State of Iowa, Department of Human Services, Iowa Medicaid Enterprise: Basic Health Program

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State of Iowa, Department of Human Services, Iowa Medicaid Enterprise

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I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Healthcare and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), represent Federal legislation poised to change the way health insurance products are designed, sold, and administered in the United States.

The Iowa Medicaid Enterprise (IME) has engaged Milliman, Inc. (Milliman) to model the ACA defined Basic Health Program option.

The U.S. Department of Health and Human Services (HHS), through the Center for Consumer Information and Insurance Oversight (CCIIO), is responsible for promulgating regulations and guidance to assist the states in making ACA decisions. This report makes extensive use of proposed regulations and guidance published by HHS and CCIIO as of the date of this report.

This executive summary provides a high-level overview of the topics covered in this report. Readers are asked to refer to specific sections of the full report for a comprehensive discussion of these matters. It should be noted that this report is limited in its scope and is not intended to be an in-depth examination of *all* decisions and options available for consideration by Iowa.

Basic Health Program

A Basic Health Program (BHP) can be used to bridge coverage between Medicaid/CHIP and products available through the Exchange, focusing on the population that is most at-risk of moving in and out of Medicaid eligibility because of changes in income. BHP eligibility is limited to non-elderly individuals with household incomes less than 200% of Federal Poverty Level (FPL) who are not eligible for Medicaid or employer sponsored insurance (ESI) with certain exceptions based on affordability and acceptable coverage levels of ESI. Without a BHP, these individuals would be eligible for coverage through the Exchange with subsidies, but likely at a higher premium and level of cost sharing. With a BHP, these individuals would not be eligible for other coverage through the Exchange.

Potential Basic Health Program Population

The ACA allows states to create a BHP for residents with incomes less than 200% of FPL who are not eligible for Medicaid and lack affordable access to comprehensive employer-based coverage. The population eligible to enroll in the BHP includes two groups, both of which would otherwise be eligible for Federal premium tax credits if they enrolled through the Exchange:

1. Individuals (including lawfully present non-citizens) with incomes from 138% to 200% of FPL. [1]

[1] Individuals with 133% of the FPL based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard.

2. Lawfully present non-citizens with incomes below 138% of FPL[1] who are ineligible for Medicaid.

Basic Health Program Design Flexibility

States have considerable flexibility in designing a BHP that specifically meets the needs of this population. States must adhere to the following design constraints:

- The BHP must provide at least the essential benefit package.
- Member premiums and out-of-pocket cost sharing amounts are limited by federal requirements and vary based on income level. Legal immigrants with incomes less than 100% of FPL have no cost sharing.
- Plans may be offered by licensed HMOs, insurers, or networks of providers, such as an accountable care organization (ACO).
- A minimum medical loss ratio standard of 85% will be applied to BHP insurers.

Funding of the Basic Health Program

Funding for the BHP would come from the following sources: (1) Federal funding equal to 95% of the Federal subsidies that the enrolled population would have received if enrolled in a product offered through the Exchange. Subsidies will be adjusted for differences in age, income, health status, and geographic distributions to reflect the acuity of the BHP population. (2) Member premiums as determined by the state. The BHP will also likely participate in the risk adjustment process that is applied under ACA. There is some debate on whether or not this will take place, but in our models we have assumed that it will.

The state will be at risk for any BHP costs that exceed the funding. This financial risk will vary by state, depending on numerous dynamics including demographics. States should weigh all quantitative and qualitative factors when deciding whether to offer a BHP. This includes both short-term and long-term considerations.

Summary of Findings

Our analysis finds that the BHP will cost the state additional funds if commercial level fees are paid, but not if Medicaid level fees are paid. These results are very sensitive to two of our assumptions. One is the health status of the BHP population which is assumed to range from 10% less than the average cost of those enrolled in the Exchange to a population having a cost 10% higher than the average of those in the Exchange. Another assumption is the relationship of Iowa's fee schedule to that of the carriers offering insurance in the Exchange. We have assumed that the Iowa Medicaid fees are on average 80.45% of the medical fees being paid by commercial carriers in Iowa. The assumption of a healthier population or a lower ratio of Medicaid to Commercial fees might make the BHP financially neutral for the state if a Medicaid HMO is the carrier for the BHP. However, the use of a commercial carrier for the BHP will likely cost the state under any reasonable set of assumptions.

