SOCIETY OF ACTUARIES

Article from:

Health Watch

May 2015 – Issue 78

Basic Health Program: Why Do Some States Bother and Others Don't?

By Karan Rustagi, Tim Courtney and Julia Lerche

Karan Rustagi, ASA, MAAA, is a consulting actuary at Wakely Consulting Group in Englewood, Colo. He can be reached at *karanr@wakely.com*.

Tim Courtney, FSA, MAAA, is a senior consulting actuary at Wakely Consulting Group in Clearwater, Fla. He can be *reached at timc@wakely.com*.

Julia Lerche, FSA, MAAA, is a senior consulting actuary at Wakely Consulting Group in Clearwater, Fla. She can be reached at *julia.lerche@wakely.com*.

The Affordable Care Act (ACA) provides several policy alternatives for states. One of these options, which we explore in this article, is the Basic Health Program (BHP). The January issue of *Health Watch* introduced the key features of the BHP and the federal payment methodology from a technical viewpoint. This article is intended to move the conversation forward by sharing insights into the decisions and challenges that states face when deciding whether or not to implement a BHP. While we draw heavily from our experience in Massachusetts and Oregon, we also refer to experience of other states that have considered the BHP.

The BHP allows states the option of providing alternative coverage to individuals with household incomes below 200 percent of the federal poverty level (FPL)[1] who would otherwise have been eligible for subsidized coverage through the exchange. The BHP must provide covered benefits and cost sharing that are at least as rich as those available through the exchange, at a premium that is no more than what the individual would be required to pay for exchange coverage after applicable subsidies (for both premiums and cost sharing). Federal funding is provided to states to offset the costs of the BHP, which is based on the amount of federal subsidies that would have been available had the BHP population been covered through the exchange. States were eligible to begin BHP implementation in 2015. At this time, only Minnesota has implemented a BHP.

Potential Benefits of a BHP to States

Richer benefits at a lower cost to consumers than subsidized qualified health plans (QHPs). These richer benefits are achievable either through care delivery savings (lower provider reimbursements, better care management and/or lower administrative costs), or through additional state funds. Massachusetts and Minnesota had state-subsidized plans for the BHP-eligible population prior to the ACA going into effect in 2014. In the absence of BHPs, these members would have to move to QHPs. The QHPs are significantly leaner (even after considering silver plan cost-sharing subsidies) than these state-subsidized plans and the transition would have resulted in a reduction in both benefits and affordability for this population. If there is political will in a state to continue offering coverage with richer benefits and lower out-of-pocket costs to this population, then BHPs can provide a means.

Reduced Medicaid churn. Because of income fluctuations, especially among low-income households, Medicaid members gain and lose Medicaid eligibility throughout the year. During the periods when they are not eligible for Medicaid, QHP plans can cushion the impact of increased out-of-pocket expenses through premium and cost-sharing subsidies. However, these plans will likely have a different network of providers and covered benefits than the Medicaid plans. When BHPs are set up to leverage Medicaid provider networks and reimbursement contracts, they can offer continuity of care and can simplify navigating a complex health care system for the low-income population. The ease of access and continuity of care could also offer incentives for the beneficiaries to continue enrolling in coverage.

Increased coverage take-up rates. BHPs must offer covered benefits and cost sharing that are at least as rich as what are offered through the exchange. The improved affordability and benefit richness increase the value proposition for more members, which presumably results in higher take-up of coverage among those who might otherwise go uninsured, even with the availability of subsidized QHP plans. At income levels where a person is eligible for a BHP, the penalty for not purchasing coverage is approximately $325 for a single-person household. This penalty may not be a sufficient motivator to purchase QHP coverage that still entails out-of-pocket expenses. In addition, some people in the BHP income range are exempt from the penalty because their incomes are below the filing threshold. To the extent that the lower-cost and richer-benefit BHP plan increases take-up rates, there will be added benefits of a bigger risk pool and reduced uncompensated care.

Coverage for legal immigrants. Immigrants legally residing in the United States for less than five years are generally not eligible for Medicaid coverage. Though these immigrants are eligible for subsidized coverage through a QHP on the exchange, the premi-

um and cost sharing required for these plans may pose a significant financial barrier for this population to receive care. The BHP provides states with an option to improve the benefits available to this population.

Savings to the state. Some states like Massachusetts have offered a subsidized plan for the BHP-eligible population prior to the ACA. Previously, these states paid for the entire subsidy out of state funds. Offering the same coverage through a BHP will enable these states to receive federal funding for the program through the BHP and result in lower state spending. Of course, if the state ceased to offer the state plan for BHP-eligible members and transitioned them into QHPs, the state could drastically reduce its spending. However, as we have seen, the political will in some states is such that these states seek to maintain the former levels of coverage for these income groups. The BHP may also provide states with an option to cover mental health and other benefits that are currently covered through state-funded programs. In January 2014, Wakely completed financial analysis of a BHP program for the Massachusetts Connector. We believe a final decision regarding the program is still pending.

Challenges Associated with the BHP

The BHP benefits discussed above also come with challenges that may lessen the appeal for some states. Some of the key challenges are summarized below.

