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State of California

Financial Feasibility of a

Basic Health Program

MERCER

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California HealthCare Foundation

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Executive Summary

Mercer Government Human Services Consulting (Mercer), assessed the financial feasibility of the Basis Health Program (BHP) option, as defined in the Patient Protection and Affordable Care Act (ACA) in California. The feasibility determination, prepared with funding from the California HealthCare Foundation (CHCF) is based on whether the BHP option could potentially be implemented in California at existing Medi-Cal managed care payment rates at no cost to the State (i.e., entirely funded by federal subsidies).

The task of assessing the feasibility of the BHP option in the State of California is broken down into the following steps:

- Estimate the size and demographic characteristics of the population eligible for the Exchange in California and the subsets likely to enroll in the BHP and Health Benefit Exchange (Exchange)
- Estimate the Silver-Level benefits and premiums likely to be offered in the Exchange
- Calculate the resulting federal premium and cost-sharing subsidies that would be made available to fund the State BHP based on the estimated Silver-Level benefits offered in the Exchange
- Estimate the premiums that would be required to fund health care benefits to the BHP population up to 200% of the Federal Poverty Level (FPL) at existing Medi-Cal managed care provider payment rates
- Calculate the resulting difference between the estimated federal BHP subsidies available and the estimated BHP premiums and identify the risk factors that could significantly alter the results and the conclusion about financial feasibility

The results of the analysis outlined above indicate that the State of California may be able to implement the BHP option at no cost to the state general fund. Mercer estimates the average 2014 federal BHP monthly subsidy to be between $441 and $497 PMPM. Using our conservative assumptions with respect to health status and costs, Mercer estimates the average monthly BHP premium cost to cover this population to be between $294 and $353 PMPM with very low premiums and cost-sharing levels. Based on these

estimates, under any scenario there is a projected excess of BHP subsidy over BHP costs. In addition, it appears that there would be enough excess funding to allow the State to implement the BHP option at provider reimbursement rates near, or possibly even exceeding, Medicare payment levels.

These estimates are speculative at this early stage with so many provisions of the ACA undefined and specifics of the BHP undetermined. However, the relatively large gap between the estimated premium subsidy and projected health care cost to cover the BHP population is consistent with findings from other studies (non-California specific) on this topic. In fact, three other studies (by Milliman, the Urban Institute and the Community Service Society (CSS)) have analyzed the BHP option and come up with similar results as to the financial feasibility of the BHP. In California, the excess of the federal subsidies over the resulting costs of a BHP could be used to increase provider reimbursement rates, reduce member premiums and cost-sharing (even further than already assumed), expand benefits, and extend outreach to enroll a greater share of this low-income population.

Mercer and CHCF are not advocating for or against the BHP option. The results of this study simply indicate this may be a viable option for the State to consider as it decides how best to implement the many provisions of the ACA. While the results of the analysis do show this to be financially feasible, clearly, implementation of a BHP would not be without some element of risk to the State.

In addition to the question of financial feasibility of a BHP option, the CHCF asked Mercer to address some of the potential impacts that adopting a BHP could have on the Exchange in California. Specifically, the following potential areas of impacts were considered:

- Impact on Exchange risk
- Impact on Exchange self-sustainability
- Impact on the Exchange's ability to selectively contract

Impact on Exchange Risk

The level of premiums and cost-sharing in a BHP and in an Exchange population (with or without a BHP option) will have a direct impact on the risk of the population that enrolls. That is to say, higher premium and cost-sharing levels increase the level of adverse risk among the enrolled population. With the assumption that a BHP option would only be implemented with reduced premiums and cost-sharing (as compared to what would be available under the Exchange for the same BHP-eligible subgroup), it is reasonable to conclude that the risk of the enrolling population up to 200% FPL would be better under a BHP than the risk of the same population subgroup that would enroll under an Exchange.

