THE HENRY J. KAISER FAMILY FOUNDATION

FOCUS *on* *Health Reform*

THE ROLE OF THE BASIC HEALTH PROGRAM IN THE COVERAGE CONTINUUM:

OPPORTUNITIES, RISKS, AND CONSIDERATIONS FOR STATES

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EXECUTIVE SUMMARY

The Basic Health Program (BHP) is an optional coverage program under the Patient Protection and Affordable Care Act (ACA) that allows states to use federal tax subsidy dollars to offer subsidized coverage for individuals with incomes between 139-200% of the federal poverty level (FPL) who would otherwise be eligible to purchase coverage through state Health Insurance Exchanges. States can use the BHP to reduce the cost of health insurance coverage for these low-income consumers, a highly price-sensitive population with high rates of uninsurance. Depending on how it is designed, the BHP also can help consumers to maintain continuity among plans and providers as their income fluctuates above and below Medicaid levels.

As states weigh whether to implement a BHP, they face significant questions and challenges. Critical among these are how to design the BHP to enhance continuity of coverage as people move among Medicaid, the BHP, and coverage through qualified health plans (QHPs) in the Exchange; how to assess the BHP's impact on the viability and effectiveness of state Exchanges; and how to estimate revenues and costs to evaluate the financial feasibility of the BHP. Building on a roundtable discussion of state and federal officials and policy makers convened by the Kaiser Family Foundation to explore these issues, this paper provides a framework for assessing the BHP option and exploring the advantages and risks associated with a BHP. It also offers strategies for states to manage and reduce those risks.

The BHP delivery model will influence both the BHP cost and the program's success at bridging Medicaid and QHP coverage. States with Medicaid managed care programs may look to Medicaid managed care plans and networks as the delivery system for the BHP. These plans offer an existing infrastructure and also accept lower reimbursement rates than commercial plans, which will enable states to offer coverage through the BHP with the available federal funding. States may, however, need to enhance provider rates above Medicaid levels to ensure the plans are able to offer robust provider networks.

It is estimated that the BHP could reduce the size of the Exchange population by about one-third, which could impact the risk profile, weaken the purchasing power, and undermine the administrative viability of the Exchange. The risk profile of the BHP eligible population will affect the premiums in the Exchanges, driving them up if the BHP population is healthier than those remaining in the Exchange or lowering the premiums if the BHP population is sicker. Similarly, reducing the size of the population purchasing coverage through the Exchange by creating a BHP may reduce the leverage of the Exchange to promote innovations that improve quality and lower costs. Further, by drawing participants away from the Exchange, a BHP reduces the financing base for Exchange operations.

States may consider a number of different strategies for minimizing the impact of the BHP on the Exchange. To avoid adversely affecting the risk profile of the Exchange, states can combine risk across the markets or include the BHP in the Exchange risk adjustment and reinsurance

systems. States may also consider integrating the BHP procurement with that of the Exchange to pool market leverage across the programs and align quality standards and program features. Finally, integrating BHP functions with those of the Exchange, and potentially with certain functions of public programs, will allow states to achieve economies of scale to promote efficiency and spread program costs across a larger pool of beneficiaries.

Although federal funding is available to finance the costs of the BHP, it is essential for states to accurately estimate the amount of funding they will receive and the costs of the program to ensure that funding will be sufficient. The federal funding for the BHP is tied to premium and cost-sharing subsidies BHP enrollees would have received if they had purchased coverage in the Exchange (states will receive 95% of premium subsidies and either 95% or 100% of the cost-sharing subsidies). Therefore, to estimate the funding that will be available, states must first use actuarial modeling to estimate the value of the benchmark plan in the Exchange and then subtract individual contributions to the premiums, which are based on enrollees' incomes. Any funding states receive is then subject to a year-end reconciliation, which adjusts the payments based on enrollee characteristics, such as age and health status, and changes in enrollee income that occurred during the year. States may want to reduce revenue projections to account for these adjustments. They should also factor in whether any state funding will be available. Once the BHP revenue is estimated, states must compare the funding to anticipated program costs. States have broad flexibility to determine BHP benefits, consumer premiums and cost-sharing levels, and provider networks and payment rates, all of which can be altered to impact costs. Further federal guidance will be needed on how to calculate the value of the premium and cost-sharing subsidies and the mechanism for implementing the annual financing reconciliation in order for states to fully assess the financial feasibility of the BHP.

States must plan for the administrative infrastructure of the BHP and the financing of planning and operations costs. States must make important decisions regarding who will be responsible for designing, implementing, and operating the BHP. Another important consideration is how the administrative functions of the program will be financed. Federal guidance will be needed to resolve how BHP operating costs can be financed and whether this financing can be similar to or integrated with the financing of the Exchange.

Conclusion

Federal officials have yet to provide details about how the program will be financed, administered and certified, and states are struggling to evaluate the BHP's impact on the viability and effectiveness of state Exchanges. Federal regulations will inform state deliberations, but are unlikely to fully resolve the complexity or eliminate the risk. Ultimately, states that opt for a BHP will want to design BHP programs so as to minimize the state's financial exposure and address any negative impacts on the Exchange. States in which a BHP is not a viable option may want to consider alternative strategies to advance affordability and continuity goals.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) creates a continuum of affordable health insurance coverage programs for uninsured individuals across the income spectrum. Under the ACA, individuals with incomes under 139% of the Federal Poverty Level (FPL) are eligible for free or very low cost coverage under Medicaid. Those with higher incomes up to 400% FPL may purchase subsidized coverage through qualified health plans (QHPs) offered by state Health Insurance Exchanges (Exchange(s)); while those with incomes over 400% may purchase unsubsidized coverage through QHPs. The Basic Health Program (BHP) is an optional coverage program under the ACA that allows states to use federal tax subsidy dollars to offer subsidized coverage for uninsured individuals with incomes between 139-200% FPL. With state flexibility to define benefits, cost-sharing, delivery systems and procurement strategies, BHP offers a potential bridge between Medicaid and subsidized coverage under QHPs.

