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Basic Health Program: Considerations Regarding the Federal Payment Methodology

By Steven Armstrong, Michael Cook and Lindsy Kotecki

The Patient Protection and Affordable Care Act (ACA) includes numerous provisions that aim to provide greater access and more affordable health care coverage to low- and moderate-income individuals. Most notably, these programs include the option for states to expand their Medicaid programs to individuals with incomes up to 138 percent of the federal poverty level (FPL) and premium and/or cost-sharing subsidies on public exchanges for individuals with household incomes between 100 and 400 percent of FPL. A lesser-known provision of the law, Section 1331, gives states the option to establish a Basic Health Program (BHP). The BHP is intended to provide states with the flexibility to design programs that meet the specific needs of the state and the low-income population. Through the program, states may be able to provide such benefits as additional premium and/or cost-sharing reductions (CSRs) to low-income individuals beyond those offered through the exchanges, as well as to reduce the churn of beneficiaries in and out of the Medicaid program as eligibility status changes throughout the year.

In states electing to implement a BHP, coverage through the program will be available to individuals under the age of 65 with household incomes up to 200 percent of FPL who

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are not eligible for Medicaid or affordable/creditable employer-sponsored insurance. Coverage will also be available to lawfully present noncitizens with incomes under 200 percent of FPL who are not eligible for coverage through Medicaid or the Children's Health Insurance Program (CHIP). Under the BHP, states must provide coverage that includes at least the essential health benefits required for plans offered on their exchanges. Federal funding for the BHP will be calculated based on the level of premium tax credits (PTCs) and CSRs that enrollees would have received had they been enrolled in a qualified health plan (QHP) offered through the exchanges. Specifically, the federal government will pay 95 percent of these amounts into a BHP trust fund, with states being required to fund any remaining costs of the program through other sources.

To date, Minnesota is the only state to have opted to implement a BHP. The BHP will essentially replace the current MinnesotaCare program, which serves individuals with household incomes between 138 and 200 percent of FPL who do not have access to insurance coverage through an employer or other assistance programs. The Minnesota Department of Human Services has submitted a BHP blueprint[1] to the U.S. Department of Health and Human Services (HHS) for approval, which is scheduled to take effect beginning Jan. 1, 2015.

In August 2014, the Oregon Health Authority (OHA), which was tasked with studying options to increase continuity of coverage and reduce the impact of transitions between Medicaid and QHPs on the exchanges, issued a report[2] advising against the implementation of the program. Though the report notes several potential benefits of the program, the committee concluded that this option would place additional financial risk and administrative burdens on the state, would limit coverage options for BHP-eligible individuals, would reduce provider reimbursement rates for services provided to individuals enrolled in the BHP relative to those paid by plans sold on the exchanges, and would reduce the size of the risk pool for plans on the exchange. It is estimated that, nationwide, as much as one-third of the individuals eligible to purchase subsidized coverage on the exchanges have incomes below 200 percent of FPL and would instead be required to obtain coverage through the BHP.[3] Such a reduction in the size of the risk pool would have the potential to alter the risk profile of the exchange population and, in turn, impact premium levels on the exchanges. Though the OHA report focused on a variety of options to reduce churn, a more thorough feasibility study focused on the BHP is scheduled to be delivered to the legislature in November 2014.

Other states, such as New York, Massachusetts, California, Hawaii and Washington, have explored the viability of this option in their states. However, it is unclear at this time whether or not these states will move to implement a BHP after 2015.

Federal Payment Methodology

In March 2014, HHS released the final rule payment methodology for the BHP,[4,5] which outlined the specific formulas that will be used to determine the payments made by the federal government into the BHP trust fund. Though the payment formulas are simplified, they are designed to account for relevant factors that would be considered in the determination of the actual PTC and CSR amounts for individuals enrolled in a QHP through the exchanges. These factors include:

- Reference premium (see the Reference Premium section below)
- Tobacco rating factors
- Induced utilization
- Premium trend
- Administrative costs included in premium
- Actuarial value
- Health status (potentially)
- Income reconciliation (for changes in eligibility throughout the year).