It is impossible to be sure how the risk of the remaining Exchange population above 200% FPL would compare to the less than 200% FPL group under an Exchange. However, one could argue that with less disposable income at the lower income (FPL)

levels, the impact of adverse risk would be greater at the lower income levels. If that holds true, Exchange risk may actually improve with the implementation of a BHP.

Impact on Exchange Self-Sustainability

All Exchanges must be self-sustaining by January 1, 2015. Therefore, it is reasonable to be concerned about removing some Exchange eligible members from the pool of members from which the Exchange may be funded. Our estimate of Exchange membership (net of BHP) is approximately 1.8 million. This net number for California is likely to be larger than any other state's gross Exchange enrollment. Therefore, from a purely fiscal perspective, the somewhat reduced Exchange population should not pose a significant issue with respect to being able to achieve self-sustainability.

Impact on the Exchange's Ability to Selectively Contract

California's Exchange enabling legislation has authorized the Exchange to use selective contracting. This was most likely set up this way to create some level of competition among licensed health plans for a place in the Exchange. Such competition can be used to drive higher quality and potentially lower costs (or improved efficiency). Therefore, it is reasonable to be concerned as to whether removing some Exchange eligible members from the pool will lower the "demand" to be part of the Exchange.

As mentioned previously, the estimate of Exchange membership (net of BHP) is still approximately 1.8 million. This net number is approximately twice the size of California's Healthy Families Program (HFP) population. MRMIB currently has 24 licensed health plans under contract and competing for the HFP membership of less than 900,000. A group of 1.8 million people constitutes a large pool of potential membership. We cannot speak to the specific size that will ultimately attract the State's desired level of demand for participation in the Exchange. However, if the estimate of Exchange enrollment net of BHP is reasonable, the somewhat reduced Exchange population should not create a dramatic difference with respect to being able to drive competition for selective contracting.

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Introduction

Mercer assessed the financial feasibility of the BHP option, as defined in the ACA, in California. The analysis was prepared with support from CHCF. The feasibility determination is based on whether the BHP option can be implemented in California at existing Medi-Cal managed care payment rates at no cost to the State (i.e., entirely funded by federal subsidies). Medi-Cal was selected as the benchmark because this program's provider reimbursement rates are typically lower than reimbursement rates of the HFP, or of commercial health plans. Therefore, feasibility is first tested at this lowest level, with further analysis available with respect to other payment levels.

Background

Under the ACA, Medicaid eligibility will be increased to 133% FPL in 2014 (138% FPL, including the 5% income disregard). The ACA defines health care premium and cost-sharing subsidies for individuals below 400% FPL for purchasing mandatory health care through products offered in the state's Exchange. The BHP option creates a separate state run health program to cover individuals up to 200% FPL, who are not eligible for other government programs. If the BHP option is elected by a state, BHP eligible individuals would not have coverage available through the state Exchange.

The criteria that individuals eligible for coverage under the BHP must meet are as follows:

- Income up to 200% FPL
- U.S. citizen or lawfully present immigrant
- Under age 65
- Not be eligible for coverage under Medicaid (Medi-Cal), Medicare, Children's Health Insurance Program (CHIP) or Military/CHAMPUS-TRICARE
- Not have access to Employer-Sponsored Insurance (ESI) that meets certain ACA standards (comprehensive and affordable)

Therefore, the two groups of individuals that would be covered by a BHP are:

- Adults with modified adjusted gross income (MAGI) between 133% and 200% FPL
- Lawfully present individuals with income below 133% FPL, not eligible for Medi-Cal or HFP because of immigration status

The ACA includes the following requirements related to a BHP option:

- Cover the minimum essential benefits (not yet fully defined)
- Member premiums must not *exceed* premiums charged for the second lowest cost Silver-Level plan offered through the Exchange
- For individuals up to 150% FPL, cost-sharing cannot *exceed* Platinum-Level (10%)
- For individuals 151% to 200% FPL, cost-sharing cannot *exceed* Gold-Level (20%)
- Plan offered is either a managed care system or offers similar benefits of care management [e.g., Fee-For-Service (FFS) + Enhanced Primary Care Case Management (EPCCM) may work]
- To the extent feasible, the consumer is offered a choice of options
- Plan medical loss ratio can be no less than 85%
- Plan selection through a competitive process

