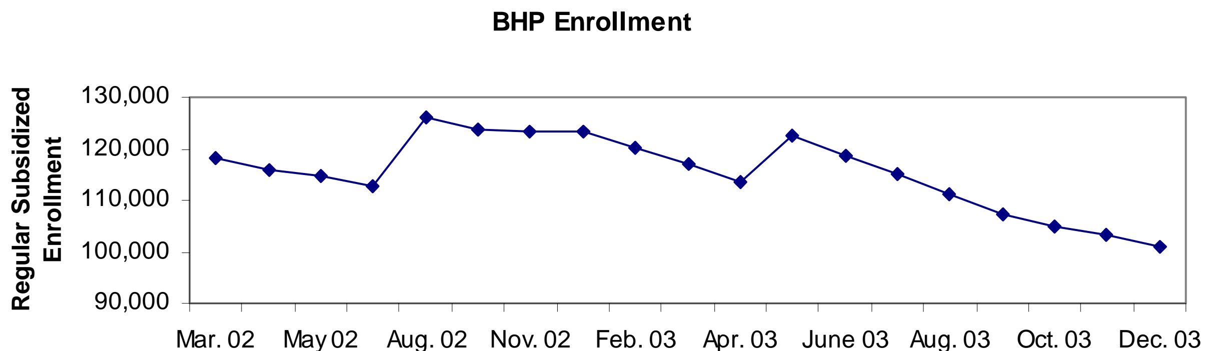
Just 15 months later in 2003, the state found itself in the midst of a recession-induced fiscal crisis. The legislature responded by overturning the vote of the people from 2001. It diverted funding from the BHP, removing the requirement athat 125,000 enrollments be funded from state sources other than the increase in the tobacco tax and calling for an actuarial decrease in the benefits package by 18%.[7]

Effective in 2004, these BHP cuts resulted in higher monthly premiums and out-of-pocket costs for participants. Along with higher premiums, participants were required to pay higher co-pays, deductibles, and 20% of their medical bills out-of-pocket until a $1,500 maximum was reached. This drastically increased the price of health coverage for many low-income working families in Washington.

The legislature also "directed the HCA [Health Care Authority] to lower Basic Health's enrollment level to 100,000 members."[8] This mandate caused BHP total subsidized enrollment to drop from 134,644 in January of 2003 to 100,763 in January of 2004.

The Economic Opportunity Institute (EOI) has compiled three scenarios that illustrate the effects of the additional BHP costs on a family budget. These theoretical scenarios are drawn from common medical needs of families in Washington in 2005. Based on the costs of these medical needs and the coverage information provided by the Basic Health Plan, we present estimated annual costs paid by families at different income levels. This analysis reveals the unaffordably high percentage of a working family's household budget that BHP coverage can require.

BHP Enrollment



Source: Health Care Authority

The following is a breakdown of participant costs under the BHP today. The income eligibility ceiling of 200% of the Federal Poverty Level (FPL) translates to an annual pre-tax income of $25,660 for a family of 2 or $38,700 for a family of 4.

BHP participants have the following costs:

1) monthly premium based on income, age, and family size, ranging from $17 to $235;
2) $150 annual deductible for each recipient;
3) 20% co-insurance until $1,500 out of pocket maximum is reached;
4) $15 general co-pay (office visits);
5) $100 emergency room co-pay;
6) pharmacy drugs

   Tier 1: $10 co-pay (generic drugs in health plan's preferred drug list)

   Tier 2: 50% of the cost of the drug (brand-name drugs in health plan's preferred drug list).

(In the appendix is a summary comparison of benefits for 2003 and 2005.)

Scenario 1: A middle-aged couple with two children living in King County

Participant costs: 2005

Erin, 52 years old, and Patrick, 57 years old, live in King County with their two children. They expect their annual pre-tax earnings to total $29,025 (150% of the 2005 FPL for a family of 4). Erin works as a childcare teacher earning $9.00 an hour, and Patrick works as a cook in a local restaurant. Patrick earns $10.00 an hour, but business has been slow this year, and his hours have been cut significantly. Neither of their employers cover health insurance. Medicaid covers their children, and in 2005, Erin and Patrick decide to join the BHP.