Rather than estimating the reference premium, PTC and CSR amounts at the individual level, these amounts will be calculated on average for

different rate cells. The rate cells prescribed in the BHP payment methodology vary by the following characteristics:

- Age range
- Household income
- Level of coverage (self-only or family)
- Household size (in states where children at or below 200 percent of FPL are not eligible for Medicaid or CHIP)
- Geographic rating area.

The federal payments will equal 95 percent of estimated PTC and CSR amounts, and will be deposited into each state's BHP trust fund on a quarterly basis.

Reference Premium

PTCs paid through the exchanges are determined based on the premium rate for the second-lowest-cost silver plan. Therefore, in order to estimate the PTC that would have been paid to BHP-eligible individuals had they enrolled through the exchanges, the BHP payment methodology includes the calculation of a reference premium. The reference premium is calculated for each age range and coverage level, and reflects the average nontobacco premium rate for the second-lowest-cost silver plan in a given geographic area.

For 2015, the reference premium will be calculated using actual 2015 premium rates for the second-lowest-cost silver plans, unless a state requests that 2014 premium rates be used instead. If 2014 premium rates are used, a premium trend adjustment will be applied to reflect the anticipated premium change for 2015. The methodology used to calculate reference premiums for future years will be published in the annual notice.

The reference premium may be adjusted to account for the health status of the BHP and non-grandfathered, ACA-compliant individual market populations combined relative to the health status of the non-grandfathered, ACA-compliant individual market population excluding the BHP-eligible population. This adjustment is called the population health factor (PHF), and is intended to reflect the expected impact that BHP-eligible individuals would have had on exchange premium rates if they were included in the exchange population (more on this below in the Health Risk Adjustment section).

Calculation of Premium Tax Credit

The PTC amount paid into the BHP trust fund will be calculated at the rate cell level, and will be based on the difference between the average adjusted reference premium and the average maximum premium that would be charged to BHP-eligible individuals if they purchased the second-lowest-cost silver plan through the exchanges. The average maximum premium amount varies based on household income as a percent of the FPL.

An additional adjustment will be made to the PTC payment to account for the expected impact of income reconciliation. For enrollees on the exchanges, the PTC will be paid prospectively based on income at the time of application, with an annual reconciliation to reflect actual changes in income over the course of the year. Though BHP enrollees are not eligible for these prospective payments, HHS will use historical income data for BHP-eligible individuals to estimate the expected change in tax credit eligibility through the year and adjust the PTC payment accordingly. For 2015, this factor will equal 94.92 percent.

Calculation of Cost-Sharing Reduction

In determining the CSR payment, the adjusted reference premium will be used as the basis for estimating the average claims cost in each rate cell. Because the reference premium is based on the nontobacco rate, an adjustment factor will be applied to account for additional medical costs related to tobacco use. HHS will base this adjustment on the relativity of nontobacco and tobacco rates for the second-lowest-cost silver plan on the exchanges, and will account for the expected proportion of tobacco users within the BHP population based on tobacco utilization rates published by the U.S. Centers for Disease Control and Prevention (CDC). The impact of administrative costs will also be removed from the resulting premium to estimate

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the expected net claims costs for the population. This adjustment has been set at 80 percent, which is consistent with the factor used for calculating CSR advance payments for plans on the exchanges.

The CSRs that BHP members would have received though coverage on the exchanges are estimated by first grossing up the estimated net claims costs to an allowed cost basis and then calculating the expected reduction in cost sharing using a simplified approach. Allowed costs will be calculated by dividing the estimated net claims by an actuarial value (AV) of 70 percent, which is the nominal actuarial value for a silver-level plan. Then the estimated portion of total allowed costs that would be subsidized by federal dollars through an exchange is estimated based on the difference between the nominal AV of a standard silver plan (70 percent) and the nominal AV of the applicable CSR plan. The nominal AV for silver CSR plans is 94 percent for enrollees who are under 150 percent of FPL, and 87 percent for enrollees who are between 150 and 200 percent of FPL. Therefore, the portion of subsidized allowed costs is estimated to be 24 percent (= 94% – 70%) for enrollees under 150 percent of FPL, and 17 percent (= 87% – 70%) for enrollees between 150 and 200 percent of FPL.