Section 1331 of the ACA provides for financing of BHPs in two ways. The federal government will pay states a premium subsidy of 95% of what it would have paid for the BHP members (premium credit) under the Exchange. In addition, the federal government will pay states a cost-sharing subsidy, based on the cost-sharing subsidy available under the Exchange. These subsidies vary by income as defined by the ACA in relation to the FPL.

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Project Scope and Approach

The task of assessing the feasibility of the BHP option in the State of California is broken down into the following steps:

- Estimate the size and demographic characteristics of the population eligible for the Exchange in California and the subsets likely to enroll in the BHP and Exchange
- Estimate the Silver-Level benefits and premiums (second lowest price) likely to be offered in the Exchange
- Calculate the resulting federal premium and cost-sharing subsidies that would be made available to fund the state BHP, based on the estimated Silver-Level premium and cost-sharing offered in the Exchange
- Estimate the premiums that would be required to fund health care benefits to the BHP population up to 200% FPL at existing Medi-Cal managed care provider payment rates
- Calculate the resulting difference between the estimated federal BHP subsidies available and the estimated BHP premiums and identify the risk factors that could significantly alter the results and the conclusion about financial feasibility

Each of these steps is discussed in more detail, along with results, in the following section (Analysis and Findings) of this report. There have been other studies done and reports published on the BHP option, including the aspect of financial feasibility. However, CHCF is interested in examining the financial feasibility of the BHP option specifically for California. It is important to note that the analyses performed included the assumption that there would not be modifications to existing program eligibility requirements, other than those required by law. Therefore, the assumption used was that eligibility and coverage for Medi-Cal, HFP and the Access for Infants and Mothers Program (AIM) would remain at least at their current levels, in addition to the new coverage requirements of ACA.

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Analysis and Findings

Demographic Characteristics of the Uninsured Population Eligible for the Exchange

The primary data source used by Mercer for estimating the size and demographic characteristics of the population eligible for the Exchange was the Census Bureau annual Current Population Survey (CPS) dataset, which breaks down the population of all fifty states. California-specific CPS data for 2007 – 2009 was used as the base, or starting point, of the demographic analysis. We compared the results of this analysis to multiple other California-specific studies and/or data sources and found very comparable results.

Mercer's estimate of the total Exchange and BHP *eligible* population is 4,454,000. It is important to understand that not everyone who is eligible for the Exchange or a BHP option will enroll. As a point of reference, the October 2010 issue of Health Affairs estimated that approximately 18.5% of Californians eligible for Medi-Cal or the HFP have not enrolled. These programs have little to no premiums required of their members. Therefore, it is reasonable to assume an even higher percentage of eligible members would not enroll in a BHP option or Exchange, which will both have some premium requirements for members.

There are three tables displayed on the following pages that show estimated enrollment for the Exchange (net of BHP), the BHP population, and then finally, the combined total enrollment for all Exchange-eligible populations. The assumptions that drive these enrollment estimates are addressed in the bullet points that precede each table.

In estimating the size of the Exchange eligible and enrolling population (net of BHP), Mercer incorporated the following working assumptions:

- The Exchange risk pool (net of BHP) will consist entirely of adult individuals and families with incomes above 200% FPL
- There would not be any children below 250% FPL, due to maintenance of effort requirements for CHIP
- Individuals with existing government-provided health benefits – Medicare and Military/CHAMPUS-TRICARE – will remain in these programs and will not be eligible for, or covered by, the Exchange
- The number of individuals with ESI will not change significantly with the implementation of the ACA in 2014
- Virtually all individuals between 200% and 400% FPL, with privately purchased individual policies, will migrate to the Exchange to take advantage of federal premium and cost-sharing subsidies
- Relatively few individuals above 400% FPL will enroll in the Exchange; instead they may enroll in non-Exchange offered products
- An assumed 70% of the eligible 200 – 400% FPL group will enroll and only 25% of those greater than 400% FPL will enroll (due to the fact that the over 400% FPL group will receive no government assistance under the Exchange)

Table 1 below displays the estimated Exchange (Net of BHP) eligible population assumed to *enroll* in the Exchange.