II. STUDY PURPOSE, SCOPE, AND APPROACH

LIMITATIONS AND DATA RELIANCE

This report is intended to provide information and education about decisions, considerations, and options available to the state in terms of the Basic Health Program (BHP) option. The report may not be suitable for other purposes.

This report has been solely prepared for the use of, and is only to be relied upon by, the State of Iowa, Department of Human Services, and the Iowa Medicaid Enterprise (IME). This report may not be distributed to any other party without the prior written consent of Milliman, which consent will not be unreasonably held. Milliman does not intend to benefit, or create a legal duty to, any third party recipient of its work. If this report is distributed to third parties, it should be distributed only in its entirety.

The information and discussion points provided in this report are technical in nature. No party should rely upon this report without a thorough understanding of the subject matter.

The contents of this report are based on Milliman's understanding of the ACA and its associated regulations issued to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of the ACA, necessitating an update to the content of this report. For this reason, this report should be considered time-sensitive material, which may change as new information becomes available.

In developing this report, Milliman relied, in part, on information provided by third parties. We have not verified the accuracy or completeness of third-party input. Milliman performed a limited review of the information used in preparing this report for reasonableness and consistency. If the information used in preparing this report is inaccurate or incomplete, the contents of this report may likewise be inaccurate or incomplete.

Milliman's consultants are not attorneys and are not qualified to give legal advice. Users of this report are advised to consult with their own legal counsel regarding interpretation of legislation and administrative rules, possible implications of specific ACA-required features, or other legal issues related to implementation of an ACA-compliant entity/program.

The views expressed in this report are made by the authors of this report and do not represent the opinions of Milliman, Inc.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this paper who is an actuary is a member of the American Academy of Actuaries, and meets the qualification standards for performing this analysis.

APPROACH TO COMPLETING THE STUDY

In preparing this study and report, the Milliman consultants worked in conjunction with IME to model the impact of the Basic Health Program (BHP). The steps used included:

- Model demographics of the BHP population, including health status.
- Model the *hawk-i* plan as the base plan.
    - Adjust the base plan to include any Essential Benefits not already included.
    - Adjust the base plan to include any state mandated benefits, primarily for adults, not already in the plan.
    - Model a range of costs for the plan assuming the current *hawk-i* level of benefits, existing *hawk-i* vendors, projected commercial fee levels, a range of projected utilizations, and projected enrollment.
- Model Plans in the Exchange.
- Estimate member premiums and cost sharing, within federal constraints.
- Estimate federal reimbursement to the state under the BHP option.
- Estimate state surplus/deficit under the BHP option.
- Consider the impact of other state programs such as IowaCare that will, or could potentially, be absorbed by the BHP/Exchange.
- Repeat the process assuming that the *hawk-i* plan is used as the base plan with the Medicaid level of fees.
- Comment on additional considerations including design, program administration, and relationship with the Exchange.
- A discussion of the impact of using a state-wide Medicaid HMO in place of the Medicaid PCCM program.

Each of these tasks is described in more detail within this report.

III. Overview of the Basic Health Program

This section of the report provides an overview of the Basic Health Program (BHP) concept and establishes context and background information.

The BHP is an important consideration for the state as it develops its Exchange strategy. The decision of whether or not to offer a BHP is a complex issue that affects many stakeholders. This report focuses on the potential financial impact of the BHP option. The details of the BHP administrative (including state capacity and infrastructure), financial, and policy are outside the scope of this analysis.

This report is not a comprehensive examination of the BHP option. Such a review would need to be done in cooperation with various state agencies and Exchange workgroups. Evaluation of the BHP option should be done in the context of its current and future expanded Medicaid and CHIP programs and other state initiatives, goals, opportunities, and priorities to develop a coordinated healthcare system for the population with household incomes under 200% of the Federal poverty level (FPL).

