BASIC HEALTH PLAN:
Is it an option for your State?

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Charting the Road to Coverage

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AGENDA

- Statutory Requirements
- Goals of a Successful BHP
- Assessment of BHP Option
- Consideration and Implications
- Open Implementation Issues
- Alternatives to BHP

STATUTORY REQUIREMENTS

- **Enrollee Eligibility Requirements**
- **Benefit & Cost Sharing Requirements**
- **Delivery Model Requirements**
- **Contracting Requirements**
- **Financing Requirements**

Enrollee Eligibility Requirements

- Eligible to enroll in a QHP
- Income between 133% and 200% of the FPL and ineligible for Medicaid
- Lawfully present immigrants below 133% of FPL who are not eligible for Medicaid
- Under age 65
- No access to employer- or government-sponsored "minimum essential coverage"

BHP Eligible individuals may not enroll in QHPs

Benefit & Cost Sharing Requirements

- Must cover at least essential health benefits
- Enrollee's monthly premium cannot exceed second-lowest silver plan, based on income
  - 3% at 133% FPL
  - 6.3% at 200%
- Enrollee cost-sharing cannot exceed:
  - platinum plan for individuals with incomes below 150% FPL
  - gold plan for individuals with incomes between 150%-200% FPL
- If offered by health insurance issuer, must have MLR greater than 85%

Delivery Model Requirements

- Managed care plans or “systems that offer as many of the attributes of managed care as are feasible”
- May include:
  - Licensed HMO
  - Licensed health insurer
  - Network of health care providers “established to offer services under the program”

Contracting Requirements

- States must use competitive selection process
  - Include care coordination and incentives for use of preventive care
  - Maximize patient involve in health care decisions
  - Offer multiple standard health plans to extent feasible
- Establish specific quality measures
  - Report to State
  - Make available to enrollees
- Offer multiple plan options to extent feasible

Financing Requirements

- 95% of tax credit subsidy BHP enrollees would otherwise have received in second-lowest silver plan
- 100% or 95% of cost sharing reduction BHP enrollee would otherwise have received linked to:
  - platinum plan for individuals with incomes < 150% FPL
  - gold plan for individuals between 150–200% FPL
- Amount of payment to state must take into account:
  - enrollee's age, income, health status, geography
  - whether any reconciliation would have occurred
  - experience of other states with respect to Exchange enrollees below 200% FPL
- State must establish trust to hold funds that may *only* be used
  - to reduce premiums or cost sharing
  - to provide additional benefits

Goals of Successful BHP

Minimize State's financial exposure

Maximize coverage and care across the *full* continuum

- Medicaid/CHIP
- BHP
- QHP (subsidized and unsubsidized)

Smooth transition points

- Benefits
- Plans
- Providers
- Cost sharing

ASSESSMENT OF BHP OPTION

Step One: Assess Financial Feasibility of BHP for State

Step Two: Assess Logistics of Administration of BHP

Step Three: Assess Delivery Model Options

Step Four: Assess Impact on Exchange

Potential BHP Eligibles in Context

Coverage Source	Population	
Newly Eligible Medicaid/CHIP	16M	Medicaid/CHIP total: 51M
Currently Eligible Medicaid/CHIP	35M	
Basic Health Plan (133-200% FPL)	5.5M	BHP total: 5.5M
Subsidized Private Insurance through QHPs (201-400% FPL)	13.5M	Individual Coverage through QHPs total: 18.5M
Unsubsidized Private Insurance through QHPs	5M	

STEP 1

Assess Financial Feasibility of BHP for State

1. **Determine** size and demographics of eligible population likely to enroll
2. **Estimate** value of second lowest cost silver plan
3. **Calculate** value of premium tax credit and cost sharing reduction – amount HHS will transfer to State trust fund
   - Consider whether additional State dollars are available
4. **Calculate** cost of purchasing BHP; iterative process considering key toggles
   - Benefits covered (EHB, Medicaid benchmark or standard, other)
   - Consumer cost sharing
   - Provider network and provider reimbursement
     - What providers rates are necessary to attract providers?

STEP 1

Assess Financial Feasibility of BHP (cont')

5 **Calculate** difference between BHP related revenue and BHP cost

- funds received from federal government for premium credits and cost-sharing subsidies *plus*
- any state dollars available *plus*
- enrollee cost sharing amounts *minus*
- cost of BHP

(a + b + c) – d = State Exposure

STEP 2

Assess Logistics of Administration of BHP

- Administrative responsibilities include:
  - Federal certification
  - Plan/delivery system criteria
  - Plan contracting and oversight
  - Management of trust fund
  - Eligibility and enrollment process
  - Funding reconciliations

Key Questions

- Does State have bandwidth to operate a new health insurance program?
- What agency will operate BHP, considering, expertise and efficiencies?
  - Medicaid
  - Insurance
  - Exchange
- With what resources?
  - BHP trust fund
  - Plan assessments
  - Federal Exchange funding in 2014
  - State dollars