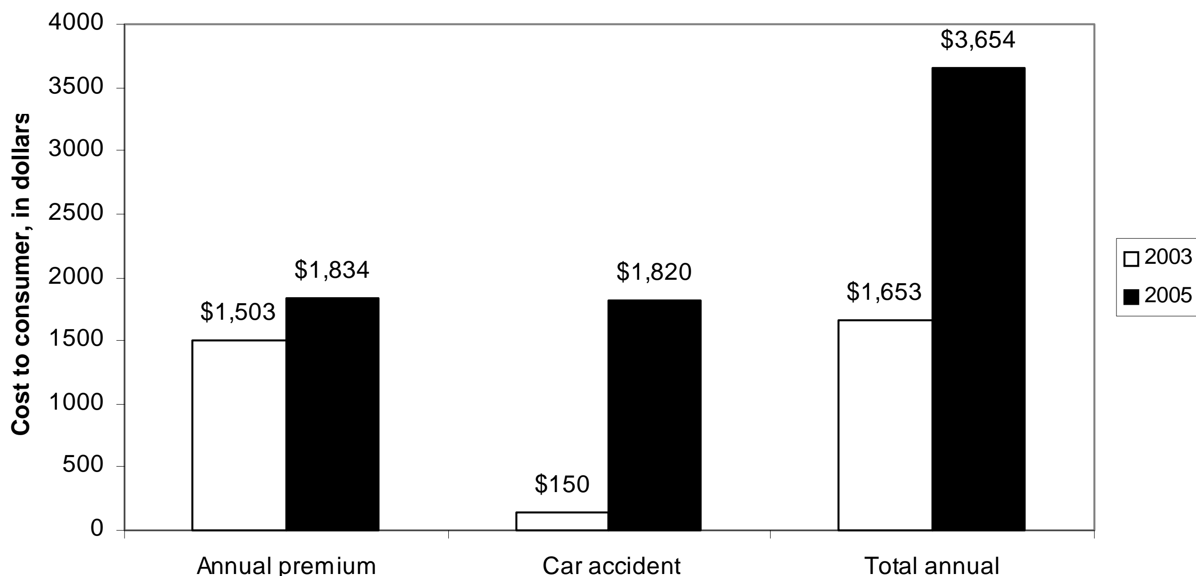
At 150% of the FPL, they will be placed in income band E, a classification that is a main determinate of their monthly BHP premiums. They elect to join the Community Health Plan of Washington, a King County provider of the BHP services.

All providers of the BHP charge higher premiums to higher age brackets. At 52, Erin is in a lower age group than Patrick. Her monthly premium with the Community Health Plan of Washington is $56.39, and Patrick's is $96.43. These premiums add up to an annual total of $1,834, 6.3% of their pre-tax family income.

Erin and Patrick start the year healthy. All of their screenings and preventative care are fully covered by the BHP. However, Patrick is involved in a minor car accident. He suffers a separated shoulder. He is taken from the scene to a hospital emergency room by ambulance. The ambulance ride costs $500 and is subject to his deductible and co-insurance. Therefore, he pays the first $150 completely and 20% of the remaining $350 for a total of $220. He is charged a $100 emergency room co-pay.

The estimated out-patient hospital charges for this visit are close to $18,000;[9] he will pay co-insurance up to his $1,500 out-of-pocket maximum, and insurance will cover the rest. Additionally, he is charged $60 in co-pays on his four follow-up visits, as well as a $10 co-pay for drugs. These services cost Patrick $1,820. When combined with his and Erin's monthly premiums, they add to a total annual out-of-pocket cost of $3,654 (12.6% of their pre-tax family income).

	2003	2005	$ Increase	% Increase
Annual premium	$1,503	$1,834	$330	22%
Car accident	$150	$1,820	$1,670	1,113%
Total annual	$1,653	$3,654	$2,000	121%
% of family income	6.0%	12.6%		110%



Two years ago: same coverage, lower costs

Had Patrick and Erin been in the BHP of Washington at the equivalent income level in 2003 (as measured by the Federal Poverty Level), their premiums would have been lower: $46.23 a month for Erin and $79.06 for Patrick. Additionally, they would not have had any co-insurance costs. Therefore, their only fees would have been premiums plus co-pays. Patrick would have been charged a $50 ambulance co-pay, a $50 emergency room co-pay, a $10 out-patient hospital co-pay, and a $10 co-pay for each follow-up visit. Along with their premiums, their out-of-pocket annual expenses would have been $1,653.43 (6% of their annual income), or less than half of comparable BHP expenses in 2005.

