Basic Health Program: Issue for Consumers and States

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Overview

- Federal law
- Options
- Issues

But first

A WORD ABOUT AFFORDABILITY

Premiums and actuarial value of coverage for a single, uninsured adult, at various income levels qualifying for subsidies under the ACA

FPL	Monthly pre-tax income	Monthly premium	Actuarial Value (AV)
150	$1,354	$54.15	94%
175	$1,579	$81.34	87%
200	$1,805	$113.72	87%
225	$2,031	$145.70	73%
250	$2,256	$181.63	73%

Note: assumes 2010 FPL levels.

Examples of health plans at various actuarial value levels

AV	Annual deductible	Office visits	Inpatient hosp.	Prescr. drugs
93 percent	None	$20 copays	$250 co-pay	$10/$25/ $45 copays
87 percent	$250	$15	$100 co-payment, then 10%	25% of all costs

Source: Congressional Research Service, 2009.

Maximum repayment obligation for tax credit recipients, by income

	Single filer	Joint filer
<200 percent FPL	$300	$600
200-249 percent FPL	$500	$1,000
250-299 percent FPL	$750	$1,500

I.

FEDERAL LAW

Who qualifies for the Basic Health Program (BHP)?

- Requirements
  - At or below 200 percent FPL
  - Ineligible for Medicaid, CHIP, Medicare
  - Citizen or legally present immigrant
  - No access to affordable, comprehensive ESI
- Major groups
  - Adults 133-200 percent FPL
  - Immigrants 0-133 percent FPL, ineligible for Medicaid
  - Possibly, CHIP children if allotments end after 2015

What happens to consumers in BHP?

- No subsidized coverage in the exchange
- State contracts with plans or providers
- All essential benefits must be covered
- Premiums may not exceed levels that would be charged in the exchange
- Actuarial value may not fall below specified levels
- **Note: states can provide more generous coverage, such as the coverage furnished by Medicaid and CHIP**

BHP dollars

- Federal government pays 95 percent of what it would have spent for tax credits and OOP cost-sharing subsidies if BHP members had enrolled in the exchange
- Federal dollars
  - Go into state trust fund
  - Must be spent on BHP enrollees

II.