Under the BHP, states are offered slightly less federal financing than would have been provided for QHP tax subsidies within the state Exchange and are expected to provide coverage better than or equal to what would have been offered through the Exchange. While BHP benefits and consumer subsidies must be at least as generous as the essential benefits and tax subsidies mandated for QHPs, states have the option to add services and reduce cost-sharing to levels closer to Medicaid. Like the tax subsidies for eligible QHP enrollees, BHP is federally financed, and does not require state matching funds. However, states are at risk if federal funds are inadequate to cover the program's costs. Finally, while BHP offers states considerable flexibility in selecting the provider networks and determining reimbursement strategies, the reduced federal funding creates incentives to rely on safety net and other traditional Medicaid providers and health plans, which typically are reimbursed at lower rates than commercial providers and plans.

Ultimately, states have broad discretion to determine whether and in what form a BHP could meet the needs of the state. To date, published evaluations of the BHP option have been released in eight states, either as the central topic of a study or as part of a discussion focused on other health care reform-related topics.[1] States' decisions with regard to BHP will be guided by a range of considerations, chief among them: (1) the extent to which the state is able to enhance coverage options for BHP-eligible populations while minimizing the state's financial exposure; and (2) the potential impact of the BHP on the ability of the Exchange to secure value for the remaining populations within the Exchange and to drive efficiency and economy across the delivery system.

The purpose of this paper is to provide a framework to assess the BHP option from the vantage point of consumers, the Exchange, and the state. The paper explores the advantages and risks associated with the BHP for states, as well as potential strategies to manage or reduce those

[1] At the time of this writing, analyses of BHP have been published for the following states: California (two studies), Connecticut, Maryland, Massachusetts, Minnesota, New York, North Carolina, and Tennessee. See the Resource List for citations to these studies.

risks. Finally, the paper identifies areas where federal guidance is needed to fully assess the program's impact and suggests how such guidance could make the BHP more or less desirable.

The Kaiser Family Foundation convened a roundtable discussion on October 21, 2011 with state and federal officials and experts to discuss issues related to the implementation of the BHP. This paper builds and expands on the issues raised during that discussion.

BACKGROUND

Description of Basic Health Program under the ACA

The BHP offers an alternative coverage vehicle for individuals at the lower end of the income scale who would otherwise be eligible for tax subsidies for coverage in the Exchange. Individuals may be eligible to enroll in a BHP if they have incomes below 200% FPL, are ineligible for Medicaid, are under age 65, and do not have access to affordable employer- or government-sponsored "minimum essential coverage." As with tax subsidies, lawfully present immigrants with incomes below 139% FPL may qualify for the BHP if they are ineligible for Medicaid coverage. Significantly, if an individual qualifies for the BHP, he or she may not receive tax subsidies for enrollment in a QHP.

The BHP must meet minimum standards related to benefits and cost-sharing. It must cover at least the essential health benefits (EHB) that enrollees would have received had they been enrolled in a QHP through the Exchange. The enrollee's share of the monthly premium cannot exceed what it would have been had the enrollee purchased the second-lowest cost silver plan (referred to as the benchmark plan). Enrollee cost-sharing cannot exceed the equivalent platinum plan for individuals with incomes below 150% FPL, and the equivalent gold plan for individuals with incomes between 150%-200% FPL, which have actuarial values of 94% and 80%, respectively. If offered by a health insurance issuer, BHP plans must have a medical loss ratio greater than 85%.

The ACA requires that BHP utilize managed care plans or "systems that offer as many of the attributes of managed care as are feasible." This may include licensed HMOs, a licensed health insurer, or a network of health care providers "established to offer services under the program." States must use a competitive selection process and include care coordination and incentives for use of preventive care within the BHP offerings. States also must offer multiple standard health plans to the extent feasible. Finally, the state must establish specific quality measures that are reported to the state and made available to enrollees.

The BHP is financed with federal funding. States receive 95% of the premium subsidy BHP enrollees would otherwise have received in the benchmark plan offered through the Exchange. In making the calculation, federal officials must consider the age, income, health status, and type of coverage for enrollees, geographic differences in spending, and whether any reconciliation of tax credit or cost-sharing subsidies would have occurred. States also receive

either 100% or 95% of the cost-sharing reduction the BHP enrollee would otherwise have received.[2] Payment to the state for any fiscal year will be adjusted to reflect errors in the determinations for any preceding fiscal year.

The state must establish a trust to hold BHP funds. BHP trust funds may only be used to reduce premiums or cost-sharing or increase benefits for BHP enrollees. States have the option to commit state dollars to the fund but are not required to do so.

Improving Affordability and Continuity of Coverage

The potential to make coverage more affordable for low and modest income individuals is driving much of the interest in the BHP option. Populations at the lower end of the tax subsidy scale face what has been described as an affordability cliff: while those with incomes under 139% FPL have no or minimal premium or cost-sharing obligations under Medicaid, those with incomes just above 139% FPL will be obligated to contribute approximately 3.3% of their income, or about $45 per month for subsidized coverage through the Exchange, not including additional out-of-pocket costs that could run as high as $174 per month.[3]

While tax subsidies under the ACA are based on a sliding scale intended to ensure affordability, low-income families have limited disposable income. Even premiums ranging from 2 - 6.3% of annual income, as provided under the ACA, could prove cost prohibitive. These premium requirements may lead some lower-income individuals to forego coverage. A BHP offers the opportunity to lower these consumer costs and potentially increase participation among the target population.[4] With lower costs, consumers are also less likely to drop coverage, reducing the "churn" on and off of coverage over time, which enhances administrative efficiency and, ultimately, continuity of care.

Another advantage of a BHP is the potential to increase continuity of care for those whose incomes fluctuate above and below Medicaid eligibility thresholds. Many low-income families experience significant changes in income that would cause them to move between Medicaid and coverage in the Exchange. States can design their BHP to enable individuals to keep the same plans and providers as their income fluctuates above and below Medicaid eligibility levels. The ability of states to decouple eligibility for the different programs from the provider network and plans individuals are offered is key to facilitating continuity of coverage.

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[2] ACA §1391(d)(3)(A)(i). The statute is unclear whether the state must receive 100 or 95% of the cost-sharing funds.