Scenario 2: An older working couple in Pierce County

Participant costs: 2005

Dante and Gretchen, both 62 years old, are married, have no children, and live in Pierce County. Dante works part time as a waiter, and Gretchen works 25 hours a week as a parking lot attendant. They collectively earn $22,452 a year, which places them at 175% of the FPL for a family of 2. Neither Dante nor Gretchen receives health coverage from their employers.They select Group Health Cooperative, a Pierce County provider of the BHP.

Because both Dante and Gretchen are in the 55+ age group, they each pay a monthly premium of $200.59. Therefore, their total

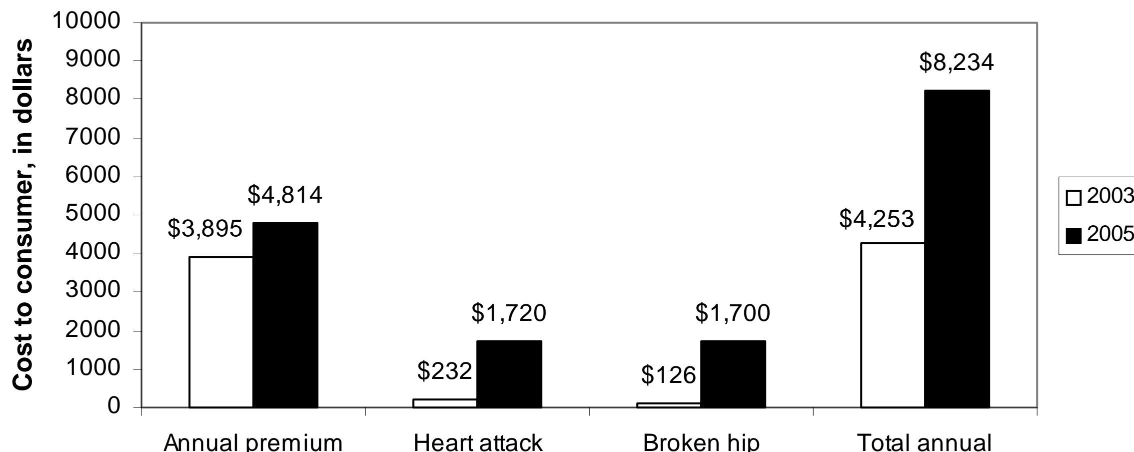
annual combined premium charge is $4,814.16 (21.4% of their family income).

Dante and Gretchen have a rough year. Dante has a heart attack, and although he survives physically, he may not survive financially. The total medical costs for Dante's heart attack are the ambulance ($500), hospital charges ($52,000[10]), and two follow-up appointments for which he must pay co-pays ($30). After his $150 deductible, he must pay 20% co-insurance on the remaining costs up to his $1,500 out-of-pocket maximum and co-pays for four prescriptions ($40). His total out-of-pocket cost is $1,720.

When Gretchen falls and breaks her hip, Dante drives her to the hospital where she stays for two days. Her costs include the hospital charge ($23,000[11]), which is subject to her deductible and co-insurance, two follow-up appointments with a $15 co-pay each, and two prescriptions for pain medication with a $10 co-pay each. She also reaches her $1,500 co-insurance maximum and is responsible for $1,700 in out-of-pocket costs.

Including their premiums, these medical costs equal $8,234.16, a whopping 36.7% of their family income. Although they are insured, it is unlikely that Dante and Gretchen will be able to devote this percentage of their family income to health care. The median rent in Pierce County is $660 per month,[12] and Dante and Gretchen are likely to be paying 31% of their income in rent alone. They may decide to take out loans to pay their medical bills, and they could decide to go uninsured in 2006 in order to pay off their medical debts from 2005.

	2003	2005	$ Increase	% Increase
Annual premium	$3,895	$4,814	$919	24%
Heart attack	$232	$1,720	$1,488	641%
Broken hip	$126	$1,700	$1,574	1249%
Total annual	$4,253	$8,234	$3981	94%
% of family income	20%	36.7%		83%



Although the purpose of health coverage is to insure people in the event of an emergency, this family's coverage through the BHP is not sufficient for them to remain financially stable during a medical emergency.

