IOWA HBE PMO PROJECT

BASIC HEALTH PROGRAM (BHP)

VERSION: 2.0
STATUS: FINAL REPORT

NOVEMBER 30, 2012

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Document Information

Document Title	< Report Title>
Version	1.0
Document Approval Date	
Author	
Approved By	

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Amendment History

Document Version	Date	Modifications
1.0	April 16, 2012	Initial Submission
2.0	June 28, 2012	Final Submission
2.0	November 16, 2012	Updated date

1. Executive Summary

While the decision to implement a Basic Health Program (BHP) continues to be evaluated by Iowa, this report is intended to identify and discuss certain additional policy, strategic and financial issues that should be considered by Iowa as part of that decision-making process.

Iowa's decision to continue to consider implementing a BHP is rooted primarily in the following findings contained in a report prepared by the Urban Institute:

- Average annual cost (Premium and Out-of-Pocket) to enrollees will decrease by $1,496 in a BHP compared to purchasing health insurance in the non-group exchange;
- Federal funding for BHP payments will be 21.4% higher than baseline costs;
- The uninsured rate in Iowa would decrease by 5,630 individuals from 183,578 (7.0%) to 177,948 (6.8%) as a direct result of the BHP; and
- The loss of membership to the health benefit exchange and the resulting impact on its financial viability would be modest.

Wakely was not asked by Iowa to validate the findings above or question the preliminary assessment by Iowa to continue to explore the possibility of implementation, but to expand on certain other aspects of the BHP that would provide additional context and perspective to more fully inform future state decision making. Our findings are as follows:

- A significant financial element of the BHP is to reimburse providers at or near Medicaid payment levels. While such a scenario is possible, sensitivity analysis indicates that if baseline costs increase by approximately 25% or greater, the program may be in a deficit, creating a liability for the state;
- The competitive dynamic of the carrier market in Iowa appears to be favorably structured to introduce a BHP and attract the interest of carriers to participate;
- Although the exchange could lose between 23 – 32% of its enrollment base, it is reasonable to expect that is will still have enough scale to be financially self-sustaining; and
- A number of operational functions will be required in order to administer a BHP. While Iowa does have a limited Medicaid Managed Care program, which is a likely candidate to leverage for a BHP, a more suitable candidate for Iowa to leverage are certain elements of its hawk-i program.

As the BHP is a complex program with a lot of current uncertainty and unknowns that are difficult to model, we recommend that the state delay a final decision on the BHP until further analyses and more definitive regulations are published by the federal government regarding the

calculation of state payment rates, how will payments be adjusted to reflect BHP risk levels, and other methodological questions regarding risk pooling and payment calculation.

Additionally, we would also recommend that another Iowa-specific analysis be completed after the release of the federal BHP regulations, which will allow for a refresh of the findings represented in the Urban Institute Report.

Finally, beginning a discussion as soon as possible with carriers and providers regarding the BHP option will provide Iowa with important market data. A decision to move forward with a BHP should not be finalized until the state can solicit feedback from these extremely important stakeholders.

2. BACKGROUND

Wakely Consulting Group (Wakely) has been hired by the State of Iowa, through a subcontract with CSG Government Solutions, to develop a document that builds on a report prepared by the State (see *Appendix 1 – 9.1*) that recommends the state continue to study the implementation of a Basic Health Program (BHP). This State-prepared report was based primarily on data produced by the Urban Institute and contained in a report prepared by the Urban Institute for the Association for Community Affiliated Health Plans titled: "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States", dated September 2011 (see *Appendix 1 – 9.2*).

Wakely's report builds off of the state prepared report by identifying and discussing additional policy, strategic, and financial issues Iowa will need to wrestle with in implementing a BHP should it decide to move forward. More specifically, Wakely discusses the following in relation to implementing a BHP:

- A conceptual discussion regarding the impact on health status of the non-group risk pool,
- Cost implications to the State of Iowa,
- Financial impact on the Exchange,
- Carrier participation, and
- Operational needs for a BHP.

This report is intended to provide the State with additional implementation details regarding a BHP, so the State can fully assess, weigh, and prioritize all of the issues, as it continues with its decision-making process.

3. Summary of The Basic Health Program (BHP)

The Affordable Care Act (ACA) offers states the option of creating a Basic Health Program (BHP) to those with incomes at or below 200% of the Federal Poverty Level (FPL) and are ineligible for Medicaid or CHIP. Without a BHP, these individuals would be accessing premium tax credits and cost-sharing subsidies through a federally facilitated or state-based exchange. States electing a BHP would contract with one or more health plans offering at least the level of coverage required of plans provided through exchange.

To be eligible for a BHP, state residents must be under age 65, and not eligible for Medicaid, CHIP, or other minimum essential coverage or for employer-sponsored coverage that is "affordable," as defined by the ACA. Individuals must have incomes greater than 138% of the FPL, and at or below 200% of the FPL. Lawfully present aliens who are not eligible for Medicaid and who have incomes below 133% of the FPL are also eligible. In a state with a BHP, individuals eligible for the BHP are not eligible for the exchange.