Table 1 – Total Population Estimated to Enroll in the Exchange

	200% – 400% FPL		400% FPL and Above		
	Females	**Males**	**Females**	**Males**	**Total**
Average Adult Age	**40.8**	**38.9**	**44.8**	**43.2**	**40.6**
0-18	107,190	124,784	22,061	28,262	**282,297**
19-24	88,855	102,498	10,561	14,645	**216,559**
25-34	136,834	180,862	23,008	35,179	**375,883**
35-44	111,072	132,757	22,682	31,378	**297,889**
45-54	142,436	134,659	34,757	39,393	**351,245**
55-64	101,394	82,950	34,100	36,162	**254,606**
Total	**687,781**	**758,510**	**147,169**	**185,019**	**1,778,479**

The working assumptions related to the BHP eligible and enrolling population are as follows:

- The BHP risk pool will consist entirely of adults, ages 19 through 64, with incomes up to 200% FPL
- Children up to 200% FPL will be covered by the HFP or Medi-Cal, and will not be enrolled in the BHP
- Legal immigrants with residency status less than five years will be eligible for the BHP, including those below 133% FPL, who are currently ineligible for federally funded Medicaid benefits
- Individuals with existing government-provided health benefits – Medi-Cal, HFP, Medicare and Military/CHAMPUS-TRICARE – will remain in these programs and will not be eligible for, or covered by, the BHP

- The number of individuals with ESI will not change significantly with the implementation of the ACA in 2014 (assuming some employers will drop coverage while others will add coverage)
- Virtually all individuals up to 200% FPL, with privately purchased individual policies, will migrate to the BHP due to the incentives of minimal premiums and low levels of cost-sharing
- Assume 70% of the BHP eligible population will actually enroll

Table 2 below displays the estimated BHP eligible population assumed to *enroll* in the BHP option.

Table 2 – Total Population Estimated to Enroll in the BHP

	< 150% FPL		150% – 200% FPL		
	Females	**Males**	**Females**	**Males**	**Totals**
Average Age	39.0	39.9	42.9	39.9	**40.8**
19-24	16,584	14,026	24,568	39,276	**94,454**
25-34	25,360	25,911	46,260	76,201	**173,732**
35-44	22,768	22,988	65,237	59,968	**170,961**
45-54	19,301	25,355	65,034	50,555	**160,245**
55-64	13,513	12,694	49,645	48,174	**124,026**
Total	**97,526**	**100,974**	**250,744**	**274,174**	**723,418**

Table 3 below, displays the total Exchange and BHP eligible population estimated to *enroll* in the Exchange and the BHP combined. It is important to understand that the figures in this table do not reflect our estimate of the number of people that would enroll in the Exchange absent a BHP. This is because we would assume a smaller percentage of individuals up to 200% FPL would actually enroll in the Exchange, as compared to a BHP, due to the higher premiums and cost-sharing requirements.