Two years ago: same coverage, lower costs

Before the increased cost-sharing, their financial burden for medical coverage would have been substantial but much more manageable. Dante and Gretchen's premiums would have totaled $3,895.44, but their only additional fees would have been co-pays. Dante would have paid the $50 ambulance and emergency room co-pays, a $100 hospital fee, $20 in co-pays on two follow-up visits, and $12 in co-pays for prescriptions. Gretchen would have paid a $100 hospital co-pay, $20 for co-pays for the two follow-up appointments, and $6 for co-pays on her generic drug prescriptions. When added with their premiums, these co-pays would come to a total annual expense of $4,253.44 (20% of their annual income), still a hefty expense, but a significantly lighter load than the costs in 2005

Scenario 3: A young married couple with a young child in Spokane County

Participant costs: 2005

Matt, 26, and Rochelle, 28, have one child and live in Spokane County. Matt works full time at Wal-Mart for $13.50 an hour, earning an annual income of $32,180. Rochelle takes care of their baby and earns no income. Their income puts them at 200% of the FPL for a family of 3 and barely eligible for the BHP. (Matt limited his overtime to stay underneath the income ceiling for qualifying for the BHP.) They elect Molina, a BHP provider in Spokane County.

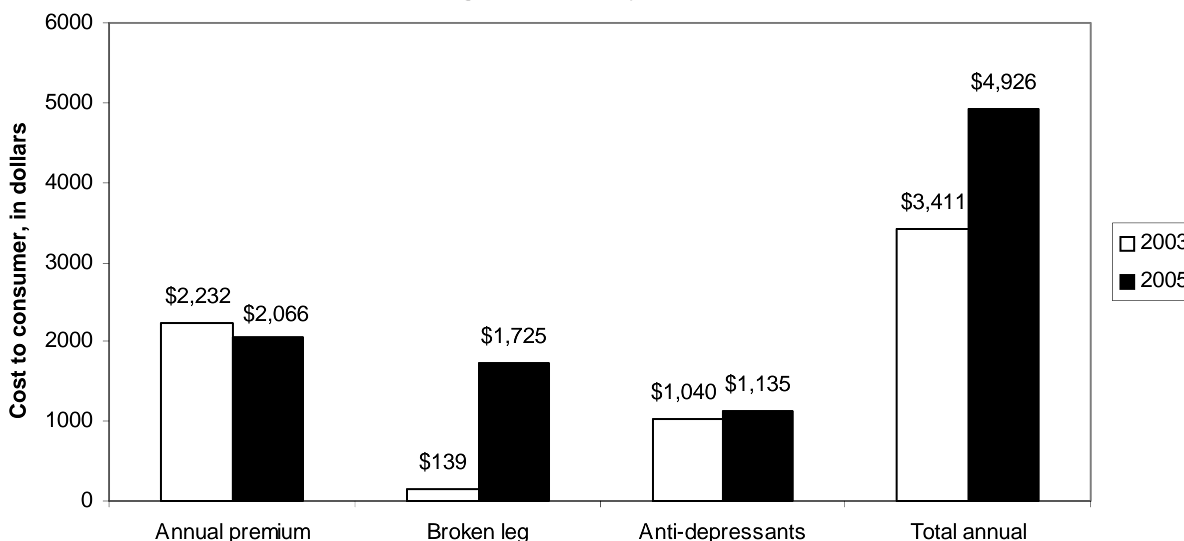
For their age group (19-39), Molina charges an $86.07 monthly premium. Therefore, their annual cost in premiums comes to $2,065.68, or 6.4% of their family income.

Rochelle's mother has just died from cancer, which aggravates her struggles with post-partum depression. To cope with her depression, Rochelle is on Zoloft all year. This is a brand-name (Tier 2) drug for which BHP only covers 50% of the cost. The cost of this prescription for one year is $2,000. Rochelle pays her $150 deductible and then 50% of the remaining cost, totaling $1,075. She also pays $60 in co-pays for office visits.

Also this year, Matt slips and falls on a flight of wet stairs and breaks his leg. The hospital charges for his visit, including an x-ray, are $24,000;[13] he pays his $150 deductible and 20% co-insurance up to his $1,500 maximum. Additionally, he pays co-pays on three follow-up appointments ($45) and on three Tier 1 prescription drugs ($30). This comes to a total of $1,725 for his broken leg.

Including their premiums, Matt and Rochelle's health insurance costs in 2005 total $4,926 (15.31% of their family income).