An important policy goal of the BHP is to eliminate the difference in benefits and cost sharing between Medicaid and an affordable health benefit plan typically offered in the commercial health insurance market. This transition in benefits and enrollee cost sharing or "cliff effect" as it is commonly called, can be difficult for individuals moving between Medicaid and the commercial market. The BHP can offer more of a glide-path between the two markets, by offering benefits and cost sharing that while less than a typical Medicaid plan (i.e. more costly to the enrollee), will be of higher value to the enrollee through less premium and point-of-service cost sharing.

While final guidance has not been issued by the federal government establishing how the BHP payments to the states would be calculated, based on the spirit of the ACA language it is expected that states choosing to establish a BHP would receive federal funding equal to 95% of the premium tax credits and 95% of the cost-sharing subsidies that BHP members would have received had they purchased coverage through the exchange.

Primarily based on a report produced by the Urban Institute for the Association of Community Affiliated Health Plans, Iowa has tentatively recommended moving forward with the implementation of a BHP.

4. Impact on the Health Status of the Non-group Risk Pool

Understanding the health status of the BHP population relative to the remaining exchange population is an important evaluative criterion with implications beyond the BHP. For example, if the health status of the BHP population is significantly healthier than the remaining exchange population, then the cost of premiums in the exchange would increase. While this premium increase would not affect the subsidized-eligible population, as their total cost is tied to income levels, it would affect the rest of the purchasers in the non-group market. Ironically, it would provide a benefit to the State through enhanced BHP payments, as an individual's premium tax credit is pegged to the second-lowest priced silver plan which would now be higher. Conversely, if the BHP population is significantly sicker than the remaining exchange population, the cost of premiums would decrease making healthcare more affordable for purchasers in the non-group market that are not subsidy-eligible. However for the State, again, as the BHP payment is tied to the second lowest-priced silver plan, the amount of revenue Iowa would receive to cover the medical cost of the BHP population would be less, subjecting the state to a revenue shortfall and potential added cost.

Nationally, based on reports published by the Urban Institute, the health care costs for the BHP-eligible population relative to the other adults in the non-group market are expected to be lower as the BHP-eligible population will tend to be younger and less costly than the population remaining in the non-group risk pool. In a separate study performed by Wakely for another state, our conclusion was similar in that the health status of the BHP population relative to the 200% to 400% of poverty population was about the same.

In the report prepared by the Urban Institute, and the basis for the State BHP White Paper, the average health care cost for the BHP-eligible population nationally is 79.0% of the level for all individual market participants under the ACA. From this same report, specific to Iowa, the average health care cost of the BHP-eligible population is estimated to be 96.8% of the individual market participants. This relative neutrality in the average health care costs suggests that implementing a BHP would not materially affect, in either direction, the rest of the non-group market in Iowa, and just as importantly, lowers the concern that the BHP-eligible population is significantly sicker than the rest of the non-group market, thus eroding the difference in BHP payments to cover the cost of medical care for BHP enrollees.

Before a final decision is made by Iowa in regards to a BHP, Wakely would suggest that the analysis regarding heath status be repeated using state-specific data, or through commissioning a micro-simulation study similar to the report in which the State recommendation is based. Many of the analytical reports have important limitations, are somewhat dated, and should be

refreshed to ensure the most recent data available has been analyzed and assessed by Iowa. Analyzing enrollment and claims data received directly from the carriers based on Calendar Year 2011 dates of service or later, and having the ability to work directly with the local carriers to ensure data integrity, will provide Iowa with the most robust dataset in which to perform the analysis.

5. Cost Implications to the State of Iowa

In addition to the health status question regarding the BHP-eligible population, another important element in deciding whether to move forward with a BHP implementation is the question regarding potential state costs.

As noted earlier, BHP payments to the state to cover the medical and administrative cost of this population is pegged to 95% of the amount that BHP enrollees would have received as premium tax credits and 95% of cost-sharing subsidies if they were purchasing health insurance through the exchange. The sum total of this payment, along with any member premiums imposed on BHP enrollees, represents the total funding stream the state will receive to cover the cost of the population. If medical and administrative costs are below this revenue stream, the state must reinvest the surplus back into the program. If costs are above this revenue stream, the state will need to offset the full amount. Going forward, the state could manage the medical expenses by reducing member benefits, increasing member premiums, or both, but such changes are not likely to be implemented retroactively, so should the program be in deficit, the state will likely be absorbing some cost prior to implementing any such programmatic changes.

The financial lynchpin of the BHP economics is driven primarily by the cost of goods sold. That is, reimbursement payments made to providers under a BHP are expected to be at or near Medicaid payment levels, while the BHP revenue payment to the state is based on premium levels reflective of provider reimbursement rates at or near commercial levels. Therefore, one of the most significant financial assumptions is the ability of carriers to contract with providers at Medicaid rates for the BHP population.

To sensitize Iowa to this issue, we have taken the baseline assumption for Iowa from the Urban Institute Report (*Figure #1*) which indicates that the annual BHP cost of care per enrollee at 98% actuarial value, which is a Medicaid-like level of benefits, will be approximately $3,919. The corresponding BHP Revenue Payment inclusive of annual Member Premiums of $100, is $4,757. The result is an annual per enrollee savings (or revenue above cost) of $858 or $33,520,000 for all enrollees assuming a BHP enrollment level of 40,000.