Table 3 – Total Population Estimated to Enroll in the BHP and Exchange Combined

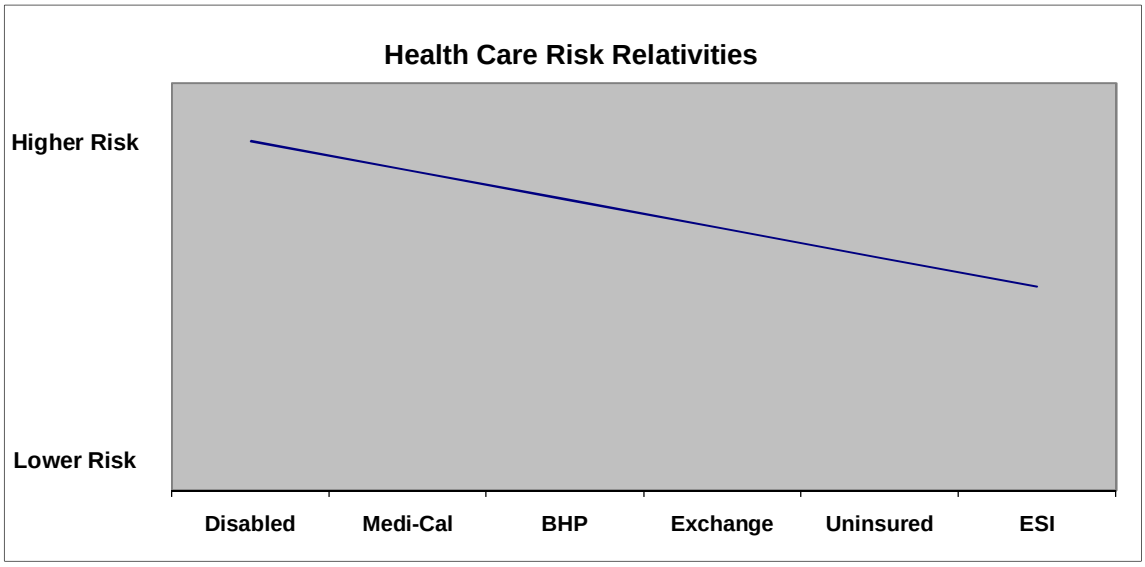
	Females	**Males**	**Total**
Average Adult Age	**41.6**	**39.8**	**40.6**
0-18	129,251	153,046	**282,297**
19-24	140,568	170,445	**311,013**
25-34	231,462	318,153	**549,615**
35-44	221,759	247,091	**468,850**
45-54	261,528	249,962	**511,490**
55-64	198,652	179,980	**378,632**
Total	**1,183,220**	**1,318,677**	**2,501,897**

Relative Health Status of Populations

Generally, health status improves as income increases, resulting in decreasing average health care costs. Conversely, health status declines as income decreases resulting in increasing health care costs. Relative health status also improves for those who are employed, both because employed individuals have higher incomes than the unemployed and because they are healthy enough to work.

Since Medicaid (Medi-Cal) represents the lowest income population, this population group is assumed to have the highest health care risk and utilization levels, with the disabled Medicaid population generating higher costs than the non-disabled Medicaid population. The uninsured population represents a mix of relatively healthier individuals, who view purchasing coverage as uneconomical, and those with existing health conditions representing additional risks that cause health insurers to typically deny coverage or make the premiums unaffordable. This mix has been shown to reflect an overall average health status that is better than the Medicaid population – with lower average health care risk and utilization – but is somewhat worse than the ESI covered population.

These assumed health care cost relativities, as illustrated in the graph below, are consistent with the self-reported health status scores collected as part of the CPS dataset. While these self-reported scores are subjective and do not easily convert to a numerical rating scale, they confirm the generally held actuarial assumptions and support developing projected health care costs under the ACA from these income relativities.



Silver-Level Benefits and Premiums Offered in the Exchange

Section 1331 of the ACA authorizes the BHP and defines the premium and cost-sharing subsides based on the "Essential Health Benefits", yet to be fully defined by the Secretary of Health and Human Services (HHS). Because the concept of Essential Health Benefits is modeled on the Federal Employee Health Benefits Program (FEHBP), Mercer estimated the 2014 Silver-Level premiums based on a typical FEHBP plan of benefits.

The Silver-Level of benefits is defined by the ACA as having an actuarial value of 70%, meaning that 70% of the total health benefit costs (excluding plan administration, risk and profit charges) are paid by the plan, with the remaining 30% paid by the member through per service cost-sharing in the form of deductibles, coinsurance and copayments. Mercer defined the level of member cost-sharing and estimated the premium using its proprietary Uninsured Model, which uses a national, commercial employee benefit and cost database, adjusted for the California health care market.

