Key Findings from Policy Research for the Idaho State Planning Grant on the Uninsured

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During the summer of 2002, the Center for Health Policy conducted research funded by the Idaho State Planning Grant on the Uninsured to inform policy decisions regarding strategies to expand health coverage to uninsured Idahoans.[1] The research summarized here focuses on two key policy design questions:

1. What forms and levels of cost sharing are viewed as affordable to low-income Idaho families?
2. What are the program design implications of how price affects consumer behavior in the decision to purchase and utilize health insurance and health care?

Key Findings

- Low income, uninsured parents and other adults overwhelmingly express a willingness to pay for health insurance and health care costs. In fact, they believe they should pay something. However, the extent of their ability to pay is limited by concerns about also being able to pay for other basic survival needs.
- Idaho is among a minority of states that do not provide for any form of cost sharing in its public health insurance programs (CHIP and Medicaid). This is primarily because Idaho implemented SCHIP (the federal State Children's Health Insurance Program) as an expansion of its Medicaid program which precludes cost sharing on services for children and pregnant women.
- Thirty-five states have created a CHIP program separate from Medicaid thus enabling application of cost sharing for at least a portion of CHIP-eligible children.[2] Eighty percent of the states' separate SCHIP programs require cost sharing. Of those charging premiums, the vast majority only charge premiums to those families with incomes greater than 150 percent of the poverty line. Premiums ranged from $5-25 per month per child. Co-pays were around $5 per visit.
- Among the 16 states that have expanded coverage to adults, most have implemented some form of cost sharing including modest premiums and co-payments; however, the majority do not charge premiums for those below the poverty line.
- Co-payments were the most popular of the various forms of cost sharing among the low-income Idaho families interviewed, especially among the lowest income group. Premiums were also preferred, while deductibles were identified as least acceptable. Reasons for preferences related to the stability of bills or payments relative to household cash flow and the perceived cost benefit between payments made and the value of services received.
- Cost sharing reported as affordable included:
  - Premiums of $35-$50 per person per month combined with total co-payments of $10 per visit were reported as a maximum affordable amount for adult coverage by over half of participants.[3]
  - For family coverage, premiums of $50-$80 per family per month with co-pays of $5-$10 per visit were viewed as affordable to low-income parents.
  - Larger families expressed a willingness to pay a higher premium for family coverage than smaller families. Older participants also expressed a willingness to pay larger premiums.
- Dental and vision coverage were mentioned as important in the decision of low-income, uninsured to purchase health insurance.

[1] A full copy of the research can be obtained from the BSU, Center for Health Policy web site at: http://hs.boisestate.edu/CHP/chp_report.htm.

[2] This includes states/territories that implemented separate SCHIP programs as well as those that chose both a separate program and Medicaid expansion.

[3] It should be noted that respondents quoted affordable co-pays per visit as being inclusive of all charges related to a particular visit including prescriptions, diagnostic tests or therapies.

- Cost sharing can be used to shape cost-conscious utilization of health services.
- Program design requires a decision between competing goals of cost effectiveness versus equity. If cost effectiveness is a higher priority, strategies to discourage crowd-out of existing employer and employee contributions would be important. If equity between low-income employees or employers who are currently paying for insurance and those who are choosing to forego insurance is a higher priority, then policies that prevent crowd-out of employee and employer contributions would be less important.
- Program design determines the cost effectiveness of the program.[4]
  - Take-up of health insurance is highly sensitive to cost. Take-up rates drop off quickly when premiums as a percent of annual income increase.
  - At similar levels of cost sharing, take-up of private insurance tends to be higher than take-up of public health insurance programs.
  - As premiums increase, the risk of adverse selection (greater enrollment of persons in poorer-than-average health) also increases. The result is a higher average cost per newly insured person.
  - Proposals focusing on poor and near-poor families are likely to be less costly per newly insured person than those targeting firms with low-wage workers or small firms.
  - Effective mechanisms to avoid crowd-out of private coverage counter the price incentive for low-income persons currently paying for private coverage to drop their coverage to enroll in the new program. State policies that attempt to prevent crowd-out of private coverage by using a "look-back" period are generally difficult to enforce.
- Premium assistance programs that subsidize workers' purchase of employer-sponsored health insurance take advantage of the employers' contributions to the cost of coverage. This decreases the average cost to the state per covered person and enhances the cost effectiveness of the coverage expansion.
  - In setting the premium subsidy amount, the worker's portion of costs should be set low enough to be an incentive to enroll themselves and their families in the employer's plan.
  - It has been estimated that between one-third to one-half of the uninsured are without coverage for only short periods of time. Subsidizing COBRA coverage for low-income workers who are laid off would help bridge those periods of uninsurance and create an incentive to enroll in employer-sponsored insurance when they become employed again.
  - Since only 20% of uninsured employees lack coverage because they decline offered insurance, premium assistance programs are an effective adjunct to other insurance coverage strategies, but alone would have a minor impact on the number of uninsured. The balance of uninsured employees work for employers who do not offer health benefits or are not eligible to receive such benefits.