Finally, higher utilization of services is expected as a result of CSRs because beneficiaries will be able to receive services at a lower cost. This will be accounted for in the CSR calculation through an induced utilization factor. For 2015, this factor will be 112 percent (meaning aggregate allowed claims costs are expected to be 12 percent higher as a result of CSRs).

Health Risk Adjustment

For 2015, HHS has proposed adjusting the reference premium used in the calculation of the PTC and CSR by a PHF of 1.00. A PHF of 1.00 was established because of the analytical challenges and uncertainties regarding the characteristics and risk level of BHP-eligible enrollees in 2015. However, states have the option to submit a proposed methodology for retrospectively calculating the difference in health status between the combined BHP and non-grandfathered, ACA-compliant individual market populations and the non-grandfathered, ACA-compliant individual market population excluding the BHP-eligible population.[6] Based on this protocol, the federal BHP payment for 2015 would be reconciled to reflect the actual level of risk in the plan year. This adjustment was appropriate for Minnesota, because the BHP-eligible population was already covered through the state's Medicaid program in 2014, and was therefore not reflected in exchange premium rates. Minnesota has proposed a methodology for implementing a health risk adjustment factor for 2015 with CMS approval or feedback due Dec. 31, 2014.

Notable Payment Methodology Implications and Considerations

There are several factors and simplifications made in the BHP payment methodology that may have implications for states choosing to establish a BHP. First and foremost, BHP payments only reimburse 95 percent of estimated PTC and CSR payments.

Table 1

	A	B	C	D	E	F	G	H
Eligibility Category	Premium for 2nd Lowest Cost Silver Plan	Maximum Premium	Population Health Factor	Adjusted Reference Premium	Premium Tax Credit (PTC) [1]	Reference Premium less Admin	Cost-Sharing Reduction (CSR) [2]	Federal BHP Payment
				A x C	A - B	D x 0.8	F / 0.70 x 1.12 x (CSR AV – 0.70)	95% x (E + G)
< 150% FPL	$200.00	$50.00	1.00	$200.00	$150.00	$160.00	$61.44	$200.87
150% - 200% FPL	$200.00	$90.00	1.00	$200.00	$110.00	$160.00	$43.52	$145.84

NOTE: Premiums and maximum premiums are for illustrative purposes only.

[1] Assumes 1.0 income reconciliation factor

[2] Assumes 1.0 tobacco rating adjustment factor

These payments will not necessarily be sufficient to cover the total cost of expanding coverage. That is, states establishing a BHP will be responsible for taking on the added cost, if it is not already a Medicaid-covered population. Table 1 demonstrates the calculation of the PTC and CSR payments to a state at the individual level (note that actual payments will be calculated at the rate cell, rather than individual level). The premium amounts are strictly illustrative. Note that estimating the final net cost assumed by a state under BHP requires a good deal of effort because of significant differences between BHP programs and the exchanges upon which federal funding is based, including potential differences in:

- Provider reimbursement levels
- Covered benefits
- BHP actuarial values relative to federal funding assumptions
- Taxes and assessments
- Administrative costs
- Risk mitigation mechanisms.

Next, the BHP payment methodology is developed on a statewide basis. It is up to the states to establish the new program structure and determine how payments will be made to those offering plans. Given the variety of coverage options that low-income individuals may qualify for (Medicaid, BHP, or a QHP through the individual exchange), there is potential for confusion among members and providers regarding service benefits and reimbursement. This could also introduce an administrative burden to a state, and there are no federal funds for administration included in the BHP payments. Again, these concerns are mitigated for states that already cover the BHP population.