[3] Maximum out-of-pocket cost-sharing will be an estimated $2,083 per year in 2014 for families below 200% FPL. However, the actual out-of-pocket cost-sharing that members will pay depends on the amount of care they use. Kaiser Family Foundation, "Health Reform Subsidy Calculator." Available online at http://healthreform.kff.org/subsidycalculator.aspx

[4] E. Benjamin and A. Slagle. "Bridging the Gap: Exploring the Basic Health Insurance Option for New York." Community Service Society of New York. June 2011.

Along with the benefits, designing the BHP to build on Medicaid also comes with some risks. Closer alignment with Medicaid MCOs at the lower end of the BHP income eligibility scale transfers the potential for disruption up the line, as individuals at 200% FPL face transitions between the BHP and QHP coverage purchased through state Exchanges. These risks can be partially abated through the alignment of health plans, standards and procurement processes across the continuum of coverage from Medicaid to BHP to QHPs.[5] However, even carriers participating in both the public and commercial markets typically offer vastly different provider networks for their public and private products. Similarly, reducing cost-sharing for individuals between 139-200% FPL may result in transferring the "affordability cliff" upstream, as well.

While it is a concern when consumers experience disruptions in care and affordability, consumer advocates note those who fall into higher income brackets generally have increased access to resources and can manage the affordability and continuity cliffs more easily than individuals with lower incomes. Regardless, it will be important for states to evaluate provider networks and cost-sharing requirements, and craft programs to facilitate transitions that enable continuity of coverage across Medicaid, the BHP, and QHPs, even where the coverage vehicles are not perfectly aligned. Successfully addressing this issue is vital to enabling the BHP to serve as a bridge between Medicaid and QHP coverage.

HEALTH PLAN SELECTION AND DELIVERY SYSTEM OPTIONS

The BHP delivery model will influence both the BHP cost and the program's success at bridging Medicaid and QHP coverage. First, the ability to offer a more affordable product is dependent on the use of lower cost coverage vehicles than would otherwise be available through the benchmark QHPs. Second, continuity of coverage is advanced where consumers are able to access the same carriers and providers across the continuum of coverage (Medicaid, BHP, and QHP). Section 1331 of the ACA does not require a particular coverage model. However, it does require that states use a competitive process that includes "contracting with managed care systems or with systems that offer as many of the attributes of managed care as are feasible in the local health care market."

Medicaid Managed Care

States with Medicaid managed care programs may look to Medicaid managed care plans and networks as the delivery system for the BHP.[6] In addition to the benefit of building on an existing infrastructure, the capitation rates paid to Medicaid managed care plans are often lower than the rates paid to commercial carriers. It is this savings that may enable states to offer a BHP with the available federal funding, while still lowering consumer premiums and

[5] Such alignment has the added potential to maximize market leverage for payment and delivery system reform but would require a highly coordinated if not centralized procurement process across the multiple programs.
[6] For information on state managed care programs see K. Gifford and J. Paradise. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." Kaiser Commission on Medicaid and the Uninsured. September 2011.

cost-sharing. The savings, however, depend on the ability of the public plan to establish a provider network at closer to Medicaid payment levels than commercial payment levels. Notably, the lower a state's Medicaid rates relative to commercial rates, the more likely it will be able to fund a BHP within the subsidies it receives.

States have varying degrees of overlap between commercial and Medicaid managed care plans. According to a recent Kaiser survey, approximately one-third of Medicaid managed care enrollees are in health plans serving both Medicaid and commercial markets. By participating in both markets, these plans offer the potential to provide continuity of plans as people move from one program to another. However, carriers that participate in both commercial and public markets in the state often offer markedly different products, provider networks and provider reimbursement rates. Plans and products designed for public programs are generally more heavily dependent on safety net providers and offer lower reimbursement rates than their commercial counterparts.

In addition, Medicaid reimbursement in most states is lower than commercial provider rates, raising questions about the adequacy of these Medicaid payment rates for attracting and sustaining robust provider networks. This problem could be addressed through enhancing provider rates – and plan premiums – under the BHP. Indeed, recent BHP studies in New York and California assumed some enhanced provider payments when modeling the BHP.[7,8] Yet such policies highlight an uncomfortable reality—the same provider is paid more or less by the same carrier for the same service and patient as the patient's family income goes up or down. This is the case today—carriers participating in both markets often pay the same providers more for the same service within their commercial products than under their public products. Offering a middle ground rate under the BHP would graduate what is now a stark cliff; however, it brings this disparity into sharper relief.

Use of public products at enhanced rates also could create more competition for providers and services which, given the rate differential, could reduce access to care for Medicaid beneficiaries. Also, to the extent public products offer a more limited range of providers, their use for BHP could constrict consumer choice compared to offerings by QHPs in the Exchange.

Other Delivery Models

While the ACA requires the use of managed care to the maximum extent feasible,[9] it allows states flexibility to use other delivery models where managed care is not feasible. For example, North Carolina has no Medicaid managed care plans and relies on a well-developed PCCM model to serve its Medicaid beneficiaries. Oregon has recently enacted legislation that would move Medicaid beneficiaries from Medicaid managed care plans to "Continuing Care

[7] E. Benjamin and A. Slagle. "Bridging the Gap: Exploring the Basic Health Insurance Option for New York." Community Service Society of New York. June 2011.
[8] Mercer. "The State of California Financial Feasibility of a Basic Health Program." California HealthCare Foundation. June 28, 2011.

Organizations" which more closely resemble integrated delivery systems. It remains to be seen what standards federal officials will demand for non-plan models under state BHP programs. One crucial question is whether the model will be required to carry risk. Even if not required by the ACA, states will need to consider the potential financial risks of building a BHP on non-capitated delivery models.

Safety Net Providers and Plans

In most states safety net providers are a crucial source of care for what would be a BHP-eligible population in 2014 – those with incomes between 139-200% FPL. With disproportionate rates of uninsurance, greater income volatility and increased likelihood of living in medically underserved areas, those potentially eligible for a BHP are more likely to rely on federally qualified community health centers, disproportionate share hospitals and other safety net providers. Likewise, public health plans both rely on these providers and have experience serving low-income populations. A BHP potentially preserves and builds on these assets.