Introduction to the Basic Health Program

Section 1331 of the ACA allows states the option to develop and offer a BHP to certain low income individuals. The BHP can be used to bridge coverage between Medicaid/CHIP and products available through the Exchange, focusing on the population that is most at-risk of moving in and out of Medicaid eligibility because of changes in income. BHP eligibility is limited to non-elderly individuals with household incomes less than 200% of FPL who are not eligible for Medicaid or employer sponsored insurance (ESI) with certain exceptions based on affordability and acceptable coverage levels of ESI. Without a BHP, these individuals would be eligible for coverage through the Exchange with subsidies, but likely at a higher premium and level of cost sharing. With a BHP, these individuals would not be eligible for other coverage through the Exchange.

Potential Basic Health Program Population

The ACA allows states to create a BHP for residents with incomes less than 200% of FPL who are not eligible for Medicaid and lack affordable access to comprehensive employer-based coverage. The population eligible to enroll in the BHP includes two groups, both of which would otherwise be eligible for Federal premium tax credits if they enrolled through the Exchange:

1. Individuals (including lawfully present non-citizens) with incomes from 138% to 200% of FPL. [2]

[2] Individuals with133% of the FPL based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard.

2. Lawfully present non-citizens with incomes below 138% of FPL[2] who are ineligible for Medicaid.

A state's BHP population has the potential to increase if CHIP funding ends and/or current Medicaid programs covering individuals with household incomes greater than 138% of FPL[2] are eliminated.

If Iowa implements a BHP, the eligible population must obtain coverage through the BHP. Eligible individuals would not be able to purchase coverage through the Exchange. If Iowa does not opt to implement the BHP, this population would be eligible for subsidized coverage through the Exchange starting in 2014.

This particular population may find plan options within the Exchange too expensive, even with subsidies. The BHP has the potential to encourage more individuals to enroll in a health insurance program, thereby, reducing the number of uninsured.

Basic Health Program Design Flexibility

States have considerable flexibility in designing a BHP that specifically meets the needs of the population. The BHP can allow a state more control over the program including the potential to encourage healthy behaviors by incorporating incentives and other wellness options. Use of similar delivery systems, providers, benefits, and eligibility processes between the Medicaid/CHIP programs and the BHP may improve the continuity of care across transitions in coverage. Any differences between Medicaid/CHIP, BHP, and products offered through the Exchange in terms of rates, benefits and cost sharing, and access to providers would need to be considered. States must adhere to the following design constraints:

- The BHP must provide at least the essential benefit package.
- Member premiums and out-of-pocket cost sharing are limited by federal requirements and vary based on income level. Legal immigrants with incomes less than 100% of FPL have no cost sharing.
- Plans may be offered by licensed HMOs, insurers, or networks of providers, such as an accountable care organization (ACO).
- A minimum medical loss ratio standard of 85% will be applied to BHP insurers.

Funding of the Basic Health Program

Funding for the BHP would come from the following sources: (1) Federal funding equal to 95% of the Federal premium subsidies and cost sharing that the enrolled population would have received if enrolled in a product offered through the Exchange. Subsidies will be adjusted for differences in age, income, health status, and geographic distributions to reflect the acuity of the BHP population. (2) Member premiums as determined by the state.

The state will be at risk for any BHP costs that exceed the funding. This financial risk will vary by state, depending on numerous dynamics including demographics. States should weigh all quantitative and qualitative factors when deciding whether to offer a BHP. This includes both short-term and long-term considerations.

To the extent that the Federal subsidies collected by the state are in excess of the cost to provide coverage through the BHP, the ACA requires states to reduce member premiums and cost sharing and/or to provide additional benefits compared to coverage available through the Exchange. Reduced member costs and/or enhanced benefits under the BHP could result in more individuals enrolling in the program and could ease the transition from Medicaid benefits to the benefits offered through the Exchange.

Many people in the industry assume that states can provide coverage through the BHP for a lower cost than options available through the Exchange for the following reasons:

- States may use their existing Medicaid delivery system for the BHP. Using the same delivery system would take advantage of existing Medicaid managed care programs and Medicaid provider reimbursement. This conclusion assumes that the current providers would be willing and have the capacity to accept this population at the existing or similar reimbursement levels.