To project future health care costs from the base data, Mercer used current annual commercial health care unit cost and utilization trends for the 18 distinct Categories of Service (COS) employed in the Uninsured Model to project costs for the target year of 2014.

A demographic profile is defined as the relative distribution of a population by age and gender. The Exchange demographic profile used to estimate the Silver-Level premiums in 2014 was developed from the population in the CPS dataset in the 200% and above FPL income levels.

Mercer adjusted this demographic profile slightly by assuming that younger people, who are less likely to have ongoing health care needs, will be slightly (or somewhat) less likely to comply with the federal mandate to purchase coverage through the Exchange, while older people, conversely, are slightly (or somewhat) more likely to have ongoing health care needs, and be more likely to comply with the federal mandate to purchase coverage through the Exchange. Therefore, while we assume an average of 70% of the Exchange eligible population between 200% and 400% FPL will enroll, we assume that only 60% of the youngest age brackets will enroll and 80% of the oldest age brackets will enroll. This adjustment increased the average age of the estimated enrolled population by about one year.

We also assumed the population that enrolls in the Exchange will be primarily in the 200% ─ 400% FPL income bracket because they are eligible for the premium and cost-sharing subsidies. Those with incomes exceeding 400% FPL will not have any subsidies available to them under the Exchange and may be able to find more attractive coverage options outside the Exchange, thus, we assume that only 25% of individuals above 400% FPL will purchase coverage through the Exchange. The demographic profile of the uninsured Exchange eligible population expected to enroll and pay

premiums is 53% male, with an average age of 41 and estimated to be 1.8 million, as shown in Table 1 earlier in this section.

In addition to adverse selection due to age, the enrolled population in the Exchange will experience adverse selection in all age brackets at both extremes of the health spectrum. Less healthy individuals with above average health care risk will select against the insurers in the Exchange by enrolling at premium levels insufficient to cover the health care risks they present (i.e., they will enroll), while some of the healthier individuals with little to no health care risk will opt-out of the Exchange and avoid the unnecessary and unreasonably high health care premiums (i.e., they will not enroll).

This adverse selection, which will increase the average risk levels of the members who purchase coverage in the Exchange, will be somewhat offset by the fact that the BHP premium and cost-sharing subsidies will be based on the second lowest Silver-Level premium offered in the Exchange. As with any other product or service in the marketplace, Mercer anticipates that there will be a range of premiums offered at the Silver-Level by the health insurers participating in the Exchange, some of which will overestimate the resulting risk pool (at higher premium levels), while others will underestimate the resulting risk pool (at lower premium levels). Thus, it's possible that the BHP premium and cost-sharing subsidies, based on the second lowest Silver-Level premium offered in the Exchange, will underestimate the ultimate risk level and be lower than the average. Consequently, to be conservative, Mercer developed the BHP subsidy estimate by not including an adverse selection risk loading into the projected 2014 Silver-Level premium estimate.

In order to create a range of possible premium and cost-sharing subsidies, two different pricing scenarios were utilized (lower and higher). The key differences between these scenarios were varying the annual trend and administrative loading percent that were applied as well as varying the cost-sharing subsidy calculation. The two different sets of annual trends (weighted across all categories of service) were 7.9% for the lower scenario and 8.9% for the higher scenario, on a PMPM basis. The health plan administrative loading was set at 12% (lower) and 15% (higher). Finally, to further differentiate scenarios, we utilized 95% (lower) and 100% (higher) for the cost-sharing subsidy calculation. See the discussion below on the issue of 95% versus 100% for the cost-sharing subsidy.

The resulting Silver-Level premiums for the year 2014, priced for the demographics above, as calculated by the Uninsured Model, are $441 PMPM for the lower scenario and $486 PMPM for the higher scenario.