Disrupting the rest of the commercial individual market. Removing the BHP group from the QHP single risk pool could significantly alter the risk profile of the single risk pool. The single risk pool contains all members in the individual market and enrolled in a QHP. For example, if the BHP population is younger and healthier than the rest of the individual market risk pool, BHP implementation could have a negative impact on rates in the individual market. The BHP is not included in the federal risk adjustment program, so there would be no mechanism (unless established by the state) to offset any negative impact on the risk pool. In California,[2] one of the reasons cited by government officials for not implementing a BHP was that a BHP could disrupt the risk profile of the single risk pool as it draws members with incomes between 138 and 200 percent of FPL out of the exchanges. A Kaiser study[3] estimated that up to 677,000 members fall within this income category. Additionally, changes in individual market premiums will affect BHP revenues because the BHP federal funding is determined using second-lowest-cost silver premiums on the exchanges.

Disrupting the exchange operations. In California,[4] implementing a BHP was viewed as a risk that might interfere with the success of the exchange. The reduced membership on the exchange would lower the base to fund the exchange operations and could have an impact on the number of carriers interested in participating. Insurers and providers in California expressed significant concerns about the disruption a BHP would cause. California was focused on seeing the exchanges succeed and the concerns over BHP disrupting the exchange operations shelved the BHP discussions for the time being.

Financial risk to the state. States are liable for any difference between premiums quoted by insurers for the BHP members and the federal payments for the BHP. The federal funding for BHPs is 95 percent of the premium tax credits and cost-sharing reduction subsidies the BHP population would have received had they enrolled in QHPs. The state has to find savings to offset the 5 percent reduction.

It is important for states to model the potential cash flows and risks of a BHP program to determine if the savings from implementing a BHP offset some of the risks. States that had a program covering this population prior to ACA such as Massachusetts and Minnesota are in a better position to conduct this modeling since they will have claim experience for this population. Most states, however, do not provide coverage for this population and as such have little reliable information on the cost of providing health care coverage to them; such states risk entering into a BHP arrangement without a good understanding of the potential size and variability of financial results.

Beyond estimating claim costs for this population, revenues can also fluctuate. In particular, BHP federal payments are based on the second-lowest-cost silver plan premiums in the commercial market,

CONTINUED ON **PAGE 20**

which can be volatile year to year. The volatility could be driven by new carriers entering the market, current carriers rolling out plans with narrow networks, or carriers correcting pricing from early years of ACA when little information was available on newly insured. While low trends in commercial premium levels would typically be celebrated, a BHP program would now be faced with lower revenues that may not necessarily be related to the underlying population costs, which could create unanticipated expenses for the state.

Program administration. States would need to dedicate resources to administer the BHP. In many states, the BHP could leverage existing capabilities within the Medicaid program, including plan contracting and eligibility functions. Federal funds for the BHP cannot be used to directly cover program administrative expenses. States could presumably assess the carriers providing BHP coverage to cover state administrative expenses, in which case the additional cost would be included in the premiums that could in turn be paid for with federal funds.

Consumer disruption. In states that implement the BHP, BHP-eligible consumers are no longer eligible for subsidies through the exchange. Transitioning from a non-BHP to a BHP environment could create disruption for consumers enrolled in subsidized QHPs through the exchange. These consumers may need to change providers and/or health plans, and may prefer the choice of commercial plans to the BHP options defined by the state. Consumer impact will vary based on each consumer's personal circumstances and preferences.

Provider negotiations. Provider reimbursement is a key component in making a BHP viable. In the absence of a BHP, the BHP-eligible population would be covered under federally subsidized QHPs. The QHPs typically pay commercial reimbursement rates to providers. As a result, providers would get reimbursed more for the same services for a member with insurance through the exchange relative to a member with a BHP plan. Based on our experience in Massachusetts and Oregon, the ability to negotiate a lower provider reimbursement rate than commercial was found to be key to making a BHP financially viable for the state. The insurers would need a good business case to bring providers to the table and discuss alternative reimbursement rates. A higher take-up rate due to BHP and, hence, lower uncompensated care, may be motivators for providers to accept lower reimbursements on BHP members. Providers may also be motivated by reduced uncompensated care and reduced churn as members gain or lose Medicaid eligibility.

Conclusion

The BHP provides states with the ability to provide more affordable coverage to its low-income population and expand Medicaid-like benefits to individuals whose incomes exceed Medicaid eligibility. As discussed, there are many considerations for states in determining whether to implement a BHP. For states that have existing programs for the BHP-eligible population, the BHP clearly offers an opportunity to take advantage of federal funding to continue to offer similar benefits as the existing program. For all other states, the decision to implement a BHP will depend on the state's goals and political environment and its ability to become comfortable assessing and taking on the financial risks associated with the program.

END NOTES

1 For 2015, 200 percent of FPL is $11,770 for a single household and $24,250 for a four-person household in all states except for Hawaii and Alaska.

2 *http://www.californiahealthline.org/insight/2012/why-basic-health-plan-failed-and-why-coops-may-succeed*

3 *https://www.statereforum.org/sites/default/files/estimating-federal-payments-and-eligibility-for-basic-health-programs-an-illustrative-example-report.pdf*

4 *http://www.californiahealthline.org/insight/2012/why-basic-health-plan-failed-and-why-coops-may-succeed*