Policy Design Implications

1. Use poverty levels to most effectively target poor and near-poor families for insurance coverage expansions.
2. If policy makers wish to include cost sharing, the following approaches are suggested:
   - Create a CHIP program separate from Medicaid for non-disabled children so that cost sharing can be implemented as coverage is expanded to additional uninsured children.
   - Implement cost sharing in publicly subsidized coverage approaches using a sliding scale based on family income.
   - Limit premium costs to no more than 3% of a family's annual income to attract the healthy uninsured into the program. The following amounts were reported as affordable to low-income Idaho families or are consistent with policies in other states.

[4] The cost effectiveness of programs to expand health insurance coverage is measured as the average cost per newly insured person.

	Family Income as Percent of Poverty Level			
	<100%	100-133%	133-150%	150-200%
Child Coverage				
Co-pays per visit	None	None	$5	$5
Monthly premiums	None	None	None	$15
Family Coverage				
Co-pays per visit	$5 /adult	$5 /adult	$5	$5
Monthly premiums	None	$50	$50	$80
Single Adult Coverage				
Co-pays per visit	$5	$5	$5	$5
Monthly premiums	None	$35	$35	$50

- Exclude preventive health visits from cost sharing requirements to encourage use.
- Implement a tiered prescription drug co-payment of $2 per prescription for generic drugs, $5 per prescription brand-name drug when a generic is not available and $10 per brand-name drug prescription when an equally effective generic is available.
- Implement a larger co-pay for emergency room care for non-emergent conditions when primary care is available.

3. Create incentives for low-income workers to purchase employer-sponsored insurance when it is available to them by providing a premium assistance option.
   - Encourage use of the premium assistance option by providing a subsidy to the worker that would cover the monthly premium in excess of the amounts noted above as affordable to low-income Idaho families. This amount could be capped at some defined amount equivalent to the state average cost of employee's share of premiums. In addition, the subsidy should be large enough to cover any deductibles for physician or outpatient care in the employer's plan.
   - Provide an enhanced subsidy for extension of COBRA coverage for low-income workers who lose their jobs to partially compensate for loss of the employer's share of cost.
   - Create an incentive for employers of low-income workers in the small group market to offer health insurance, a subsidy could be provided to offset both the employee's and the employer's portion of costs so that the cost to the worker is equivalent to the amounts mentioned above as affordable and the cost to the employer is between $50-100 per worker.
4. Estimates of the eligible target population and enrollment projections should take into consideration limitations of survey estimates and changes in insurance coverage due to trends in unemployment and insurance costs.[5] In projecting the number of persons who would likely enroll and program costs, the number of persons who would drop private coverage to enroll should be included. Adverse selection would need to be estimated and cost projections adjusted accordingly.
5. Cost effectiveness is a valid measure in evaluating any coverage expansion, i.e., what is the average cost per newly insured person recognizing that some enrollees may have prior private coverage.

[5] Point-in-time survey estimates do not capture numbers of persons with spells of uninsurance. A person counted as insured at the time of the survey may become uninsured subsequently. Surveys that count persons as uninsured if they were uninsured during the entire previous year do not account for persons who were uninsured for shorter periods. Survey sample sizes limit the reliability of single-year estimates. In most cases, estimates that combine multiple years are more reliable. Survey estimates of the uninsured lag current status. As unemployment rates and health insurance costs increase, more people become uninsured. A predictive model to estimate potential eligibles would need to take these factors into consideration.