STEP 3

Assess Delivery Model Options

- Considerations
  - Plan alignment (MMC, CHIP, QHP)
  - Provider alignment
  - State's financial risk if using non-capitated model
- Plan/Delivery model options
  - Medicaid managed care plans
  - CHIP plans
  - QHPs
  - PCCM
  - ACO or other forms of integrated delivery systems
  - Medicaid FFS

STEP 4

Assess Impact on Exchange

State	% of non-elderly in Exchange	% between 133 – 200% FPL
Alabama	6.8	38.9
California	10.1	36.6
Colorado	10.7	28.1
Maryland	8.0	29.1
Massachusetts	5.4	27.4
Michigan	9.2	27.8
Minnesota	9.5	32.4
New Mexico	9.6	33.1
New York	8.3	36.4
Oregon	10.2	35.9
Rhode Island	9.0	28.5
Virginia	7.9	37.7
Washington	9.1	31.1

Source: Urban Institute, *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid,* Timely Analysis of Immediate Health Policy Issues, March 2011

CONSIDERATIONS & IMPLICATIONS

Financial Benefits & Risks of BHP for State

BENEFITS

- Opportunity to replace State dollars*
  - Adults >133% covered under Medicaid
  - Family planning waivers
  - Breast & Cervical Cancer Programs
  - Programs for HIV+ patients
  - Legally present immigrants and other adults covered with state-only funds

* Same opportunity exists with QHP, but consumer cost-sharing increases.

RISKS

- Cost of second lowest silver plan over estimated
- Cost sharing amount over estimated
- Reconciliation results in downward adjustment
- Non-capitated delivery system model

Coverage Transitions: Benefits & Risks of BHP

BENEFITS

- Smoothes transition at 133% FPL
  - Cost-sharing
  - Benefits
  - Plans
  - Providers
- Opportunity to align families with children's coverage

RISKS

- Potential for new program silo
- Creates transition point at 200% FPL
  - Cost-sharing
  - Benefits
  - Plans
  - Providers

Maximizing Coverage: Benefits and Risks of BHP

BENEFITS

- More affordable coverage
- Increases take up rates
- Decreases adverse selection
- No reconciliation risk for individual

RISKS

- Potentially more limited provider networks
- May reduce access for Medicaid beneficiaries
- May weaken Exchange
  - –Scale/market leverage
  - –Risk
  - –Financing of administrative infrastructure

Addressing the Risks: Financing and Transitions

- Financing
  - Use capitated delivery model
  - Seek federal policies to minimize risk of miscalculation and reconciliation in first year and beyond
  - Start early
  - Delay start-up until 2105 or 2016
- Transition Points (133% and 200% FPL)
  - Coordinate procurement strategy and standards across Medicaid, BHP, QHP
  - Align (some) plans
  - Minimize benefit and cost-sharing cliffs at both ends
  - Align provider networks
    - Evaluate impact of provider reimbursement rates
  - Ensure seamless eligibility and enrollment system
  - Target consumer assistance to transition points

Defining the Coverage Risk

- **The Role of the Exchange:**

  "Starting in 2014, individuals and small businesses will be able to purchase private health insurance coverage through State-based competitive marketplaces called Affordable Insurance Exchanges.... Exchanges will offer Americans competition, choice and clout. Insurance companies will compete for business on level playing field, driving down costs. Consumers will have a choice of health plans...."

  Executive Summary, Proposed Exchange Regulations, Aug. 17, 2011

- **The Question:**

  Can a State implement a BHP without undercutting or diminishing the ability of the Exchange to secure value for individuals with incomes greater than 200% of the FPL purchasing coverage through the Exchange?

- **The Risk to the Exchange includes:**
  - Scale/leverage
  - Risk profile of remaining Exchange enrollees
  - Financial sustainability

Addressing the Risks: Coverage

- BHP “purchased” or procured through the Exchange
- Plans aligned across all products
- QHP and BHP risk pool combined
- Exchange administers BHP certification, trust fund, eligibility and plan selection process
- BHP assessed or assessments on other plans support BHP administrative costs

ACA requires coordination of eligibility and enrollment for Medicaid, CHIP, BHP & QHP

Open Implementation Issues

- Federal Certification process
  - How will States secure approval initially?
  - What will be the review process going forward?
- How will Secretary determine initial value of second lowest cost silver plan?
  - Will there be any downside protection for states?
- Will Secretary require approval of provider networks?
- Can trust fund dollars be used for administration?
- How will the Secretary determine the amount the state receives for advanced tax credit? For cost-sharing reduction?
- How will reconciliation work?
  - When enrollee's income goes up
  - When enrollee's income goes down
- How will risk adjustment work?
  - May state use one risk pool for BHP and individual market?
- What will be the impact of different provider rates?

Possible Alternative Approaches to Advancing Affordability Goal

- Use “saved” state dollars to reduce QHP cost sharing
  - Adults covered above 133% FPL
  - Family planning waivers
  - Breast and Cervical Cancer programs
  - Other programs with eligibility levels above 133% FPL
- Offer Medicaid MCOs as Continuing Coverage Source
  - MCO would have to meet QHP standards
  - Only available to individuals coming off Medicaid
  - Lower premiums mean subsidy goes further and cost sharing reduced

For More Information

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