- Medicaid provider reimbursement is typically lower than commercial provider reimbursement.

The BHP decision process should consider the financial impact on the health plans offered through the Exchange for the population with incomes above 200% of FPL as well as plans available outside the Exchange. In addition, the interrelationship of changes in the markets outside the BHP will impact the BHP.

Because the funding of the BHP is based on the estimated amount that the Federal government would have paid for these members in the Exchange, the lower the premiums for plans offered through the Exchange, the lower the funding that would be available for the BHP population.

Establishing a separate BHP would decrease the population eligible to purchase coverage through the Exchange, which in turn could reduce both the Exchange self-sustainability as well as its leveraging capacity.

If the BHP's population is healthier than the population remaining in the Exchange, then its removal will result in a higher average cost of care for members enrolled through the Exchange. Conversely, if the BHP's population is less healthy than members enrolled through the Exchange, the BHP could lead to a lower average cost of care for members enrolled through the Exchange.

Considerations for Offering a Basic Health Program

Advantages and disadvantages of the BHP are described throughout this report. It is worth noting, however, that HHS has not issued regulations governing the BHP option, so this information is subject to change. It is prudent that decisions be made based on a continuing refinement and monitoring of requirements, stakeholder views, population, and industry changes.

IV. Overview of Modeling Process

Model demographics of the BHP population, including health status

The ACA allows states to create a BHP for residents with incomes less than 200% of FPL who are not eligible for Medicaid and lack affordable access to comprehensive employer-based coverage. This population would otherwise be eligible for Federal premium tax credits if they enrolled through the Exchange.

The target population for the BHP in Iowa in this study was identified as adults (including lawfully present non-citizens) with incomes between 138% and 200% of FPL and lawfully present non-citizens with incomes below 138% who would be expected to enroll through the Exchange, or remain uninsured.

We relied on U.S. Census Bureau[3] statistics for Iowa for calendar year 2011 to estimate the BHP eligible population. The U.S. Census Bureau data provided information regarding the number of individuals with and without health insurance below a stratified set of federal poverty levels. Future years were estimated using an assumed 0% enrollment growth in the Low Scenario and 1.5% enrollment growth in the High Scenario. The Census Bureau also provides reported health status information for the different groups through their Current Population Survey results.

The analysis presented in this report includes two scenarios that reflect assumed levels of BHP participation by the eligible individuals. The participation of these members was graded in over the first three years of the BHP.

Table 1
Basic Health Program Participation Assumptions

	Low Scenario	High Scenario
Uninsured	71%	90%
Insured – Group Coverage	22%	29%
Insured - Non-Group	85%	95%

- Under the High Scenario, we assumed that a higher portion of the eligible population who are currently either insured or uninsured would convert to the BHP. Under the Low

[3] http://www.census.gov/cps/

Scenario, we assumed that a lower portion of the eligible population who are currently either insured or uninsured would convert to the BHP.

- We assumed the reform legislation would not prevent crowd-out from the currently insured population who would be eligible for the BHP. Each scenario assumes that a different portion of the eligible insured population will enroll in the BHP.

Table 2

Basic Health Program Eligible and Enrollment Estimates by Income Level

Census Data from 2011 Prior to Forecasting

Income Level	Eligible	Participation Low	Participation High
0% to 100% FPL	6,178	4,386	5,560
101% to 150% FPL	44,405	25,555	31,796
151% to 200% FPL	104,978	52,370	64,751
Totals	155,561	82,311	102,107

Estimate financial impact of BHP option

The cost to the state of the BHP option is reduced by federal reimbursements as well as nominal participant premiums and copays. The federal reimbursement amounts are based on 95 percent of the federal tax credits and out of pocket expense (OOP) subsidies these members would have received if they had been enrolled in the Exchange. The premium tax credits cover a portion of the premium for the second lowest Silver Plan in the Exchange. Silver plans have a 70% actuarial value (AV) which means that the plan covers 70% of the cost of health care while the insured individual is responsible for the other 30%. The federal subsidies then cover varying proportions of this OOP depending on the FPL of the covered individual. Individuals at or below 100% FPL, which will consist of legal immigrants not eligible for Medicaid, have no OOP Costs. Individuals between 101% and 150% of FPL have an OOP of 6% of total cost resulting in an AV of 94% while individuals between 151% and 200% have an OOP of 13% resulting in an AV of 87%. Note that in the ACA there is an inconsistency in the wording of the required AVs by FPL in the Exchange vs. the Basic Health Program. We have assumed the higher AVs described above.

