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Perspective

Balancing Coverage Affordability and Continuity under a Basic Health Program Option

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According to the Congressional Budget Office, the Affordable Care Act (ACA) will bring health insurance coverage to an estimated 32 million currently uninsured people. It does so through various

mechanisms, including an expansion of Medicaid to Americans with incomes up to 138% of the federal poverty level (133% plus a 5% “income disregard”), premium and cost-sharing subsidies for coverage purchased through a new insurance exchange, small-employer tax credits, and an individual mandate to obtain health insurance.

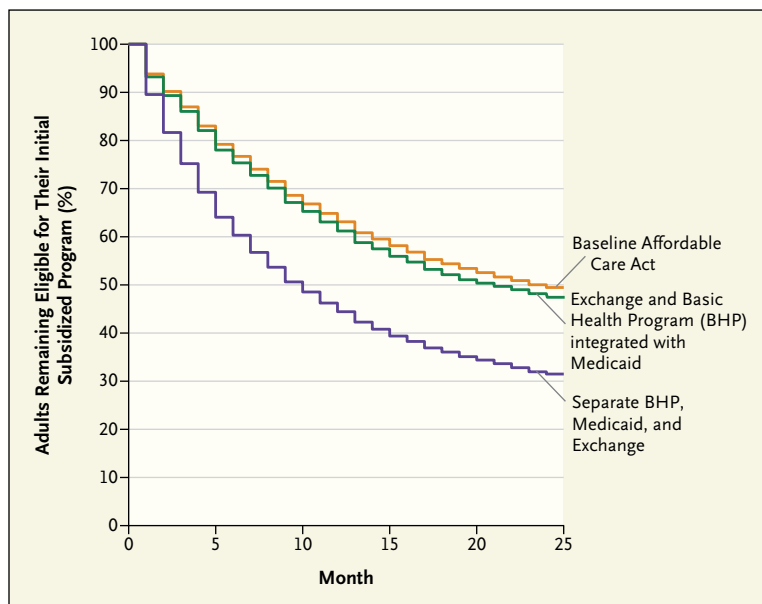
The ACA’s incremental approach to near-universal coverage has raised concerns that changes in income, employment, and family composition will shift people into and out of different coverage arrangements over time — a phenomenon referred to as “churn-

ing.”^{1,2} Avoiding disruptions in coverage is an important goal because it can reduce unnecessary administrative costs and improve health plans’ incentives to invest in achieving longer-term health outcomes. Continuity of coverage can also help maintain clinician-patient relationships, especially in places where there are substantial differences between the clinicians participating in Medicaid and those participating only in private plans.

To address concerns about churning, some states are considering adopting a Basic Health Program (BHP) — an ACA-created option modeled after Washington

State’s Basic Health Plan. Under this option, a state would receive an annual lump-sum payment equal to 95% of the projected cost of the subsidies for coverage through an insurance exchange for households with incomes between 139 and 200% of the federal poverty level. The state would then assume responsibility for financing a BHP for adults in that income range that met or exceeded the generosity and scope of benefits available in the exchange. A number of states are considering this option, including California, where BHP legislation has already passed the senate and final consideration is planned for 2012.

The BHP option could be attractive for several reasons. First, to the extent that many people move above and below the 138%-of-poverty cutoff for Medicaid, moving them to a BHP that



Outcome of a Simulation Showing Retention of Enrollees in Subsidized Coverage under Three Possible Policy Environments.

The Kaplan-Meier curves show the overall proportion of an initial cohort of adults eligible for subsidized coverage who remain income-eligible for their initial coverage source over a 24-month period. Data are from the Survey of Income and Program Participation and the Affordable Care Act Simulation Model.⁴

contracts with Medicaid plans and providers could reduce coverage disruptions for low-income adults whose incomes rise or fall over the course of a year. Second, in an insurance exchange, individuals with incomes of 139 to 200% of the poverty level face nontrivial cost sharing on their care utilization. Enrolling them in a BHP that reimburses providers at lower, public-program rates could permit states to offer a plan with lower premiums and out-of-pocket costs within the same budget.