Figure #1

Annual/Enrollee		Savings	
Cost of Care	BHP Payment	Per Enrollee	All Enrollees
$3,919	$4,757	$858	$33,520,000

As identified in an earlier section, the health status of the BHP population in Iowa is expected to be slightly better than the remaining non-group market, thus we could reasonably expect underlying utilization to be similar for both risk pools on an ongoing basis (although the smaller BHP risk pool makes it more vulnerable to larger utilization swings and cost outliers). However, Medicaid provider payment rates can be as low as 25-50% of prevailing commercial rates depending on the provider type, with Hospitals generally receiving a higher differential than physicians and ancillary providers. So although utilization may trend higher due to the smaller risk pool size, increases in provider rates are much more likely. To underscore the sensitivity of this increased cost to the overall BHP economics, whether through utilization, provider payments rates, or some combination on expected BHP savings, we have modeled increases in the BHP cost of care by 10% increments and compared to the BHP payment which would remain constant, as that figure is driven by the second-lowest priced silver plan on the exchange (*Figure #2*). The result is that at a 20% increase there is a modest annual savings of $54 per enrollee and $2.2 million for all enrollees. At a 30% increase, which is not unrealistic based on average differences nationally between Medicaid and commercial provider payment rates, there is a loss of $338 per enrollee for a total annual cost of $13.5 million for all enrollees.

Figure #2

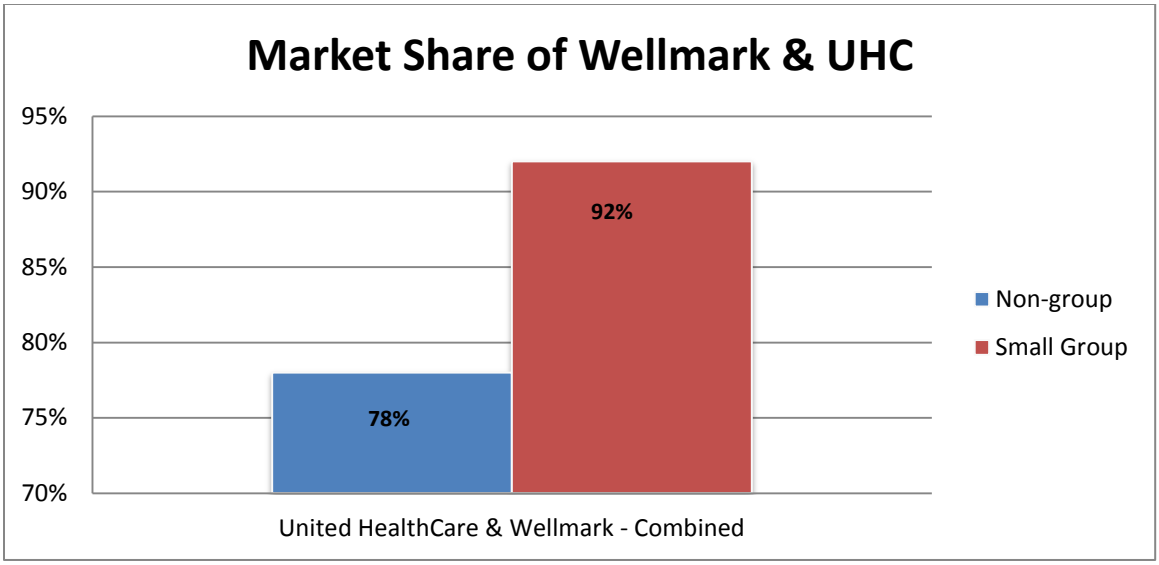
	Annual/Enrollee		**Savings/(Cost)**	
	Cost of Care	BHP Payment	Per Enrollee	All Enrollees
	$3,919	$4,757	$858	$33,520,000
Provider Cost Factor:				
1.1	$4,311		$446	$17,844,000
1.2	$4,703		$54	$2,168,000
1.3	$5.095		($338)	($13,508,000)
1.4	$5.487		($730)	($29,184,000)

While any estimate is highly speculative at this time, this simplified model does highlight the fact that at cost increases that are not improbable, deficits can occur. Thus, it will be prudent for Iowa to prepare for the potential of a loss in the program.