Estimate the costs for BHP Eligible Individuals

1) We modeled the costs for BHP with the hawk-i plan as the base plan.

Costs were estimated by modeling *hawk-i* benefits and commercial fees. Using Milliman's Managed Care Rating Model (MCRM), premiums were estimated for the BHP population income segments. This same process was later repeated using Medicaid fee levels.

We adjusted the base plan to include any Essential Benefits not already included. Also, we adjusted the base plan to include any state mandated benefits, primarily for adults, not already in the plan.

These adjustments included making sure that habilitative benefits were covered, that dollar maximums were removed, and that there was mental health parity.

We then modeled a range of costs for the plan assuming the current *hawk-i* level of benefits, existing *hawk-i* vendors, projected fee levels, a range of projected utilizations, and projected enrollment.

The MCRM was used to develop a series of cost models for the BHP. One set of models assumed commercial fee level reimbursement, while the second set assumed Medicaid fee levels. In both sets of cost models, benefit plan designs were constructed for different income levels such that they achieved the appropriate actuarial values. Specifically, for the population with household incomes less than 101% of FPL, cost model plan designs were constructed to achieve an actuarial value of 100%. For the population with household incomes ranging from 101% - 150% of FPL, cost model plan designs were constructed to achieve an actuarial value of 94%. For the population with household incomes ranging from 151% - 200% of FPL, cost model plan designs were constructed to achieve an actuarial value of 87%.

A basic outline of benefits used in the cost models is shown in the tables below. These are examples of plans. The state does not have to use these specific plans but any plan(s) that include the required essential benefits and achieves the targeted Actuarial Value (AV) by FPL.

Table 3 Basic Health Program Cost Model Plans In-network Benefits Only Assuming Commercial Fee Level Provider Reimbursement			
Population	**< 101% of FPL**	**101% - 150% of FPL**	**151% - 200% of FPL**
Actuarial Value	100%	94%	87%
Benefit/Cost-Sharing Level			
Annual Deductible	$0	$0	$0
Plan Coinsurance	100%	93%	80%
Medical Copays[1]	None	None	None
Prescription Drug Copays	$0	$3.40	$3.25

[1] – Medical Copays for services such as physician office visits, urgent care visits, chiropractic visits, etc.

Table 4 Basic Health Program Cost Model Plans In-network Benefits Only Assuming Medicaid Fee Level Provider Reimbursement			
Population	**< 101% of FPL**	**101% - 150% of FPL**	**151% - 200% of FPL**
Actuarial Value	100%	94%	87%
Benefit/Cost-Sharing Level			
Annual Deductible	$0	$0	$0
Plan Coinsurance	100%	93%	83%
Medical Copays[1]	None	None	None
Prescription Drug Copays	$0	$3.00	$3.40

[1] – Medical Copays for services such as physician office visits, urgent care visits, chiropractic visits, etc.

2) We modeled the costs for BHP Eligibles in Exchange Plans

Federal funding is tied to premium and cost-sharing subsidies that would have been paid if the individual had been enrolled in the Exchange based on the silver plan.

Due to varying requirements and limits on premiums and cost-sharing, several models were developed. Using Milliman's MCRM, costs were estimated for the various BHP population segments at assumed fee levels.

The cost models for the Exchange plans were developed assuming commercial fee level reimbursement. Benefit plan designs were constructed for different income levels such that they achieved the appropriate actuarial values (AV) in a manner analogous to the BHP plans above. Another set of cost models was developed by FPL level with plan designs constructed to achieve an actuarial value of 70%.

Section 1301(a)(1)(B) of the ACA requires issuers to offer plans that meet certain levels of coverage. These levels are identified as bronze, silver, gold, or platinum. Each of the levels is required to meet certain actuarial values: bronze (60%); silver (70%); gold (80%); platinum (90%).