There are also reasons to exercise caution, however. The eligibility range for a BHP is narrow — and there's no guarantee that there will be continuity of access for people moving from Medicaid to a BHP, or vice versa. A BHP could theoretically extend access to the same plans and providers as Medicaid does, but in practice,

states may find that providers willing to accept reimbursement that is often below their costs for their most indigent patients will be unable or unwilling to do so for an additional population. Moreover, introducing a BHP may create a new point of disruption: although patients might retain their coverage when moving above or below 138% of the poverty level (\$30,843 for a family of four in 2011), they would be more likely to have coverage disruptions when moving above or below 200% of the poverty level (\$44,700 for a family of four). Such disruptions could occur if the mainstream plans and providers used by people with incomes above 200% of the poverty level do not participate in the BHP. Finally, introducing a BHP would reduce the subsidized population in the insurance exchange by about half, which could com-

promise its efficiency and market role and reduce the proportion of uninsured people who gain access to mainstream coverage.³

To investigate BHPs' potential for reducing churning between Medicaid and an exchange by acting as a bridge between them, we used data from a dynamic income microsimulation model of the ACA.⁴ This model differs critically from existing BHP estimates in that it uses longitudinal data on income and health insurance from the U.S. Census Bureau's Survey of Income and Program Participation. Since we follow an initially eligible cohort over a 2-year period, we can more easily model relative changes in churning in varied policy environments.

For our analysis, we used a national sample of adults 18 to 61 years of age who were initially uninsured or enrolled in non-group coverage and who were eligible for subsidized coverage (had an income below 400% of the poverty level). We then simulated eligibility for Medicaid, a BHP, and an exchange in three policy environments: the baseline ACA structure, under which people with incomes up to 138% of the poverty level are eligible for Medicaid and those with higher incomes are eligible for the exchange; an integrated BHP, under which Medicaid and the BHP are run as a single program, with identical plans and providers; and three separate programs, with Medicaid, the BHP, and the exchange all operating independently, with different reimbursement rates, cost-sharing structures, and provider networks. Both Washington State's original BHP and California's pending BHP legislation would fit in the third category.

Our main findings are summarized in the Kaplan-Meier

curves (see graph), which show the overall proportion of subsidized adults who would remain continuously eligible for their initial program over a 24-month period. Lines shifted up and to the right indicate policies with greater overall stability; those shifted down and to the left indicate a greater number of eligibility changes over time.

As the graph shows, operating separate BHP, Medicaid, and exchange programs substantially increases churning. Under that policy, just 44% of adults remain eligible for their initial program after 1 year and less than one third remain so after 2 years; under the baseline ACA structure, the proportions are 63% and 49%, respectively. Given the dynamic nature of the wages and incomes of adults with moderate incomes,² this finding is not entirely surprising; a separate BHP coverage category based on a narrow income range increases the likelihood of eligibility shifts between programs.

Perhaps more striking, however, is our finding that a BHP operating within Medicaid would result in slightly more eligibility losses than would the baseline ACA structure. Although we find that a BHP would reduce churning (i.e., increase retention) at the 138%-of-poverty threshold, there would be a more-than-offsetting increase in churning between the exchange and the Medicaid-BHP

at 200% of the poverty level. The net result would be slightly more overall churning than with the baseline ACA structure. Moreover, these program-eligibility shifts would now happen around a “notch” created at 200% of the poverty level, where there are much larger implications for enrollees, in terms of premiums and cost sharing, of moving from Medicaid-BHP to private coverage. For example, a family moving from a Medicaid-like BHP program to the exchange tax-credit structure at 200% of the poverty level could suddenly see the value of its benefits fall by as much as 25% (depending on state decisions about patient cost sharing under the BHP). The ACA’s sliding-scale subsidies were designed to avoid such notches, which create major inequities between people with marginally different incomes and penalize them for additional work and earnings.

Ensuring access to stable and affordable coverage is an important ACA goal. Whether by design or through attrition of willing plans and providers, however, operating a BHP with provider networks different from those of both Medicaid and the exchange could further stratify the low-income and moderate-income population into three separate classes of coverage. As our modeling shows, such stratification would exacerbate the concerns about churning that BHPs were

designed to address. Moreover, even a BHP integrated with Medicaid would slightly increase churning overall, with the increased churning around the 200%-of-poverty point more than offsetting the reduced churning around the 138%-of-poverty point. Although various policy considerations should enter into decisions about adopting a BHP, the need to achieve coverage and provider stability is an argument against doing so.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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