6. Assessment of the Carrier Market relative to a BHP program

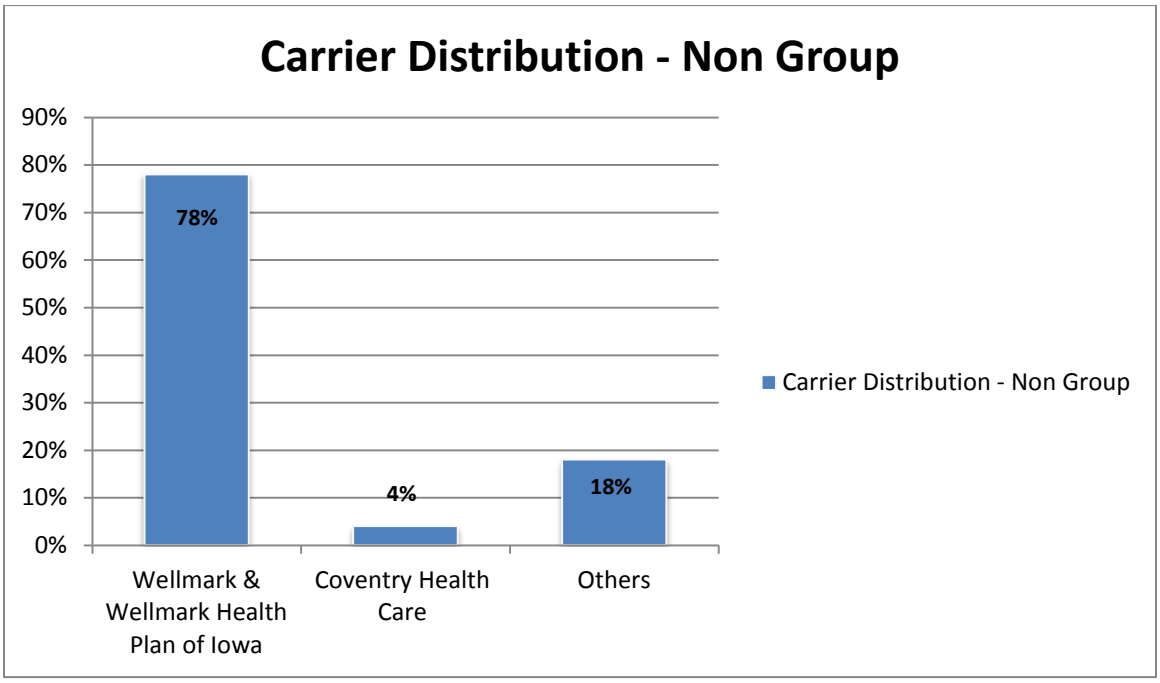
Carrier willingness to participate in a BHP program is a critical gating issue for the state in determining whether or not to move forward with implementation. Iowa is a highly concentrated market in which two carriers, Wellmark and UnitedHealthcare (UHC) dominate the landscape (*Figure #3*).

Figure #3



In assessing the Iowa market, studying the carrier participants in the non-group market is more directly relevant for the BHP, as carriers in this market segment have experience managing the health care needs of individuals and their families, and are more likely to consider participating in a BHP than carriers that do not participate in the non-group market. In the Iowa non-group market, Wellmark Inc. and its subsidiary, Wellmark Health Plan of Iowa, account for a whopping 78%, while Coventry Health Care has 4%, and four other carriers make up the remaining 18% (*Figure #4*).

Figure #4



What is notable here is that UHC, despite a strong presence in the non-group market nationally, does not participate in the non-group market in Iowa. Additionally, the four carriers that make up the 18% market share, do not have managed care organizations in their portfolio, are generally not offered in state subsidized health insurance programs, and therefore not likely to be interested or capable of organizing the care of enrollees in a BHP program. This leaves two carriers in the non-group market as likely state partners for a BHP: Wellmark and Coventry Health Care.

For Iowa however, this conclusion does not reveal the full competitive dynamic. As noted in *Figure #1* above, UHC has a strong market presence in Iowa. Although this market presence is in the small and large group market, with market share of approximately 26% and 10% respectively, nationally they have a large book of business in the non-group market. Therefore, although not participating in the Iowa non-group market, they are a carrier that has the institutional experience and capabilities to manage a non-group like BHP population and should be considered as a possible carrier partner.

Finally, one other dimension to the carrier assessment relevant for the BHP program is the amount of carrier overlap between the non-group market and the state's Medicaid Managed Care, or other state subsidized health insurance programs, and the state's non-group market. Medicaid Managed Care Organizations are generally very attracted to the BHP program due to their familiarity and ability to manage the care of low-income individuals, including the

coordination that is likely to be required with a state's Medicaid program such as eligibility, enrollment, and provider networks. An additional aspect of a Medicaid Managed Care Organization that distinguishes it from commercial carriers is the competitiveness of their provider fee schedules, and their overall lower administrative cost structure. Additionally, Wellmark and UHC participate in the state subsidized hawk-i program, which is a capitation-based program for low-income children up to 300% of poverty. This program is similar administratively to how Medicaid Managed Care and a BHP would operate in the state and therefore could be a salient data point in determining a carrier's willingness to participate in a BHP. Additionally, Coventry and UHC do participate in Medicaid Managed Care programs nationally, so all three of the major carriers in Iowa, based on market share, either participate in the local Medicaid Managed Care-like program called hawk-i, or a Medicaid Managed Care Program nationally, or both.

We have summarized at *Figure #5* a listing of the local carriers, and the markets in which they have a presence in Iowa or nationally, that are relevant to the question as to whether or not a BHP may be more or less attractive to participate should Iowa decide to move forward.