	2003	2005	$ Increase	% Increase
Annual premium	$2,232	$2,066	-$167	-7%
Broken leg	$139	$1,725	$1,586	1141%
Anti-depressants	$1,040	$1,135	$95	9%
Total annual	$3,411	$4,926	$1,515	44%
% of family income	11.2%	15.3%		37%



Two years ago: same coverage, lower costs

Under the same conditions in 2003 (200% of FPL), Matt and Rochelle collectively would actually have been responsible for a greater annual premium of $2,232.24. However, under the additional coverage of the 2003 BHP, the total percentage of their annual income spent on health care would have been significantly less. Matt would have been charged $139 in co-pays on his broken leg, and Rochelle would have paid 50% of her Zoloft prescription ($1,000) and $40 in co-pays. When added to their premium, these fees come to a total of $3,41l (11.2% of their annual income).

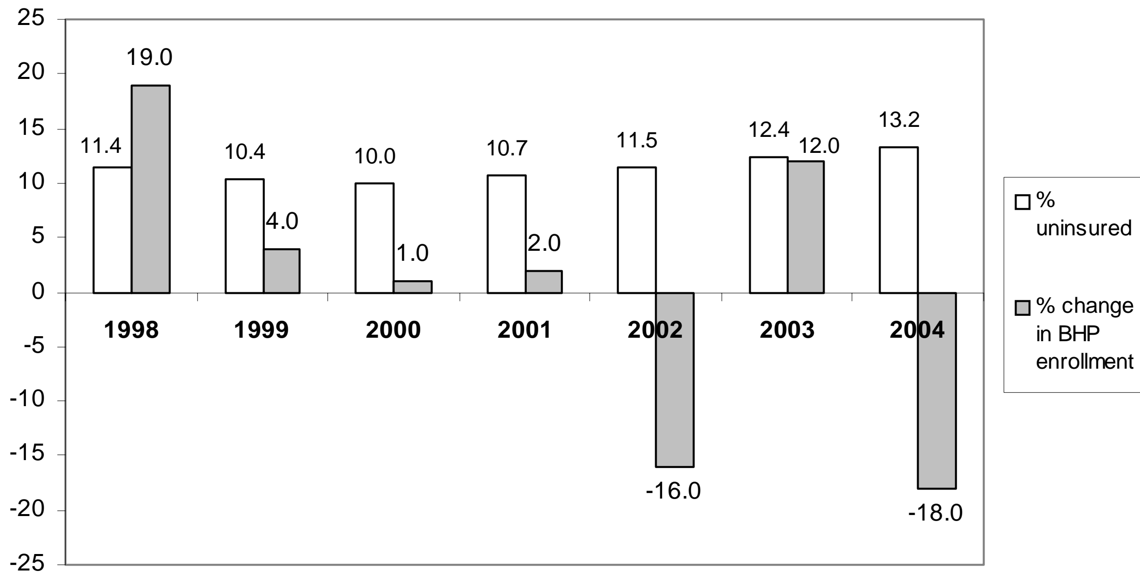
The BHP and the Uninsured

The budget cuts of 2003 overrode the vote of the people in 2001 and made the Basic Health Plan unaffordable for many lower-income families in Washington. According to research conducted by Project Hope on Health Affairs, there is a direct correlation between an increase in health insurance premiums and one's decision to go uninsured.[14] Once healthcare costs rise above 5% of family income, many families calculate that the cost of health insurance outweighs the risk of being uninsured. These families often decide to go without coverage.

The intent of the BHP was to provide affordable health coverage to working families that do not receive coverage from their employers. However, even as private employers have been diminishing coverage in recent years, the legislature has decreased enrollment in the BHP and increased participant costs. This has pushed higher costs onto lower-income workers, making it difficult for them to participate. The 2004 increases in premiums and out-of-pocket costs are driving eligible workers away from BHP coverage.

In 2002-2003, 1 out of 5 adults ages 19-64 in Washington (733,570 people) were uninsured.[15] The legislative actions of 2003 served only to worsen health coverage in the state. The compounding effect that decreased employer coverage and limited

Percent of Uninsured Adults (ages 19 - 64) Versus Percent Change in BHP Enrollment



Sources: Overview of Washington's Uninsured http://www.ofm.wa.gov/accesshealth/datasheets/chart1-1.pdf; EOI policy Brief: "Expanding the BHP Through Increased Cigarette Taxes"; BHP July 2002-2004 Enrollment Summaries

BHP enrollment has had on the number of uninsured can be seen in the above graph.