The 2011, CalPERS statewide health insurance premium rates for single employee coverage, range from $448 PMPM to $850 PMPM (midpoint of $649 PMPM) and the 2011, non-postal FEHBP premium rates range from $438 PMPM to $814 PMPM (midpoint of $626 PMPM). The rates for these plans typically reflect actuarial values in excess of 90% (higher actuarial value equates to lower member cost-sharing, compared to the 70% Silver-Level projected for the Exchange). Reducing the actuarial values of

these plans (CalPERS and FEHBP) to the 70% Silver-Level, produces premiums comparable to the $441 and $486 PMPM estimates when projecting them forward three years to 2014. These comparisons and discussion were included to demonstrate a reasonableness check of Mercer's independent Exchange premium estimate.

Federal BHP Premium and Cost-Sharing Subsidy Calculations

The BHP federal premium and cost-sharing subsidy formula is not clearly defined. Section 1331(d)(3)(A)(i) of the ACA defines it as, "… equal to 95 percent of the premium tax credits …, and the cost-sharing reductions under section 1402 …" which can be interpreted as either

- 95% x [Premium Subsidy + Cost-Sharing Subsidy] or
- 95% x Premium Subsidy + 100% x Cost-Sharing Subsidy

The Premium Tax Credit is defined mathematically as:

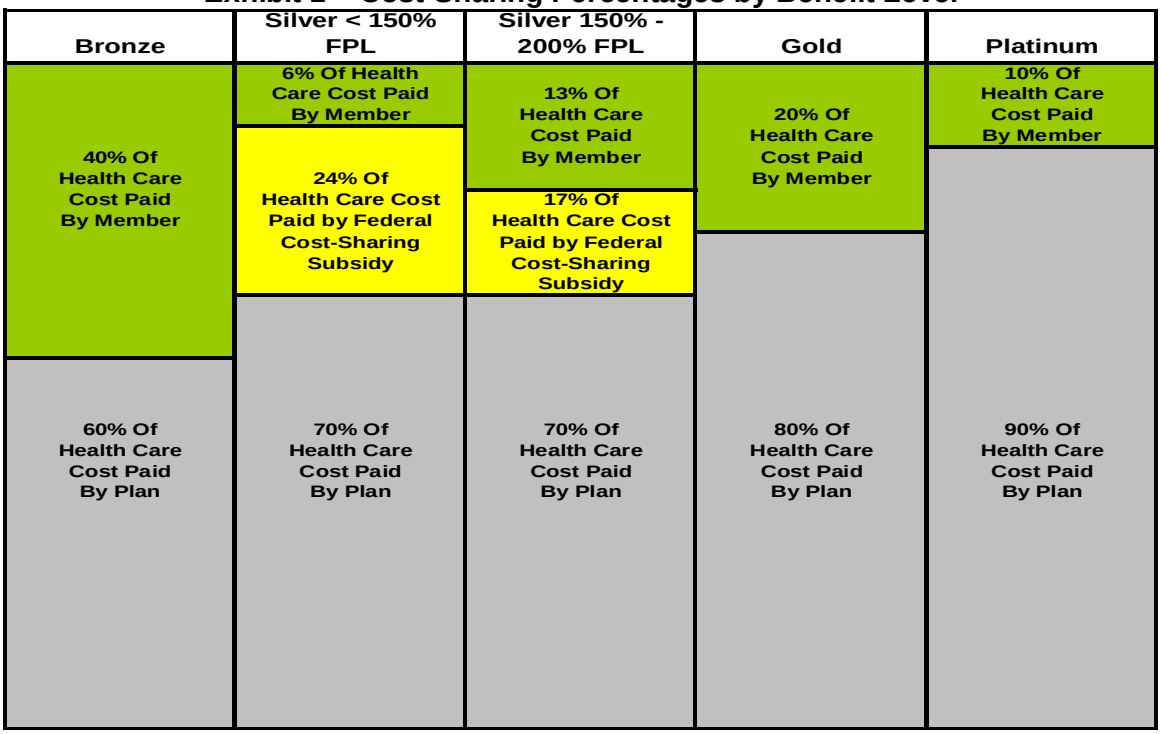
The Premium (for the second lowest Silver-Level Benefit Plan) – the member share of premium, as determined by the applicable premium offset percentage (based on income as defined in Section 1401(b)(3)(A)(i) and as specified in Table 4 below).