A basic outline of benefits used in these cost models is shown in the tables below.

Table 5 Exchange Cost Model Plans In-network Benefits Only Assuming Commercial Fee Level Provider Reimbursement			
Population	**< 101% of FPL**	**101% - 150% of FPL**	**151% - 200% of FPL**
Actuarial Value	100%	94%	87%
Benefit/Cost-Sharing Level			
Annual Deductible	$0	$100	$500
Plan Coinsurance	100%	100%	100%
Medical Copays[1]	None	$50 Emergency Room $10 Primary Care $20 Specialist	$175 Emergency Room $20 Primary Care $40 Specialist
Prescription Drug Copays	$0	$10 Generic $20 Brand	$15 Generic $30 Brand

[1] – Medical Copays for services such as physician office visits, emergency room visits, urgent care visits, chiropractic visits, etc.

Table 6 Exchange Cost Model Plans In-network Benefits Only Assuming Commercial Fee Level Provider Reimbursement			
Population	**< 101% of FPL**	**101% - 150% of FPL**	**151% - 200% of FPL**
Actuarial Value	70%	70%	70%
Benefit/Cost-Sharing Level			
Annual Deductible	$1,000	$1,000	$1,000
Plan Coinsurance	80%	80%	80%
Medical Copays[1]	None	None	None
Prescription Drug Copays	$15 Generic $40 Brand	$20 Generic $50 Brand	$20 Generic $50 Brand

[1] – Medical Copays for services such as physician office visits, emergency room visits, urgent care visits, chiropractic visits, etc.

V. SUMMARY OF RESULTS

We estimated the cost to Individuals, the Federal Government, and the State

1) We first estimated Individual Premiums and Cost-Sharing

The state has some leeway in the premium that individuals will be required to pay. However, the participant's portion of the monthly premium cannot be greater than what they would have paid if the individual had been enrolled in the Exchange. Federal regulations place a maximum on the premium as a percent of income. The following table illustrates the premium limits assumed in this study and the estimated premium rates.

Table 7
Maximum Premiums by Income Level

Income Level	Premium as a % of Income	Estimated Individual Premium PMPM
0% to 100% FPL	2.00%	$ 9.79
101% to 150% FPL	2.50%	$31.44
151% to 200% FPL	5.15%	$88.51

The ACA limits the amount that an individual can spend on out-of-pocket (OOP) cost-sharing. Participant cost-sharing cannot be greater than the equivalent platinum plan for individuals with incomes below 150% FPL, and the equivalent gold plan for individuals with incomes between 150% and 200% FPL.

2) We then estimated Federal Reimbursement

Federal reimbursement is estimated at 95% of the premium and cost subsidies that would have been paid for these individuals if they had participated in the Exchange, assuming a silver plan at a 70% actuarial value. There is some debate over the wording of the Federal reimbursement of the OOP costs. We have assumed that 95% of OOP costs are reimbursed through subsidies. The existing wording might be read to indicate a 100% reimbursement.

Table 8 Federal Basic Health Program Reimbursement to State PMPM						
Income Level	Silver Plan (70% AV) PMPM		Cost to Insured In the Exchange PMPM		Federal Reimbursement 95% * (Silver Plan – Cost to Insured) PMPM	
	Premium	Cost Sharing	Premium	Cost Sharing	Premium	Cost Sharing
0% to 100% FPL	$266.31	$ 97.23	$ 9.79	$ 0.00	$243.69	$92.37
101% to 150% FPL	$316.71	$115.36	$31.44	$25.60	$271.01	$85.27
151% to 200% FPL	$297.99	$109.41	$88.51	$50.33	$199.00	$56.13

3) Then we estimated the cost to the State

The estimated financial impact to the state is the estimated cost of the BHP less federal reimbursement and participant payments.