Providing Coverage and Rescuing the BHP

The BHP is failing in its objective to provide health insurance for low-income workers who do not receive coverage at work. To reverse the current trend and once again offer affordable coverage to Washington residents, the state should implement the following reforms:

- ▶ Cost-sharing must be returned to pre-2004 levels.

- ▶ The income eligibility lid at 200% of the Federal Poverty Level should be removed and replaced with a sliding-scale subsidy that runs up the income ladder, universalizing BHP eligibility.

- ▶ BHP enrollment should be increased by 100,000 slots. EOI estimates that these advances in health coverage would require an additional $280 million annually.

Revenue must be found in order to fund a return to affordable cost-sharing levels, expand eligibility, and meet a total enrollment goal of 200,000 members, consistent with the 1995 legislative edict.[16] There is no doubt that a remedy for the current problem will be expensive.

The BHP estimates that its shift in cost-sharing alone from 2003 to 2004 saved the state $41.4 million. EOI estimates, based on the increasing cost of insurance premiums during those years, puts the total savings closer to $55 million. The estimated cost of reverting to pre-2004 cost-sharing levels and funding an additional 100,000 slots in 2004 ranges between $266 million (BHP estimate) and

Unearned Income Tax Revenue Projections for 2005		
Tax rates and exemptions levels	**Annual revenue in 2005**	**% of Washington households taxed**
1% tax $2,000 single/$4,000 joint exemption	$55 million	16%
5% tax $2,000 single/$4,000 joint exemption	$275 million	16%
1% tax $2,000 single/$4,000 joint exemption plus $1,000 more for seniors	$52 million	14%
5% tax $2,000 single/$4,000 joint exemption plus $1,000 more for seniors	$260 million	14%
1% tax $3,000 single/$6,000 joint exemption	$49 million	11%
5% tax $3,000 single/$6,000 joint exemption	$245 million	11%

Source: Revenue projections from the Institute for Taxation and Economic Policy.
Note: Interest and dividents earned by retirement accounts are not taxed in this proposal.

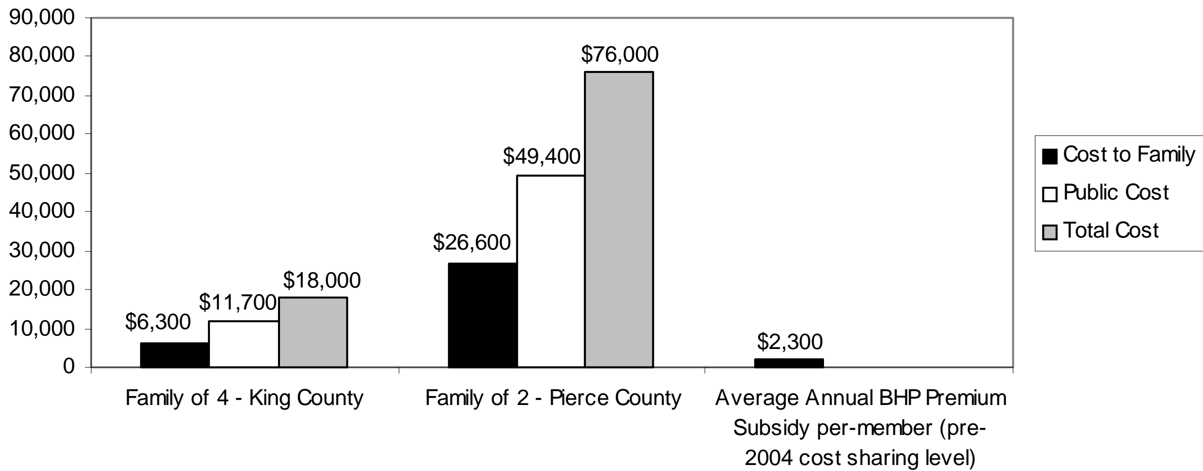
$280 million (EOI estimate). Because of medical inflation, this figure would undoubtedly rise every year. (According to BHP estimates, the BHP state subsidy per member per month, without a change in member cost-sharing, increased by about 5% between 2004 and 2005.[17])

One possible option for expanding BHP participation and closing the gap of uninsured workers is a 5% tax on dividends and interest, which would fall primarily on high-income Washingtonians. Approximately 16% of Washington households would be subject to this tax. EOI projects that this tax would generate $275 million annually and could fund the appropriate provision of health coverage through the BHP. The following table lays out several variations of such a tax.