Figure #5

	Hawk-i	Medicaid MC	Non-group	Small Group
Coventry Health	No	Yes	Yes	Yes
UHC	Yes	Yes	Yes (not Iowa)	Yes
Wellmark	Yes	No	Yes	Yes

In summary, despite an initial assessment that Iowa, as a highly concentrated carrier market may be challenged in creating a competitive environment interested in a BHP program, a deeper look at the market data and a critical assessment of the carriers participating in Iowa offers a much different assessment. A review of the analysis provides the following:

1) Iowa has three national health care companies that have the core competency and are capable of servicing the BHP population;
2) While only two carriers (Wellmark and Coventry) are in the local non-group market, United HealthCare has a strong presence nationally in the non-group market;
3) Two of the three major carriers are offered in the hawk-i program, which may create a greater incentive from the carrier not in hawk-i to want to participate in the BHP;
4) Carriers are generally very focused on growing market share, so having three carriers competing for a limited number of enrollees could create a strong incentive from a defensive perspective to participate in a BHP;

5) One carrier (Coventry) is lagging behind the other two major carriers in local market share, has the capabilities to manage a BHP, so may be highly incented to be selected exclusively to manage this population and capture a substantial % of this market bolstering its presence in Iowa; and finally
6) Two of the three (United HealthCare and Coventry) participate in national Medicaid Managed Care programs, while the third (Wellmark) does not have a Medicaid Managed Care plan, but does participate in the local hawk-i program.

All of these elements provide a reasonably strong carrier competitive dynamic to warrant further study of implementing a BHP program. However, Iowa will need to develop a procurement process that allay the fears of the carriers regarding the uncertainty of the revenue and medical expense of the population and consider the strategic implications of administering the BHP procurement relative to the Qualified Health Plan Certification process should the state decide to implement a state-based exchange. In the next section, we explore how the state could develop a compelling value proposition for the carriers regarding a BHP, and certain synergies and disintermediation to its state-based Exchange.

6.1 BHP Procurement Options

Having the requisite carrier market to implement a BHP is only one part of the implementation puzzle. Assuming the local carrier participation and competitive landscape is satisfactorily structured for a BHP, and Iowa appears to have the right dynamic in this regard as noted above, the second important element is developing a strong value proposition as part of the BHP carrier procurement process. We have identified below five elements for Iowa to consider in developing a compelling BHP procurement process. Not all five need to be included in the final procurement specifications, and this list certainly does not represent a comprehensive list of procurement options, but the state can select some combination of the five that best meets its policy and financial goals in administering a BHP.

1. *Create a communication channel with the carriers to begin a dialogue regarding carrier interest and reservations regarding a BHP.*

   Opening up a communication channel with the carriers will be an important step before making a final decision regarding the implementation of a BHP. Often times, states do not invest the necessary time and resources to properly "vet" important policy issues with key stakeholders. The complexity of the BHP model requires significant lead time with the carriers. Information to share and areas to explore with the carriers in such meetings include; (i) any modeling the state has prepared regarding revenue estimates, medical expenses, and expected demographics of the BHP; (ii) impact on the remaining

non-group risk pool if a BHP is implemented; (iii) any modeling the carriers have performed on market demographics, or the premium level of the second-lowest priced silver plan (impact on BHP revenue yield); (iv) what elements of a BHP would make the program more or less attractive to the carriers; and (v) how would a BHP affect a carriers decision to participate in the Exchange?

The meetings can be scheduled solely for the BHP topic, or can be coordinated with any discussions with the carriers regarding a state- based heath benefit exchange certification process. It is also generally helpful to have one meeting in which all of the carriers participate together and then separate follow up meetings with key carriers individually, as information shared by the carriers is more likely to be unfiltered in the individual meetings.

2. *Administrative ease in operating the program.*

Wherever possible, the state should make every effort to reduce the administrative burden on carriers of participating in a BHP. This area has the dual benefit of making the program more attractive to carriers, but can also help in lowering the overall cost of care to the enrollees. Likely areas to target in this regard include the level of reporting the state requests of the carriers. Often times, the state will require a tremendous amount of detailed reports from the carriers as a condition of participation. While access to information will be critical to managing and evaluating the overall effectiveness of the program to the state and beneficiaries, the state should ensure that all data requests are coordinated with other state agencies, including reports and data that will be required by the Exchange. In addition, the state should ensure that only critical data and information is required and the frequency of the submission is realistic. A good place for Iowa to review for lessons learned, as well as leveraging and coordination opportunities, is the Medicaid and hawk-i programs.

3. *To the extent possible, assistance with provider payment rates.*

One of the biggest obstacles to carriers desiring to participate in a BHP will be developing a provider network at Medicaid fee schedule rates. A lynchpin of the economics of a BHP is the ability for carriers to contract with providers at Medicaid levels or modestly above. Most providers will already be squeezed by carriers due to the implementation of the medical loss ratio regulation, the imposition of carrier fees, and other elements of the ACA roll-out. Providers in the market will be fully cognizant of the trade-off for the BHP population: contract with carriers for the BHP population and get a modest increase on poorly paying Medicaid rates, or do not contract and potentially

receive significantly higher commercial rates. Alternatively, not contracting with carriers may mean not having access to this population, but with the expansion of Medicaid and more insured through the Exchange, most providers will be dealing with capacity constraints.

The state should carefully review its legislative options and its ability to influence important provider networks in determining the amount of assistance it can offer to carriers on this issue.