Table 9 Net PMPM Calendar Year 2014 Cost to the State Using Commercial Fee Schedule				
Income Level	BHP Premium PMPM	Federal Reimbursement PMPM	Individual Premium PMPM	Net Cost to the State PMPM
0% to 100% FPL	$531.22	$336.06	$9.79	$185.37
101% to 150% FPL	$462.59	$356.28	$31.44	$ 74.88
151% to 200% FPL	$378.95	$255.13	$88.51	$35.30

Net Cost to State = BHP Premium – Federal Reimbursement – Individual Premium

Table 10 compares the scenario of eligible individuals enrolling in the BHP using a commercial carrier to the scenario of those individuals entering the Exchange. IowaCare will be dissolved regardless of whether or not a BHP is enacted, so it was not included in the cost/savings calculations of BHP.

The low and high scenarios incorporate a variety of assumptions and are presented to show the possible affects these variables have on cost. The varying assumptions included in these scenarios are:

- Population participation rates as described in Table 1
- Adjustment for the health status of the population
- Trend rates

Table 10
Total Cost to State in CY 2014
Using Commercial Fee Schedule
($millions)

	Low Scenario	High Scenario
BHP Premiums	$367.2	$582.5
Less Individual Premiums	$65.8	$85.1
Less Federal Reimbursement	$252.3	$418.3
Net Cost	$49.1	$79.1

The net cost to the state for calendar years 2015 to 2020 are shown in Appendix A.

We then repeated the process assuming that a Medicaid HMO program is used as the base plan with the Medicaid level of fees. This resulted in the Medicaid Fee Schedule Scenario.

Table 11 Net PMPM CY 2014 Cost to the State Using Medicaid Fee Schedule				
Income Level	**BHP Premium PMPM**	**Federal Reimbursement PMPM**	**Individual Premium PMPM**	**Net Cost to the State PMPM**
0% to 100% FPL	$444.66	$336.06	$9.79	$98.81
101% to 150% FPL	$377.88	$356.28	$31.44	($9.83)
151% to 200% FPL	$312.26	$255.13	$88.51	($31.38)

Net Cost to State = BHP Premium – Federal Reimbursement – Individual Premium

The table below compares the scenario of eligible individuals enrolling in the BHP using a Medicaid carrier to the scenario of those individuals entering the Exchange.

Table 12 Total Cost to State in CY 2014 Using Medicaid Fee Schedule *($millions)*		
	Low Scenario	**High Scenario**
BHP Premiums	$302.0	$479.1
Less Individual Premiums	$65.8	$85.1
Less Federal Reimbursement	$252.3	$418.3
Net Cost	($16.1)	($24.3)

The net costs to the state for years 2015 to 2020 are shown in Appendix A.

VI. DESIGN DECISIONS

States can design aspects of the Basic Health Program (BHP) to address the needs of this specific population and those needs may be different than the needs of the rest of the population eligible to purchase coverage through the Exchange. BHP design decisions should be made in concert with other state programs, in order to develop a coordinated healthcare system for this population. Examples of issues to address through program design include:

- Affordability of coverage can be enhanced by leveraging Medicaid provider and managed care contracts if current providers and managed care organizations are willing and have the capacity to cover the added population.

- Continuity of coverage for individuals and families moving between or split among Medicaid, CHIP, and the BHP. Iowa's CHIP program provides coverage to children in families with income up to 300% of FPL.

- Delivery system continuity related to access to care and provider networks if an integrated Medicaid/BHP or similar system is developed.

The design of a BHP will impact the Exchange as enrollees transition from the BHP to the Exchange at 200% of FPL. The design of the program should consider how differences in benefits, access to care, and individual cost responsibilities will impact the decisions made at this higher (but still financially constrained) income level.

In addition, provider reimbursement could be impacted by the introduction of a BHP—for products offered both inside and outside of the Exchange. Medicaid often reimburses providers at rates lower than those found in the commercial market. In the current market, higher commercial reimbursement rates are often used to subsidize the lower reimbursement rates of government programs. A BHP successful in contracting with providers at the lower government plan rates could increase the subsidization needed from the commercial market, which could increase the cost of plans offered through the Exchange.

Advantages of Offering a Basic Health Program

Two often-cited advantages of offering a BHP are (1) combating "churn;" and (2) reducing "split families." These concepts are expanded below.