Policy makers may also want to consider other funding mechanisms, such as a tax on employers who do not provide health care coverage, a tax on high-income families, (above $500,000/year), and/or a tax on intangible property (stocks and bonds). In any case, the BHP is the central safety net for health insurance coverage in our state. It must be revived and expanded to stabilize health coverage and improve health outcomes.

The Cost of Not Providing Basic Health Coverage

According to current estimates from the BHP, the state pays an average $1,674 per member annually. EOI projects that this number would jump to an average of nearly $2,300 per member annually if cost-sharing reverted to pre-2004 levels. While providing this coverage to 200,000 members would cost an extra $275 million, the cost pales in comparison to the medical bills that the state and the public will pay if the uninsured population continues to increase.



In our first two scenarios, if these families were uninsured instead of participating in the BHP, the impact would have multiplied public costs. The family of the first scenario, a middle-aged couple with two children living in King County, was in need of medical attention that totaled approximately $18,000. Without insurance, Patrick would have still needed medical attention for his car accident. According to Families USA, "(w)ithout insurance to pay the tab, the uninsured struggle to pay as much as they can: more than one-third (35%) of the total cost of health care services provided to people without health insurance is paid out-of-pocket by the uninsured themselves."[18] Of this family's medical bills, 35% would cost $6,300, far more than their BHP enrollment costs before or after the shift in member cost-sharing. The burden of high medical debt could drive this family into bankruptcy, as over half of individual bankruptcies are associated with high medical expenses.[19]

Of the remaining medical bills, which the uninsured simply cannot pay, "(r)oughly one-third is reimbursed by several government programs, and two-thirds is paid through higher premiums for people with health insurance."[20] Therefore, 65% of the uninsured medical bills are eventually paid by public money and insured populations. The remaining medical bills of Patrick's family total $11,700 (65% of $18,000). This is equal to the cost of subsidizing BHP enrollment (at pre-2004 cost-sharing levels) for five people.

The family of the second scenario, an older working couple in Pierce County, would have accrued even higher bills. Dante and Gretchen would have had medical bills totaling $76,000. They would have been unlikely to pay even 35% of this bill, but let us assume that they could pay $26,600. This is about $4,000 greater than their annual income and would have almost certainly driven them into bankruptcy. Once again, the public would have paid the other 65% (if not more), that is, $49,400. This amount exceeds the average cost of subsidizing BHP enrollment (at pre-2004 cost-sharing levels) for 21 people. Clearly, subsidizing BHP enrollment with affordable cost-sharing is a bargain for all the citizens of Washington.

Conclusion

Though curing the inequities of health coverage in Washington will be costly, the cost of an increasingly uninsured population is far greater. BHP premium subsidies conserve public monies by preventing the financial disasters that plague the uninsured and by insuring payment for health care through the pooled resources of insured participants.

To enable participation in the BHP, the state legislature should revert to the pre-2004 cost-sharing design. This will make it financially feasible for target population members to participate.

To open up the program to the hundreds of thousands of people, both employed and unemployed, who do not have health coverage the state should fund a minimum of 200,000 subsidized slots in the BHP.

Resurrecting the Basic Health Plan is of fundamental importance in creating a pragmatic pathway for increasing access to health care and reigning in the escalating cost of that care.

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APPENDIX

Basic Health Plan Benefits Summary Comparison Between 2003 and 2005

Benefits	2003 Enrollee Cost	2005 Enrollee Cost
Ambulance services	$50/transport	20% co-insurance
Annual deductible	Does not apply	$150 per individual
Annual out-of-pocket maximum	Does not apply	$1,500 per individual
Chemical dependency	$100/admission; $10/out-patient visit	20% co-insurance $15/out-patient visit
Chiropractic/physical therapy	$10/visit	20% co-insurance
Emergency room/ Out-of-Area Emergency	$50/visit	$100/visit ($0 if admitted)
Hospital, inpatient	$100/admission; maximum of $500 per member in calendar year.	20% co-insurance; $300 co-insurance maximum facility per admit
Hospital, outpatient	$10/visit	20% co-insurance
Laboratory	Part of radiology benefit	No co-payment/co-insurance for outpatient services 20% co-insurance for in-patient hospital based laboratory services
Maternity services	No co-payment	No co-pay, co-insurance, or deductible
Mental health	$100/admission; $10/out-patient visit	20% co-insurance; $300 co-insurance maximum facility charge per admit $15/out-patient visit
Office visits	$10/visit	$15/visit No co-pay for preventive care, maternity services, lab, radiology services, radiation and chemotherapy.
Organ transplants	$100/admission; $10/out-patient visit	Member cost-sharing by specific service as described in the benefit summary
Professional services not listed elsewhere	Does not apply	20% member co-insurance
Pharmacy	Tier 1: $3 Tier 2: $7 Tier 3: 50%	Tier 1: $10 YR2003 Tier 1 and Tier 2 combined and relabeled Tier 1. Tier 2: 50% YR2003 Tier 3 has been relabeled Tier 2