IMPACT ON THE EXCHANGE

One of the more difficult issues in evaluating the BHP option is assessing what impact it will have on the scale of the state's Exchange. The size of the Exchange will affect its viability and its ability to secure value for consumers by driving quality and efficiency in the state's health care delivery system. It is estimated the BHP will reduce the number of individuals eligible to enroll in QHPs by approximately one-third and the number of subsidy-eligible individuals by 50% (See Table 1).[10] Reducing the population purchasing QHPs could impact the risk profile, weaken the purchasing power, and undermine the administrative viability of the Exchange. Designing the BHP in a way that minimizes the negative impact on the Exchange while still yielding the benefits of lower costs and continuity of care for BHP enrollees will be a challenge for states.

Implications for Exchange Risk Pool

The relative risk associated with the BHP-eligible population compared to those eligible for tax subsidies in the Exchange has been the subject of debate. On the one hand, lower income populations tend to have poorer health status on average than those with higher incomes. If that is the case, removing the BHP population from the Exchange could lower premiums in the Exchange. On the other hand, the BHP eligible population is younger as a group than those above 200% FPL, and has lower cost-sharing requirements, both of which are associated with lower risk. Removing a lower risk population from the Exchange could increase premiums in the Exchange. Accurately predicting the relative risk profiles of the BHP and Exchange populations is critical for states both because it impacts the level of federal funding that the state will

[9] ACA §1391(c)(2)(C)

[10] M. Buettgens, J. Holahan, C. Carroll. "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid." Prepared for the Robert Wood Johnson Foundation State Coverage Initiatives by the Urban Institute. March 2011

receive for the BHP – a higher risk profile will result in more federal funding – and because it is necessary to gauge the potential impact of the BHP on premiums in the Exchange.

Table 1: Projected Coverage in Non-Group Exchanges and Percent in Non-Group Exchanges with Incomes 139-200% FPL and Below 400% FPL in Select States

Select States	Total Projected Coverage in Non-Group Exchange	Percent in Non-Group Exchange with Incomes between 139 – 200% FPL	Percent in Non-Group Exchange with Incomes below 400% FPL
United States	23,835,000	34.1	68.7
Alabama	275,000	38.9	74.0
California	3,435,000	36.6	67.3
Colorado	482,000	28.1	66.5
Maryland	405,000	29.1	60.4
Massachusetts	296,000	27.4	58.6
Michigan	792,000	27.8	69.0
Minnesota	426,000	32.4	61.8
New Mexico	177,000	33.1	72.0
New York	1,415,000	36.4	70.4
Oregon	342,000	35.9	71.2
Rhode Island	83,000	28.5	57.4
Virginia	546,000	37.7	68.4
Washington	538,000	31.1	66.8

SOURCE: M. Buettgens, J. Holahan, C. Carroll. "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid." Prepared for the Robert Wood Johnson Foundation State Coverage Initiatives by the Urban Institute. March 2011

To date, states have come to varying conclusions on the relative risk profile of the BHP population. It is unclear whether this is driven by differences among the state populations or simply by differences in the modeling assumptions. States that currently provide coverage to this population, either through Medicaid or a state-funded program, have some utilization data that may provide a more objective basis for this analysis. Notably, states at the Roundtable were not in agreement on the risk profile of the target population.

While the potential for the BHP to negatively affect the risk profile of the Exchange exists, states are seeking to identify strategies that might minimize the impact. One strategy that has been suggested is to combine the risk across the BHP and individual market[11] to create a single risk pool. This would more effectively spread the risk, and to the extent BHP enrollees are lower

[11] This strategy was first advanced in S. Dorn. "The Basic Health Program Option under Federal Health Reform: Issues for Consumer and States." Academy Health/Robert Wood Johnson Foundation. March 2011.

risk, fold them into the Exchange risk pool. Another option may be to include the BHP in the risk adjustment and reinsurance systems used in the Exchange. Although states can begin to undertake their analyses of the BHP-eligible population, they will need guidance from federal officials regarding what options will be available to them to address the risk pool issues and how these mechanisms will work.

Implications for Exchange Scale and Market Leverage

The creation of a BHP also raises significant concerns about the scale of the Exchange and its ability to drive price and quality among QHPs and to promote delivery system reform more widely. The more individuals purchasing coverage through an Exchange, the more interested insurers will be in participating. Similarly, the more attractive the number and quality of insurers participating in the Exchange, the better able the Exchange will be to attract purchasers into that market. Having a robust and competitive market will give the Exchange more leverage to promote innovations among plans that improve quality and lower costs. Although not wholly dependent on size, the effectiveness of the Exchange at driving change in the market will be affected by the size of the enrolled population. The impact of a reduction in the number of individuals eligible to enroll in QHPs caused by the BHP will depend in part on how many people remain eligible to purchase coverage through QHPs and whether the BHP can be designed in such a way that it enhances rather than minimizes the market power of the Exchange.

A potential strategy for minimizing the risk of erosion in Exchange scale and market leverage is to integrate the BHP procurement strategy with QHP administration within the Exchange, and potentially with Medicaid, the Children's Health Insurance Program and the state employee health benefit program. By pooling market leverage across programs, states may be able to attract carriers offering products across the continuum of coverage, smoothing transitions for the consumer and aligning quality standards and program features for broader market impact. While this strategy may increase the Exchange's ability to drive payment and delivery system reform, it is unclear whether it will enhance the ability of the Exchange to attract commercial carriers.