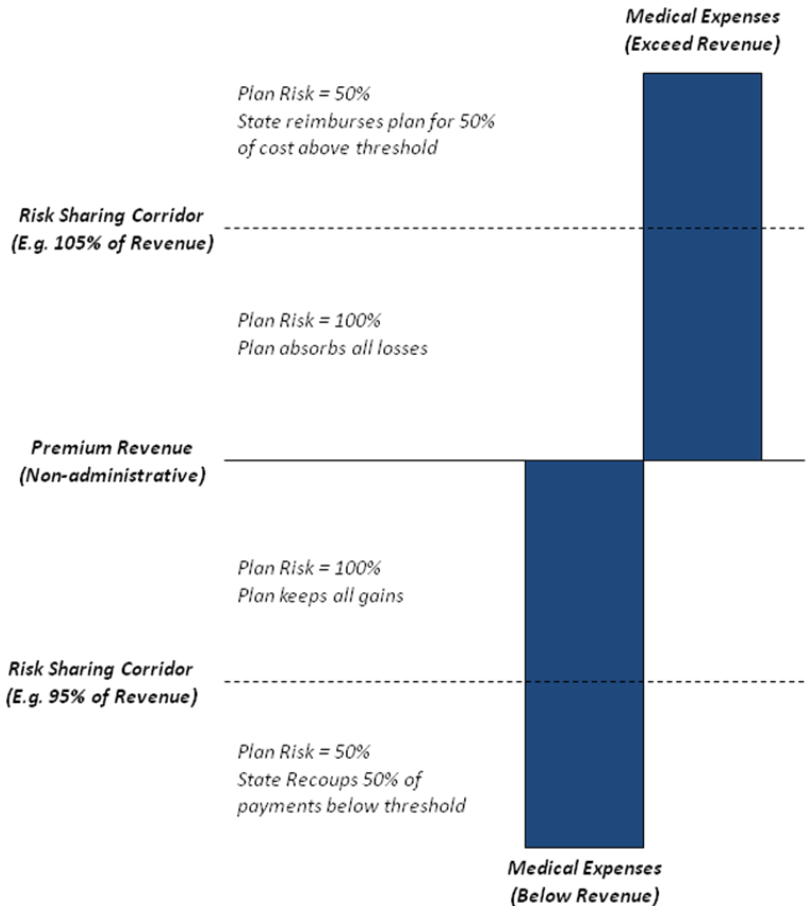
4. *Communication and Outreach plan to maximize enrollment levels.*

   Developing a strong communication plan to maximize enrollment for the 62,176 residents and legal immigrants who are eligible for the BHP will be extremely well received by the carriers. Enrollment growth is a major factor in a carrier's assessment in deciding to service any new market segment. This is especially true of the BHP to ensure a normalized risk pool, and to offset the administrative cost in developing the infrastructure for the program. As this would be an area where incentives between the state and carriers are fully aligned, understanding the perspective of the carriers and soliciting ideas on outreach to this population would be an excellent area of collaboration and partnership.

5. *Willingness to share risk with the carriers.*

   Financial administration of the BHP is likely to be structured as a risk-based capitation model in which carriers will be provided a global capitation payment and will need to manage within the budget or risk absorbing losses for actual cost above the budget (see Diagram #1 for an example). Although this area represents out-of-the-box thinking and will need to square with final federal BHP regulations, the state could have a decision-point whether or not to participate in the risk share calculation depending on the how the financing is structured. Although some carriers would prefer to retain 100% of the risk share, which allows them to retain all of the savings within a capitation amount, due to the lack of historical experience and resulting uncertainty of the BHP, as well as the number of assumptions and variables affecting both the revenue and medical expense lines, it is very likely that carriers will require states to share risk with them as a condition of participation in the program.

Diagram #1 *– Example of Risk Share Model (many variations are possible, this diagram represents one)*



Although this could result in a cost to the state, and therefore may not be a viable option, it may be necessary at least during the first few years of the program, until more certainty can be introduced into the revenue and medical expense projections. Additionally, there are many variations to how risk share could be structured to limit the state's exposure while still providing value to the carriers.

7. Impact to the Exchange – Financial & Strategic Implications

The conventional approach to funding a state-based Exchange, and the model contemplated under the ACA, is an assessment on exchange enrollment for Issuers of QHP's. States have the flexibility to solely implement this option, utilize this option with other assessment types such as assessing an Issuer of QHP's enrollment outside the Exchange, or consider a broad-based assessment on providers such as hospitals and other providers, or some other alternative developed by the state. For the purposes of this section, we will quantify the impact of implementing a BHP on the financing of the Exchange, assuming an assessment on exchange enrollment for issuers of QHP's is the model chosen by the state. We believe this will provide the most conservative impact, and thus provide the state a worst-case planning scenario for the Exchange financing.

Using a combination of data published by David P. Lind Benchmark, Data Point Research, Inc., and the Urban Institute, *Figure #6* indicates the total number of non-group and small group eligible's, as well as Exchange enrollment without and with a BHP program. Exchange enrollment with a BHP would decrease by 40,000 lives or 15.04%

Figure #6

		Exchange Enrollment		
	Total Eligible	No BHP	BHP	Difference
Non-group	437,381	171,000	136,000	35,000
Small Group	244,098	95,000	90,000	5,000
Total	*681,479*	*266,000*	*226,000*	*40,000*

However, rather than model the impact of a decrease in expected enrollment of 40,000 BHP lives, the actual impact to the Exchange would be the number of BHP eligible, due to the fact that eligibility for the BHP makes one categorically ineligible for an individual premium tax credit in the exchange. This resulting impact to Exchange enrollment can be seen at *Figure #7*, with the Exchange now expected to lose 62,176 enrollees or 23.37% of its estimated enrollment without a BHP.