OPTIONS

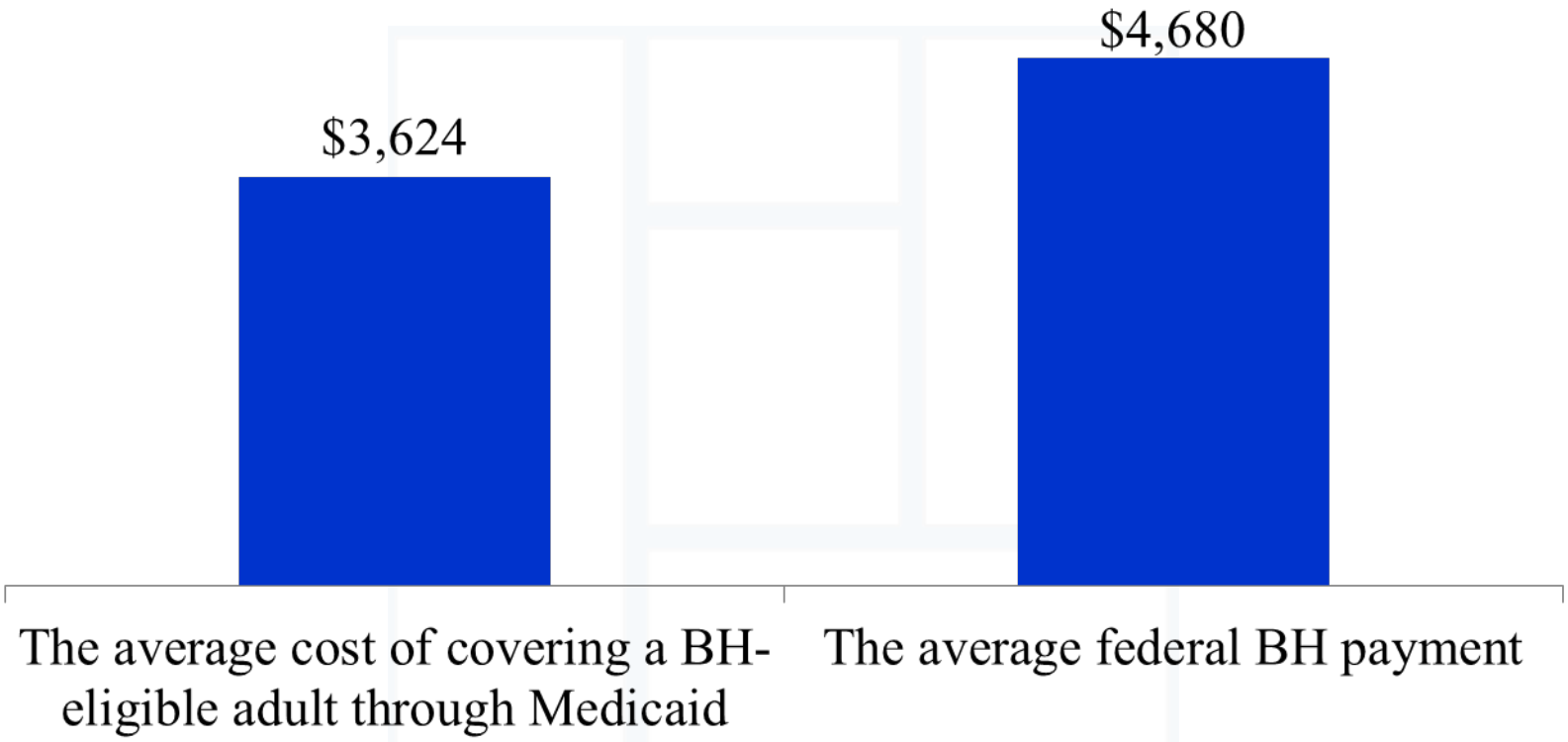
Building on existing programs to make coverage more affordable

- Medicaid look-alike
- "CHIP for adults"
- Integrating Medicaid, CHIP, and BHP to fund a single program provide all residents up to 200 percent FPL with coverage like that furnished by Medicaid and CHIP
- "Two-way bridge" – BHP consumers choose between Medicaid plans and exchange plans

III.

ISSUES

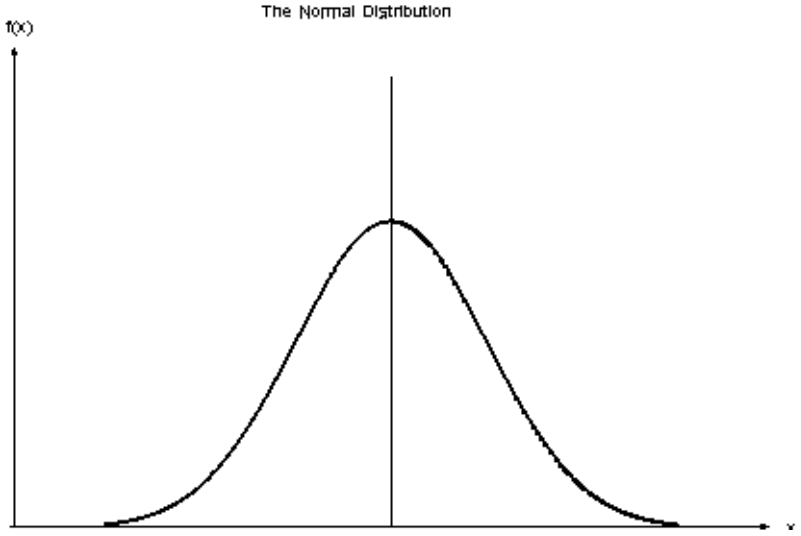
BHP federal payments vs. the cost to cover BHP members through Medicaid: national averages



Source: Urban Institute, 2011. *Note*: Results assume full implementation of Affordable Care Act in 2010, and merger of individual and small group markets. If those markets were separate, the excess of BH payments over Medicaid costs would fall.