Implications for Administrative Viability of the Exchange

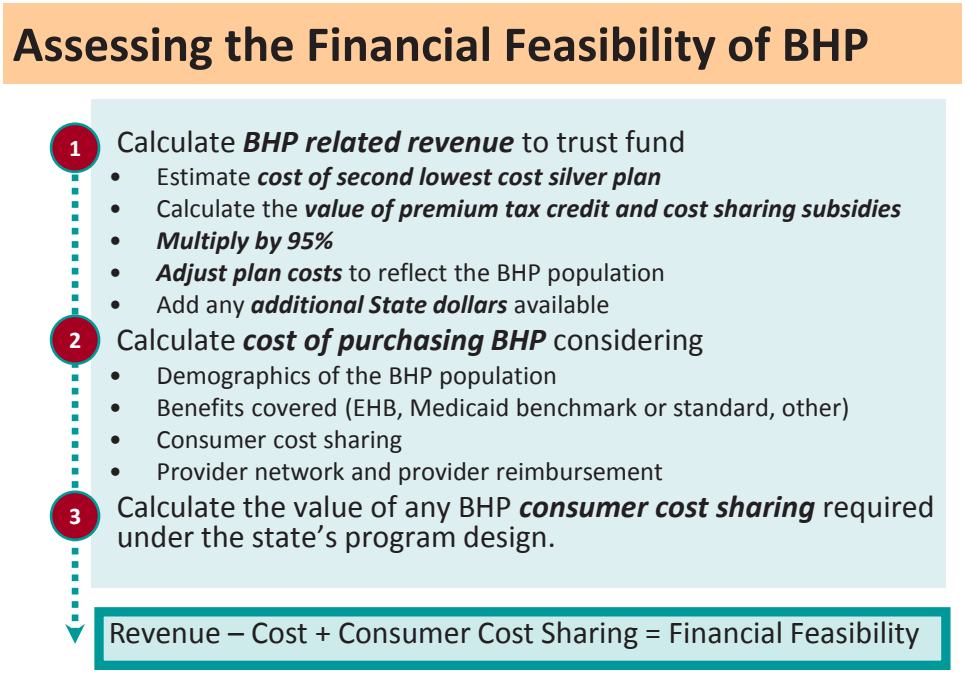
Finally, a BHP may have implications for the sustainability of the administrative infrastructure of the Exchange. Exchanges must create sophisticated administrative and IT systems to support required functions, and they must be able to finance the costs of operating these systems by 2015. One model for supporting the Exchange infrastructure contemplated under the ACA is to assess fees on the participating carriers. To the extent that the BHP leads to fewer carriers in the Exchange, any fees on those that do participate will be higher. One way to address this problem is to assess insurers both outside and inside the Exchange.

By drawing participants away from the Exchange, a BHP also reduces the financing base for the Exchange operations, which may result in higher premiums for Exchange enrollees. Spreading

administrative costs across a large pool of people leads to economies of scale and ensures that the cost to any individual will be minimal. To derive the same or similar economies of scale for Exchange functions in states with a BHP, a logical strategy would be to integrate BHP functions into the Exchange. Through integrating BHP and Exchange functions, and potentially certain functions of public programs as well, states will be able to spread program costs across a larger pool of beneficiaries and realize system-wide efficiencies. One significant hurdle to this approach is that there will need to be a mechanism for financing the BHP administration separate from the financing mechanism for the Exchange administration (financing the BHP administration is discussed in more detail in the next section).

FINANCING THE BHP: EVALUATING REVENUES AND COSTS

Financial feasibility is a key consideration for a BHP in every state. While the BHP offers states the opportunity to provide enriched coverage to the target population with full federal funding, it also leaves states at risk should that funding prove insufficient. Thus, it is critical states accurately estimate the amount of federal funding they will receive and the cost of implementing the program. At the highest level, the financial feasibility requires a series of calculations mapped out in the following graphic. Considerations related to program financing are discussed in more detail in the following sections.



Estimated Value of the Benchmark Plan

Estimating the federal financing likely to be available to support BHP costs first requires determining the estimated value of the benchmark plan for the target population. This presents a particular challenge for states in the first year of operation, as they must plan for the BHP

option well before the pricing of qualified health plans participating in the Exchange is known. The challenge also continues in future years as states will have to accommodate changes to the benchmark plan value to ensure the continued adequacy of federal funds.

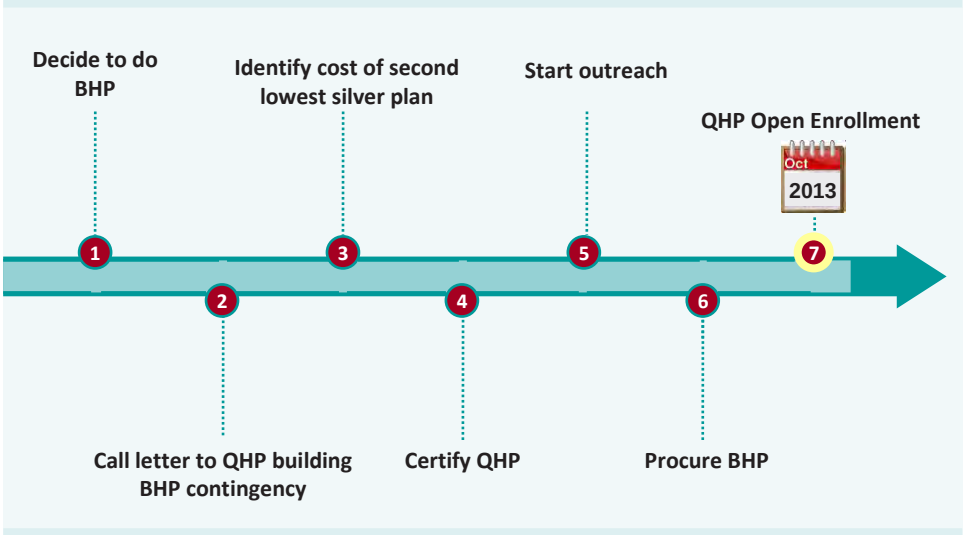
Most actuarial modeling performed for states to date has attempted to address this issue by building in estimates thought to be conservative for QHP pricing.[12] However, at least one author has observed the potential for more than marginal variation in premium estimation.[13] If in any given state the Exchange has more than one participating public health plan, which operates at a far lower cost than commercial offerings, the benchmark plan could be dramatically lower than anticipated, jeopardizing the financial viability of the BHP altogether. It is unclear, as a practical matter, how big of a risk this is. Because public health plans rely on their networks' willingness to accept Medicaid rates, which are substantially below their commercial counterparts, they are likely to face resistance to extending these rates to populations otherwise eligible for commercial coverage. Even short of the dramatic difference that would result from the participation of public plans, accurately predicting and adjusting revenue estimates as QHP prices shifts will present a challenge for states.