Preventive care	No co-pay	No co-pay
Radiology (laboratory)	No co-pay	20% co-insurance except for x-ray and ultra sounds provided in an out-patient setting
Skilled nursing, hospice and home health care	No co-pay	No co-pay, co-insurance or d deductible
Urgent care visits	\$10 - \$25/visit Varies by setting	\$15/visit

Endnotes

[1] In 2054, 200% of the Federal Poverty Level was $19,140 for a family of one, $25,660 for a family of two, $32,180 for a family of three, and $38,700 for a family of four.
[2] Washington State Health Care Authority enrollment data.
[3] Washington State Health Care Authority, BHP Premium Tables, HCA Document 24-375 (1996 - 2001).
[4] Washington State Office of Financial Management, http:///www.ofm.wa.gov/accesshealth/datasheets/chart 1-1.pdf.
[5] Washington State Secretary of State, http://www.secstate.wa.gov/eclections/voterguides/?u-2001.
[6] Washington State Health Care Authority, enrollment data.
[7] Washington State Health Care Authority, "Basic Health Background and Program Philosophy," http://www.basichealth.hca.wa.gov/bhhistory.shtml.
[8] BHP Annual Report, http://www..hca.wa.gov/annualreport/bh.shtml
[9] HCUPnet, Healthcare Cost and Utilization project. Agency for Healthcare Research and Quality, Rockville, Md., 2002-2003 data. http://www.ahrq.gov/HCUPnet/
[10] HCUPnet. Healthcare Cost and Utilization project. Agency for Healthcare Research and Quality, Rockville, Md., 2002-2003 data. http://www.ahrq.gov/HCUPnet/
[11]HCUPnet. Healthcare Cost and Utilization project. Agency for Healthcare Research and Quality, Rockville, Md., 2002-2003 data. http://www.ahrq.gov/HCUPnet/
[12] U.S. Census Bureau, Pierce County, Washington, Selected Housing Characteristics: 2003, http://www.factfinder.census.gov/
[13]HCUPnet. Healthcare Cost and Utilization project. Agency for Healthcare Research and Quality, Rockville, Md., 2002-2003 data. http://www.ahrq.gov/HCUPnet/
[14]Todd Gilmer and Richard Kronick, "It's The Premiums, Stupid: Projections Of The Uninsured Through 2013," *Health Affairs* Web Exclusive, April 5, 2005.
[15] Washington State Health Facts, http://www.statehealthfacts.org. The Washington State Office of Financial Management (OFM), using a different methodology, estimates a total uninsured population of over 600,000 individuals, for an uninsurance rate of 9.8% for the total population, or 11% for the population under age 65, or 13.2% of adults ages 19-64 (www.ofm.wa.gov/accesshealth/accesshealth.htm). Both the Kaiser Family Foundation State Health Facts and the OFM studies are snapshots of coverage and, therefore, actually underestimate the percent of uninsured. If we were to report the percent of people who lacked coverage at any time during the year, the estimates would be much higher.
[16] Washington State Health Care Authority, "Basic Health Background and Program Philosophy," http://www.basichealth.hca.wa.gov/bhhistory.shtml.
[17] Washington State Health Care Authority, BHP Quarterly Budget Report, April 1 - June 30,2005.
[18] Families USA, "Paying a Premium–The Added Cost of Care for the Uninsured," June 2005.
[19] Washington Artists Health Insurance Project, "Health Insurance: Washington State Overview," July 2005.
[20] Families USA, "Paying a Premium–The Added Cost of Care for the Uninsured," June 2005.