Figure #7

		Exchange Enrollment		
Market Segment	Total Eligible	No BHP	BHP	Difference
Non-group	437,381	171,000	116,596	54,404
Small Group	244,098	95,000	87,228	7,772
Total	*681,479*	*266,000*	*203,824*	*62,176*

We then quantified revenue lost to the exchange as a result of this total BHP eligible population not enrolling into the Exchange. To do so, for modeling purposes only, we made the following assumptions:

- Average enrollment duration of 12 months to derive a Member Month estimate
- Average Exchange Premium Yield of $417.00
- An Exchange administrative expense load of 3%

In performing the resulting calculations (*Figure #8*), we have determined that the Exchange would lose approximately $9,333,861 in revenue, and would need to increase its administrative fee from 3.00% to 3.92% or a 30% increase in order to raise the same amount of revenue as the higher enrollment level. For simplification, we assumed the expense load would be the same at both enrollment levels. It is likely that with the implementation of a BHP, certain variable expenses of the exchange would be lower, thus the total cost of the exchange would decrease. However, due to the high fixed cost aspect of an exchange, we believe this would be a modest decrease to the overall expense of the Exchange and thus did not make an adjustment for this issue.

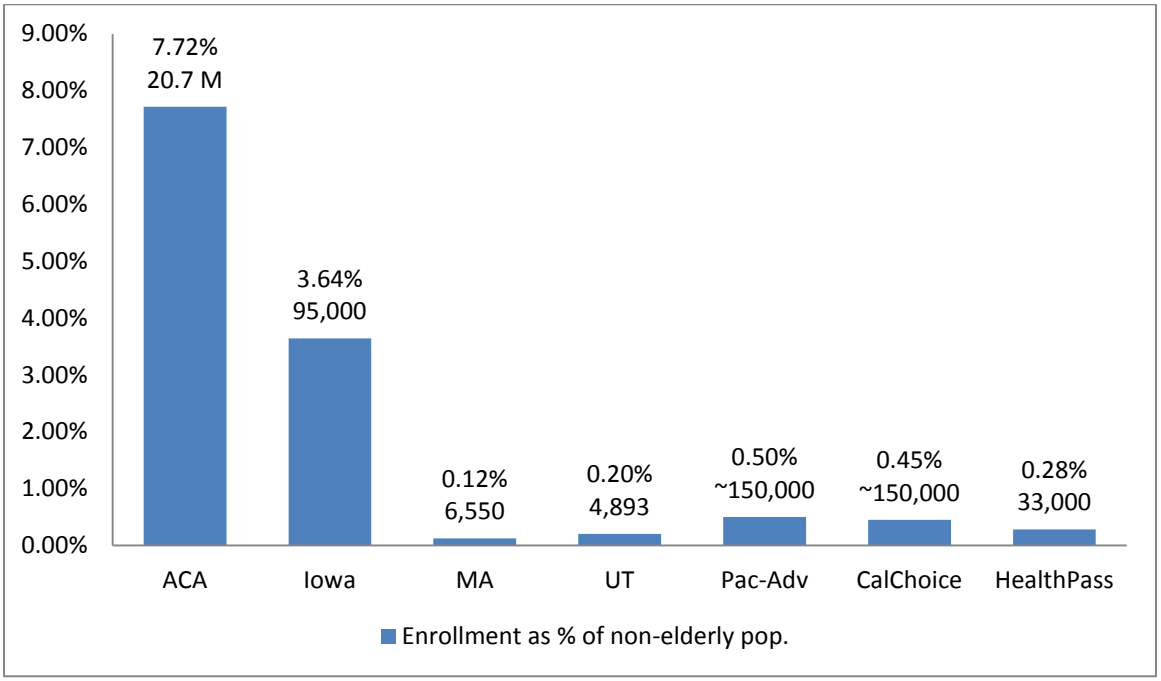
Figure #8

	No BHP	**BHP**	**Change**
MM's	3,192,000	2,445,888	
Total Revenue	$1,331,064,000	$1,019,935,296	
QHP Fee @ 3%	$39,931,920	$30,598,059	$9,333,861
Add'l Fee to offset lost revenue			0.92%

Another area we performed additional analyses is the take up rate for the small group market. The current estimated small group take-up for Iowa of 95,000 is approximately 3.5% of the total non-elderly population of Iowa. As seen in *Figure #9* below, although this is much lower than

the expected take-up under the ACA, which is closer to 8%, actual experience across the country of small employer take-up through exchanges has been under 0.5%.