One strategy for states seeking to minimize the risk of inadequate federal funding in 2014 is to coordinate timing of QHP certification to ensure rates are determined in advance of, or in concert with, BHP procurement. States could build a contingency into their QHP certification process, requiring plans to offer alternative rates for products within the Exchange with and without the BHP population's participation. States in which the benchmark QHP offering was significantly below anticipated rates could either adjust the BHP program features to drive BHP costs down, or eliminate the option altogether. While this would be a dramatic solution, requiring significant administrative planning and last minute adjustments in what is already a complex and time-compressed implementation schedule, it would avoid the risk that states launch a BHP only to later retrench.

[12] Mercer. "State of California Financial Feasibility of a Basic Health Program." June 28, 2011; E. Benjamin and A. Slagle. "Bridging the Gap: Exploring the Basic Health Insurance Option for New York." Community Service Society of New York. June 2011; and Milliman. "Healthcare Reform and the Basic Health Program Option, Modeling Financial Feasibility." Reform Center Health Intelligence. April 2011.

[13] R. Curtis and E. Neuschler. "Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population: Background and an Alternative Approach." Institute for Health Policy Solutions. July 5, 2011.

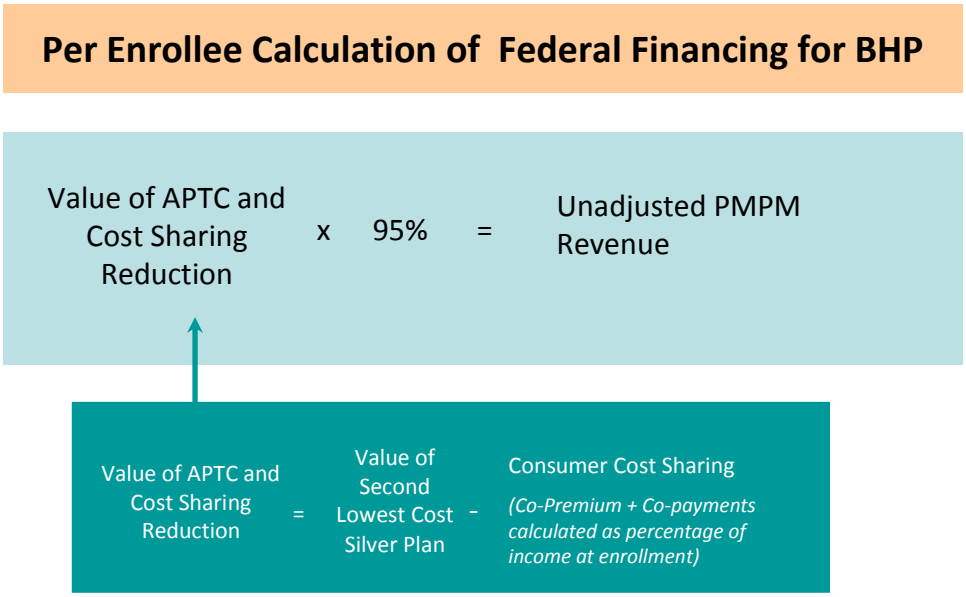
BHP Timeline



The Value of Premium Tax Credits and Cost-Sharing Subsidies

The cost of the benchmark plan provides the basis for determining the value of the advance premium tax credits (APTC) for the BHP-eligible population. Federal funding for the BHP will equal 95% of the difference between the required individual contributions (2-6.3% of income) and the cost of the benchmark plan. As mentioned, the law requires cost-sharing for BHP eligible populations not exceed the cost-sharing required under a platinum plan for individuals with incomes at or below 150% FPL or the cost-sharing required under a gold plan for eligible individuals between 150-200% FPL.

The simplest approach for implementing the cost-sharing requirement might be to enroll eligible individuals in richer plan designs. The cost-sharing subsidy would be the premium difference between the benchmark plan (with a 70% actuarial value) and the richer plans (platinum plan with 94%, and the equivalent gold plan with 87% actuarial value). Further federal guidance is required to understand how these subsidies will be implemented and how their value should be calculated.



Subsidy Adjustments

The ACA further requires the value of the advance premium tax credits and cost-sharing reductions be adjusted on a per enrollee basis to reflect "all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals."[14] This year-end reconciliation must include:

- the age and income of the enrollee;
- whether the enrollment is for self-only or family coverage;
- geographic differences in average spending for health care across rating areas;
- the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a QHP through an Exchange;
- whether any reconciliation of the tax credit or cost-sharing reductions would have occurred if the enrollee had been enrolled in a QHP in the Exchange; and
- consideration of other states' experiences.[15]

The Chief Actuary of the Centers for Medicare and Medicaid Services (CMS), in consultation with the Office of Tax Analysis of the Department of the Treasury, must certify the Secretary's methodology for adjusting the value of the subsidies to reflect the characteristics of the BHP enrollees.[16]

[14] ACA §1391(d)(3)(A)(ii)
[15] ACA §1391(d)(3)(A)(ii)
[16] See footnote 1 above.

Significant outstanding methodological questions will impact the amount of funding states can anticipate under this formula. For example, what is the significance of other states' experience in the development and certification of the cost methodology? How should states reflect risk adjustment in their methodology? These questions require further analysis and, ultimately, federal guidance to provide states greater certainty as they plan and implement BHP programs. Of course, the ultimate impact cannot be known until states have actual experience with operating a BHP.

An additional challenge in estimating BHP revenues (and anticipated costs) is the requirement that modeling take into consideration whether any reconciliation of the credit or cost-sharing reductions would have occurred had the enrollee been enrolled in a QHP. The ACA requires reconciliation of APTC payments at year end to reflect changes in an individual's income during the year. In the context of a BHP, this could result in adjustments to federal funding to support the BHP. Specifically, where BHP enrollees' annual income (as reported on their tax returns) is greater than the income used to determine the advanced premium tax credit when they first enrolled, the tax credit amount for which they are eligible will decrease. This decrease will result in reduced federal funding for the BHP. In other words, because the BHP shifts the risk of adjustments to premium tax credits due to changes in income from the individual to the state, the state will be subject to year-end adjustments to the federal monies it received during the calendar year. One study has predicted that within a year, 50% of all adults with family incomes below 200% FPL will experience a shift in eligibility from Medicaid to an insurance Exchange (or BHP), or the reverse.[17] An examination of California data found that this volatility, combined with the narrow income band for BHP, would create high rates of transference across Medicaid, BHP and QHP eligibility for individuals within the course of a year.[18] Both Medicaid and tax subsidies require that individuals report changes in income that could result in changes in eligibility. However, the remedies for the failure to report these changes differ. While tax subsidies are based on annual income projections, which are reconciled at year's end, Medicaid redeterminations do not include a retrospective reconciliation.