Combating "churn"

A commonly stated advantage of a BHP is the potential to reduce the impact of "churn" as individuals move in and out of Medicaid eligibility when their income moves above and below 138% of FPL.

The BHP can provide a buffer between an individual's low cost to participate in the Medicaid program and the relatively more expensive premiums and cost-sharing of products offered through the Exchange.

A BHP shifts the crossover point of the Exchange from 138% to 200% of FPL. However, a study published in the New England Journal of Medicine predicted that an integrated Medicaid/BHP plan (Medicaid and BHP programs that are run as a single program with identical plans and providers) with a threshold at 200% of FPL has a slightly higher level of churn as individuals move back and forth across the 200% threshold than the ACA baseline (Medicaid and Exchange) with a threshold at 138% of FPL.[4] Additionally, the "notch" then created at the 200% of FPL threshold presents greater implications for enrolled individuals as it relates to premiums and cost sharing.

Churn can be administratively burdensome for the state and confusing for consumers. Different enrollment and eligibility criteria (e.g., Medicaid eligibility is often retroactive) can increase the complexity and should be considered in the design process.

Reducing "split families"

Another commonly cited advantage of an integrated Medicaid/BHP plan is to simplify and reduce differences in coverage of families split among eligibility for Medicaid, CHIP, and products offered through the Exchange. With differences in eligibility, parents may have differing benefits and access to care than their children who are eligible for CHIP. Iowa's CHIP program, for example, provides coverage to children in households with incomes up to 300% of FPL. The BHP could potentially reduce these issues for many families.

Impact of the BHP on Exchange Administrative Costs

A decline in Exchange enrollment due to a BHP could create an additional financial burden on the Exchange as its fixed costs would need to be spread over a smaller population. This impact could be a material issue because the ACA requires the Exchange to be financially self-sustaining by 2015 and the per-unit administrative cost of operating the Exchange is expected to decrease as enrollment increases.

[4] Graves, J.A., Curtis, R., & Gruber, J. (December 15, 2011). Balancing coverage affordability and continuity under a Basic Health Program option. Perspective, *New England Journal of Medicine* 365:e44. Retrieved January 28, 2012, from http://www.nejm.org/doi/full/10.1056/NEJMp1111863.

VII. CONCLUSION

The Basic Health Program will cost the State additional funds unless a Medicaid carrier is used to provide the plan at the current Medicaid level of fees. The health status of this population is assumed to be similar to the commercial population. Assuming a less healthy BHP population could increase the burden on the state. However, since it is likely that the BHP will participate in the risk adjustment process under ACA, this burden is lessened. Another material assumption in our modeling is the relationship of Iowa's Medicaid fees to the fees that are typically paid to providers by commercial insurance carriers that would participate in an Exchange. Our research indicates that the ratio of Iowa's Medicaid fees to Medicare fees is 89.27%, and the ratio of Iowa's Medicaid fees to commercial fees is 80.45%. Both of the ratios include hospital charges.

If you have any questions regarding the information above, please let me know.

Sincerely,

Timothy F. Harris, F.S.A., M.A.A.A.

Principal & Consulting Actuary

Appendix A

The table below uses trending assumptions to forecast the total cost to the State in millions until the year 2020. The accuracy of these projections is subject to fluctuations in future cost and utilization.

Basic Health Program Financial Impact Analysis for Calendar Years 2014 to 2020
Net Cost to the State of Iowa Annually (in millions)

	2014	2015	2016	2017	2018	2019	2020
Low Trend/Enrollment Rate and Health Status Assumptions							
Commercial HMO Carrier	$49.1	$52.0	$55.2	$58.5	$62.0	$65.7	$69.6
Medicaid HMO Carrier	-$16.1	-$16.8	-$17.4	-$18.1	-$18.8	-$19.6	-$20.4

	2014	2015	2016	2017	2018	2019	2020
High Trend/Enrollment Rate and Health Status Assumptions							
Commercial HMO Carrier	$79.1	$86.2	$93.9	$102.4	$111.6	$121.7	$132.6
Medicaid HMO Carrier	-$24.4	-$25.8	-$27.4	-$29.0	-$30.7	-$32.6	-$34.5