Policy issue

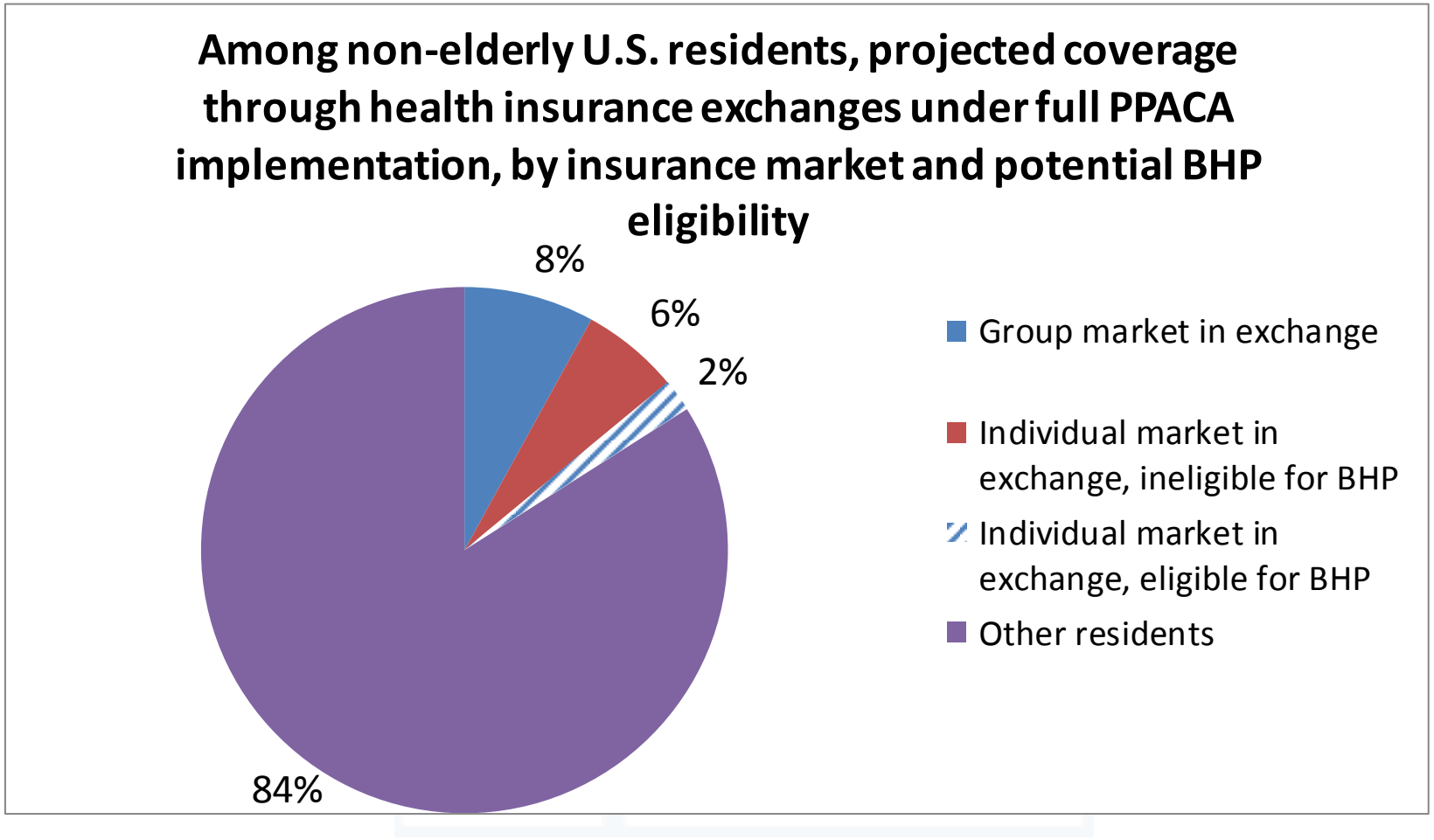
- Analysis assumes normal distribution of private insurance premiums
  - Tax credits pegged to cost of "reference" plan (second-lowest cost silver plan)
  - If reference plan is very inexpensive Medicaid plan, tax credit amounts, hence federal BHP amounts, will fall