The impact of reconciliation is unclear. On the one hand, the ACA caps reconciliation repayments for low-income populations, which could limit states' exposure under reconciliation.[19] On the other hand, modeling under one study has indicated that reconciliation would result in overpayments for BHP nationally, which would result in reductions in BHP payments to states in future years. Federal guidance on the mechanism for implementing annual financing reconciliation is necessary for states to fully assess their risk. Crafting such mechanisms to minimize the administrative complexity and state risk, while ensuring integrity

[17] B.D. Sommers and S. Rosenbaum. "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges." *Health Affairs*. February 2011.
[18] R. Curtis and E. Neuschler. "Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program (BHP) in California." Institute for Health Policy Solutions. September 2011.
[19] S. Dorn, M. Buettgens and C. Carroll. "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States." Prepared for the Association for Community Health Plans by the Urban Institute. September 2011.

of the BHP program, will be important to ensuring the program's success. In the meantime, states may wish to adjust revenue projections downward to account for potential repayments, thereby taking such risks into account in their program design.[20]

State Funding

In some states, additional state dollars may be available – or freed for other uses – by the BHP. Many states provide coverage or services to targeted populations between 139 - 200% FPL funded in whole or in part with state finances (examples include programs for HIV+ populations, Breast and Cervical Cancer Programs and Family Planning waivers). Some states provide state-funded coverage to documented immigrants ineligible for federal Medicaid funding because of the five year waiting period; [21] others provide expanded coverage for adults beyond 139% FPL.[22] The BHP offers states the ability to replace such programs with a federally-funded option. While states are not obligated to continue such coverage, and QHPs (with full federal funding) within the Exchange would be available even absent a BHP, the BHP offers the potential to craft benefits, cost-sharing and service models that are more consistent with existing programs. Whether the displaced state funding is returned to state treasuries or reinvested in the BHP will be up to each state.

Estimating BHP Costs

Once the BHP revenue is determined, states must compare the funding estimate to the program's anticipated costs. While much of the revenue calculation falls outside of a state's control, the cost of purchasing BHP coverage for the target population involves several variables which, given states' broad discretion in program design decisions, can be altered to impact costs. States have the flexibility to determine BHP benefits, consumer premiums and cost-sharing, as well as the provider network and reimbursement rates.

Determining services covered in the BHP benefit package is one factor in the program's overall cost. States must provide coverage at least as comprehensive as the essential health benefits package offer by QHPs in the Exchange. They have the option of providing broader benefits that more closely mirror the Medicaid benefit package. Importantly, states will need to balance the

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[20] A state could decide to manage the year-end reconciliation by seeking to recoup any overpayment of tax credits from BHP enrollees whose incomes increased. In other words, the state could decide to pass the risk of the tax reconciliation back to the BHP enrollee, much as it is for a QHP enrollee. However, a state might well conclude that given the limited income of BHP enrollees, such a course is not wise and that a better course is to reserve against such a possibility.

[21] States that provide state-funded coverage to documented immigrants ineligible for federal Medicaid funding include AR, CA, DC, IL, LA, MA, MI MN, NE, NJ, NY, OK, OR, RI, TX, WA, and WI. See Kaiser Commission on Medicaid and the Uninsured. "New Option for States to Provide Federally Funded Medicaid and CHIP Coverage to Additional Immigrant Children and Pregnant Women." July 2009.

[22] States that provide Medicaid or Medicaid look-alike coverage to adults beyond 139% FPL include CT, DC, IL, ME, MN, NY, RI, VT and WI. See Kaiser Family Foundation State Health Facts, http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4, accessed October 2011.

desire to offer more comprehensive coverage against the need to ensure that programs costs do not exceed available funding.

Similarly, states have a great deal of flexibility in determining consumer premiums and cost-sharing requirements. However, while increasing the enrollees' contribution level would alleviate some of the state's cost burden, there is a threshold as to how far this variable can be manipulated given the price-sensitivity of the BHP population and the overall intention of the program to be more affordable for consumers.

Additionally, states will have to negotiate provider networks and reimbursement rates for the BHP. As discussed earlier, options to states include, designing the provider network around Medicaid, using existing commercial networks, or creating a hybrid in which both Medicaid and commercial plans participate. This foundational decision will greatly impact the cost of the program.

To date, the most significant variables in state modeling have proven to be provider network and reimbursement, and cost-sharing levels. While the flexibility in program design is a formidable tool, it cannot in all cases ensure that states will be able to control costs to the extent needed to make the BHP a viable option.[23] Calculating the BHP cost will ultimately be an iterative process, which may not be fully realized until states have more experience operating a BHP.

ADMINISTRATION OF THE BHP

In opting for a BHP, states take on fiscal and operational responsibility for a new health insurance program at a time when staff resources are stretched and state budgets are tapped. Thus, another crucial aspect of evaluating and establishing a BHP is planning for its administrative infrastructure.

The BHP will occupy a middle ground between the spheres of public coverage (Medicaid and Children's Health Insurance Program) and commercial coverage (QHPs in the Exchange). For many states, this raises questions about who should be responsible for evaluating the BHP option, as well as designing, implementing and, ultimately, operating the program. The ACA and proposed rule-making require BHP eligibility and enrollment processes and systems to be integrated with public programs and tax subsidies as part of the continuum of coverage within

[23] In the case of Minnesota, various actuarial projections using Medicaid provider rates (with 5% FFS reduction and 15% managed care reduction) and Medicaid benefits still anticipated state deficits with running a BHP. See, J. Gruber and B. Gorman. Coverage and Financial Impacts of Market Reforms and a Basic Health Plan (BHP) in Minnesota. November 18, 2011. Power Point Presentation. http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs16_165329.pdf accessed January 2012.

insurance affordability programs.[24] However, guidance to date is silent on how the program must be implemented, by whom, and how the necessary staff resources and infrastructure will be financed.