Figure #9



As a result, we adjusted the Small Group take-up estimate to be 1% of the total Iowa non-elderly population which reduces the small group take-up from 95,000 to 26,122. We then modeled the impact to the exchange of removing the BHP eligible's, but from a now smaller total Exchange enrollment base of 197,122 compared to 266,000 (due to this small group adjustment). The resulting impact (*Figure #10*) indicates the Exchange would lose the same $9,333,861 in revenue, but because of the lower overall enrollment base, the scale of the exchange is significantly less and the administrative fee would need to increase from 3.00% to 4.38% or a 46% increase in order to raise the same amount of revenue as the higher enrollment level.

Figure #10

	No BHP	BHP	Change
MM's	2,365,464	1,619,352	
Total Revenue	$986,398,488	$675,269,784	
QHP Fee @ 3%	$29,591,955	$20,258,094	$9,333,861
Add'l Fee to offset lost revenue			1.38%

Although the exchange could lose between 23-32% of its enrollment base as a result of a BHP implementation, with exchange enrollment levels of between 134,946 and 203,824, we believe while certainly more difficult it is still possible for Iowa to operate a financial self-sustaining exchange. However, due to a general lack of scale even without a BHP, the exchange will need to tightly manage ongoing operational expenses and ensure the magnitude of its IT design and build does not leave it with ongoing operational IT costs that is too large for its enrollment footprint.

8. Operational Needs of a BHP

Another dimension for Iowa to consider regarding the decision of whether or not to implement a BHP are the operational needs of the program and corresponding administrative costs. Many studies have been prepared to-date outlining the estimated heath status of the population, impact on premium levels in the remaining non-group market, expected state payment rates to cover the cost of medical care provided to enrollees, and underlying provider payment rates. However despite the policy goals that could be advanced by the state in implementing this program, namely reduced health care cost for a low income population and greater continuity of care that could be provided when such members move in and out of Medicaid as is expected, a state's ability to implement such a program, and its ability to cover the administrative cost is an important aspect of the overall decision-making process.

Although not specified in regulation, a successfully implemented BHP is likely to have the following functions:

1. Member Communication and Outreach. Ensuring that the target population is aware of the program, its eligibility requirements, and how to enroll will be especially important. Calendar year 2014 will bring much change to Iowans regarding their health insurance options. Some of the options that will be available include subsidized and unsubsidized coverage through the exchange, enhanced Medicaid, and quite possibly private exchanges. Enrollee take-up for subsidized programs such as the BHP can often times is slow, as residents are not aware of the new option and communication to the target population is often difficult. Additionally, as noted earlier in this report, carriers that are considering participating in the BHP will want to maximize enrollment and will therefore, want to clearly understand how the state expects to reach out to this population.

2. Eligibility and Enrollment. A system that determines initial eligibility and tracks ongoing changes to enrollee demographic information will be required. These processes can be appended to existing systems such as hawk-i or the newly created exchange, but regardless, a significant resource effort will be necessary to develop the new eligibility logic.

3. Capitation Rate Development. There are a number of potential finance methodologies to pay for the care provided to enrollees. However, due to the need to create a financial incentive to manage enrollee costs, a capitation or budgeted-capitation model is highly likely. Additionally complexities may include the development of demographic

adjustments if more than one carrier participates (to smooth member risk issues across carriers), systems to make the capitation rate payment, and reconciling enrollment to the payment.

4. Procurement of Health Plans. As noted previously in this report, Iowa appears to be well positioned in creating carrier interest in a BHP program, but regardless of the level of interest, a sizable effort in soliciting, meeting, communication, and information sharing between the state and the carriers will be necessary.

5. Customer Call Center. Similar to the eligibility and enrollment function noted above, this function could be provided by leveraging an existing state system or vendor. However, there will still be a resource effort in developing processes and protocols for this population and member collateral materials that explain differences in the BHP and the subsidized exchange and Medicaid programs.

6. Financial Management. This function will require calculating expected state payments, forecasting medical cost, and year end payment rate reconciliation with the federal government. As a new program with a reasonable amount of complexity and high degree of variability regarding the financing of the program, this area will need to be well staffed and closely coordinated with the exchange QHP certification process.

7. Data Reporting & Analysis. As with any new state program, there will likely be a great deal of reporting required to the federal government, state legislative committees, key stakeholders, and other state agencies such as DHS, IID and the exchange.

As operating budgets are already stretched pretty thin, and excess human resources are not readily available, states electing to implement a BHP will need to get creative in regards to financing administrative costs. A likely solution, which is not currently available to Iowa, is to leverage a state's Medicaid Managed Care Program. Although there is additional cost in integrating a new program into an existing platform, economies of scale would provide a dampening of the overall total costs. One area we would recommend Iowa look to is the administration of the hawk-i program. Many of the functions required of the BHP are already performed by hawk-i, and program administrators and the current TPA possess the expertise and skills necessary to implement such a program. Additionally, as this program falls under DHS, the BHP administrative costs could be partially offset by Medicaid federal administrative matching funds which are generally 50% or higher.

Finally, one area all states will not be able to consider for funding to offset the development of a BHP administrative infrastructure is the exchange establishment grants. In an Exchange Establishment FAQ released by CCIIO, using grant money for the BHP was prohibited. However, Planning grants could be used to conduct analysis and research.

9. APPENDIX 1

9.1 State Recommendation Regarding a BHP

ACA Issue Paper
BHP (Abbreviated)

9.2 Urban Basic Health Program Report

ACAP
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