State cost savings

- Adults with MAGI >133 percent FPL
  - Who? Pregnant women, in some states parents & others
  - By ending these adults' Medicaid and shifting them to BHP, the state saves money without forcing these adults to pay more
  - Could save money by putting them in the exchange, but would harm state residents without the state saving more
- Medically needy – retain eligibility
  - If get comprehensive coverage, slower spend-down, so state savings
  - Even slower spend-down and more state savings if, compared to exchange, BHP:
    - Lowers OOP costs and
    - Covers more long-term care
- Legally present immigrants ineligible for Medicaid

Effect of BHP implementation on exchange size



Source: Urban Institute, 2011. *Note*: Individuals eligible for BHP are those with incomes <200% FPL who would receive subsidies in the exchange without BHP. http://www.urban.org/UploadedPDF/412267-america-under-aca.pdf.

Effects of BHP implementation on exchange size

- Exchange large enough for viability
- Leverage shifts from exchange to state-purchased coverage
  - Potential for savings to accrue to states rather than to federal government
- Fixed administrative costs spread over smaller population

Effect of BHP implementation on risk level of exchange

- What counts is effect of BHP implementation on the entire individual market—the exchange does not stand alone (if insurance rules work)
  - Insurers pool all individual market enrollees together, both inside and outside the exchange
  - Risk-adjustment, reinsurance, risk-corridors
- Key variables
  - If individual and small group market merged, BHP will have little effect on risk
  - If Medicaid cut back above 133 percent FPL, BHP implementation could improve the remaining risk pool
- State policy option to further reduce risk effects
  - Include BHP in reinsurance, risk adjustment mechanisms
  - If BHP plan is state-licensed, pool risk with other individual market plans

Continuity of coverage and care

- With a transition point between Medicaid and the exchange at 133 percent FPL, >35 percent of low-income adults will need to change programs at least once every six months*
- BHP moves the transition point between Medicaid and the exchange from 133 to 200 percent FPL. This improves continuity, since, at lower income levels:
  - Many more subsidy recipients
  - Much more income fluctuation
- Why continuity matters
  - Continuity of provider is clinically significant
  - Churning raises administrative cost
  - Continuity increases incentive to invest in long-term wellness

*Benjamin D. Sommers and Sara Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," *Health Affairs,* Feb. 2011, 30(2):228-236.

Access to providers and plans

- Providers
  - With Medicaid plans, lower provider payment, more limited provider networks
  - Can raise BHP provider payments > Medicaid levels, without state cost
    - Use excess of federal BHP dollars over Medicaid baseline
    - Slightly higher OOP costs
    - Negotiate for higher medical loss ratio
- Plans
  - Lose access to commercial plans
  - Retain access to safety-net plans

Conclusion

- Implemented to build on existing Medicaid and CHIP models, BHP could dramatically improve affordability for low-income consumers ineligible for Medicaid—usually at zero cost to the state
- In many states, BHP can cut Medicaid spending without taking away benefits or increasing costs to people who currently qualify
- Biggest trade-off for consumers: provider networks
- Important to track evolving federal policy and analyze state conditions
- For more information, see Stan Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States,* prepared by the Urban Institute for the State Coverage Initiatives program of AcademyHealth, March 2011, http://www.statecoverage.org/files/TheBasicHealthProgramOptionUnderHealthReform.pdf.