A threshold question is whether the BHP trust fund may be used to finance the program operations. The ACA does not specify how BHP administration is to be funded, and statutory language defining the permissible uses of the BHP trust fund raises questions regarding whether it is permissible for such funds to be used for administrative purposes. Section 1391 of the ACA states, "amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State." Even if it is permissible to use these funds for administration, fewer dollars will then be available for designing and purchasing a BHP. Federal guidance will be critical to clarifying this issue.

If not funded directly through the trust fund, another alternative may be to finance the BHP through mechanisms similar to, or integrated with, the financing of the Exchange. The ACA offers states federal funding to support the establishment of Health Benefit Exchanges, and requires them to be self sustaining by January 1, 2015.[25] Planning for the implementation of the Exchange must be fully integrated with any consideration of the BHP and its implementation efforts. While to date some states have been able to access Exchange funds to support activities related to the evaluation of the BHP option,[26] recent federal guidance limits the use of federal Exchange funds for BHP planning and implementation purposes. Specifically, the guidance states:

> *Establishment grant funds may be used for Exchange establishment activities that would coordinate or overlap with activities undertaken pursuant to the establishment of an optional Basic Health Program. For example, a call center may provide consumer information on a range of coverage options including the Basic Health Program, and could therefore be funded through Establishment grant funds. However, funding under the Establishment grants cannot be used to support operations of the Basic Health Program or to investigate the feasibility of the Basic Health Program.*

The guidance goes on to say that "States electing to establish a Basic Health Program may opt to fund administrative or establishment activities for the Basic Health Program through user fees or other State funding."[27]

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[24] *CMS-9974-P*. "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers." 76 FR 51202

[25] U.S. Health and Human Services Department. "Initial Guidance to States on Exchanges." November 18, 2010.

[26] At least three states that were awarded Level 1 Establishment grants included activities related to the evaluation of the BHP option in their grant applications (Connecticut, Illinois and Washington). At least four states—New York, South Carolina, Rhode Island and Vermont—included BHP-related activities in their Exchange Planning grant applications.

[27] Center for Medicare and Medicaid Services. "State Exchange Implementation Questions and Answers." November 29, 2011.

As states transition from planning into implementation and operation of BHP programs, further federal guidance will be necessary to determine states' options for funding these activities. One significant question is whether states may assess fees on plans participating in the BHP to finance the cost of the program administration, and whether it matters if such assessments are unique to BHP participants or more broadly applicable to carriers across the commercial and/or Medicaid markets.

Finally, while the ACA requires federal certification and approval to operate a BHP, it does not specify the standards, timeline or mechanism for this process. To the extent state requirements and federal processes can be aligned with those for financing and administration of public programs and the Exchange, states will be more likely to overcome administrative and financial barriers to creating the program.

ALTERNATIVES TO THE BHP

Regardless of whether a state ultimately pursues a BHP, the discussion has put a spotlight on the affordability of QHP coverage for adults with incomes just above the Medicaid eligibility level. Recognizing the complexity, uncertainty and implications of the BHP, policy makers have begun to explore alternative strategies to enhance subsidy levels for lower income populations. One option that may be available in some states would be to use state savings from existing coverage programs that will no longer be needed once Exchanges and premium subsidies are available to enhance the QHP subsidy levels. In some states that have expanded coverage to childless adults with incomes above 139% FPL, the savings could be considerable. The state could apply some (or all) of these savings to enhance the QHP subsidy levels for the BHP-eligible population, thereby addressing the cost-sharing cliff without taking on the risks and responsibilities of a BHP.

A recent report from the Institute for Health Policy Solutions suggests another alternative to improving both continuity and affordability in lieu of creating a BHP. Under this approach, Exchanges would certify Medicaid managed care plans as limited QHPs, open only to existing Medicaid enrollees whose incomes increase above 139 percent of the FPL. It appears the ACA might allow such limited enrollment plans. Because these plans would only be available to those moving from Medicaid to the Exchange, presumably their premiums would not be considered in determining the value of the benchmark plan. Assuming this is correct, the value of the tax subsidy (which would be based on the cost of a commercial silver plan) would go farther for enrollees in less expensive Medicaid managed care-like products, resulting in more modest cost-sharing for former Medicaid beneficiaries. Tennessee has fashioned such an approach, termed the "Bridge Option" and is now in discussions with the Center for Consumer Information and Insurance Oversight as to its legality.

Finally, while of little immediate assistance, Section 1392 of the ACA, which provides for waivers for state innovations after January 1, 2017, may offer states an additional long-term strategy to construct a BHP-like alternative without the statutory constraints of the BHP.

CONCLUSION

A BHP offers states a vehicle to make coverage more affordable for consumers with incomes between 139 and 200 % FPL and to improve the continuity of coverage for these same consumers as they cycle on and off of Medicaid. There is little doubt individuals within this income band will have access to more affordable coverage with a BHP. The difficult question states face is how to take advantage of the BHP option without exposing the state to potentially significant financial risks and without undermining the effectiveness and viability of the Exchange. States understand the benefits and risks of a BHP and anticipate their analyses will be greatly aided by federal regulations or guidance expected this year. While some of the open issues will not be resolved by the guidance, it will be crucial as states face a decision in early 2012 whether to offer a BHP in 2014. Given the implications of that decision for the operating budget of the Exchange and the QHP selection criteria and process, among other things, states cannot wait any longer than early 2012 to confront these decisions.

For some states, the BHP may be the most viable vehicle for reducing consumer cost-sharing and increasing participation for the target population. As states move forward with evaluating, planning, and implementing BHP programs, it is critical that they identify mechanisms to manage the risks and complexities inherent in the BHP, while minimizing the risks to state Exchanges and the consumers who will rely on them for access to affordable coverage. Finally, federal guidance should support states in this effort, providing states with clarity and flexibility in deploying the BHP program.

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