Because enrollees who are eligible for the BHP are not eligible to enroll in a health plan through the exchanges, it is not possible to precisely calculate the value of tax credits and cost-sharing subsidies those individuals would have received through the exchanges. In general, the BHP payment methodology accounts for relevant factors that are expected to materially impact the PTC and CSR payments, but simplified methods were used when appropriate. Specific examples include:

- The BHP payment methodology groups the BHP-eligible population into rate cells based on demographics and other characteristics. The reference premium, PTC and CSR amounts are then estimated at the rate cell level assuming a uniform distribution of enrollment within each cell. This simplifying assumption reduces the

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complexity of the calculation and allows payments to be calculated prospectively, but is not expected to have a material impact on the final BHP payment.

- The calculation of the reference premium assumes that all BHP-eligible enrollees would have enrolled in the second-lowest-cost silver plan through the exchanges. In reality, however, those individuals could have enrolled in any plan (or no plan at all).
- The CSR formula adjusts the reference premium for the expected average tobacco rating factor based on CDC statistics on tobacco users. This is a simplifying assumption because tobacco use among the BHP-eligible population may be different from the general population.
- The BHP payment methodology also does not adjust for the expected amount of federal transitional reinsurance benefits that would have been paid to insurers for high-cost BHP-eligible individuals had they enrolled through the exchanges. Therefore, states that establish a BHP will be forgoing potential reinsurance benefits, but will not receive a proportionate reduction in contributions. (Although transitional reinsurance fees will not be collected on BHP enrollees, the vast majority of reinsurance fees are assessed on the group market, and will be regardless of whether a state implements a BHP.)

There are also several implications to consider with respect to the PHF that will be used to adjust payments for expected health status differences between BHP enrollees and other enrollees in the individual market.

- The PHF is calculated on a statewide basis (based on the entire BHP and non-grandfathered, ACA-compliant individual market populations). That is, the PHF used to adjust reference premiums does not vary by rate cell. This method implicitly assumes that differences between the health status of BHP-eligible individuals and ACA individual market enrollees are similar across the state.
- The reference premium after the PHF adjustment is not likely to reflect the true morbidity of the BHP-eligible population on its own. This is intentional, because in regulation the BHP payments are to be based on the subsidies that enrollees would have received had the BHP population instead enrolled in the individual market. Instead, the PHF adjusts the reference premium to reflect the combined health status of the BHP-eligible and non-grandfathered, ACA-compliant individual market populations. In other words, BHP payments are not based solely on the health status of the BHP-eligible population, even after the PHF adjustment. As such, states would face some financial risk that the morbidity of the BHP population varies from that of the individual market population.
- A consistent model should be used to estimate health status for the BHP and individual market populations.
- Because risk scores include coefficients based on age, and the BHP payment formula also includes age rating cells, it is important to make adjustments in the PHF calculation in order to avoid double counting.
- To the extent that risk scores estimate relative plan liability net of member cost sharing—for instance, as the HHS-Hierarchical Condition Categories (HCC) model does—it is important to make an appropriate adjustment in the PHF calculation to avoid including differences in plan richness in the factor.
- For risk adjusters based on diagnosis codes, members with only a partial year of enrollment may have understated risk scores that are due to missing data. If a state expects or finds that BHP enrollees are more or less likely to have partial enrollment years than the individual market population, an adjustment to the PHF may be warranted.

Given these funding implications, several states are continuing to evaluate the fiscal impact of establish-

ing and maintaining a BHP, as well as the potential for a BHP to meet the health care needs of low- to moderate-income individuals in their states. Any states desiring to implement a BHP are required to submit a BHP blueprint to HHS outlining how the program will be organized to meet the requirements set forth in the final rule and how the program will be funded. Upon receiving approval from the Secretary of HHS, the state can begin to enroll members into the program and will be eligible to receive federal funding payments.

ENDNOTES

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