Table 4 – Premium Offset Percentages (of Income)

	Low-End Premium Offset %	High-End Premium Offset %	Cost-Sharing (Actuarial Value)
100% – 133% FPL	2.00%	3.00%	94%
133% – 150% FPL	3.00%	4.00%	94%
150% – 200% FPL	4.00%	6.30%	87%
200% – 250% FPL	6.30%	8.05%	73%
250% – 300% FPL	8.05%	9.50%	
300% – 400% FPL	9.50%	9.50%	

Section 1402(c)(2), defines the additional cost-sharing subsidy as "… the issuer of a qualified health plan … shall further reduce cost-sharing under the plan in a manner sufficient to – (A) in the case of an eligible insured whose household income is … not more than 150% of the poverty line … increase the plan's share of the total allowed costs of benefits provided under the plan to 94% of such costs; … in the case of an eligible insured whose household income is more than 150% but not more than 200% of the poverty … increase the plan's share of the total allowed costs of benefits provided under the plan to 87% of such costs." Mercer interprets this language to mean that those between 100% and 150% FPL have plans with an effective actuarial value of 94% (paying an average of 6% cost-sharing) and those between 150% and 200% FPL have plans with an effective actuarial value of 87% (paying an average of 13% cost-sharing). See Exhibit 1, on the following page, for cost-sharing percentages by benefit level.

Exhibit 1 – Cost-Sharing Percentages by Benefit Level



Mercer estimates the 2014 FPL for a single adult will be $12,196, which would generate the Exchange premium offset amounts shown in Table 5 below.

Table 5 – Estimated Exchange Premium Offset Calculation

One Adult	$ Income	Premium Offset %	Annual	Monthly
100% FPL	$12,196	2.00%	$ 244	$ 20
138% FPL	$16,830	3.29%	$ 554	$ 46
144% FPL	$17,502	3.65%	$ 640	$ 53
150% FPL	$18,294	4.00%	$ 732	$ 61
175% FPL	$21,343	5.15%	$1,099	$ 92
200% FPL	$24,392	6.30%	$1,537	$128

Figures in the table are rounded

The 138% level is used in this table since FPL levels below this will be covered by Medi-Cal (133% FPL + 5% income disregard). The number of people estimated below this income level (legal immigrants not currently eligible for Medi-Cal) is very small. Since 144% FPL is midway between the lower BHP population income segment of 138% ─ 150% FPL and 175% FPL is midway between the upper BHP population income segment of 150% ─ 200% FPL, Mercer used the 144% and 175% midpoints to represent the average of each population segment for pricing purposes.

Using this Exchange demographic profile, the weighted net federal BHP premium and cost-sharing subsidies range from about $441 PMPM to $497 PMPM. Calculations are shown in Tables 6 and 7, below.

Table 6 – Calculation of the Estimated BHP Subsidy (Lower Scenario)

	< 150% FPL	150% – 200% FPL	Combined
Total Projected Health Care Cost	$554	$554	**$554**
- 30% Member Cost-Sharing	$166	$166	**$166**
= 70% Plan Covered Health Care Cost	$388	$388	**$388**
+ 12% Administrative Loading	$ 53	$ 53	**$ 53**
= Silver Level Premium PMPM	**$441**	**$441**	**$441**
- BHP Premium Offset	$ 53	$ 91	**$ 81**
= Gross Premium Subsidy	$388	$350	**$360**
x 95% = Net Premium Subsidy	**$368**	**$332**	**$342**
Gross Cost-Sharing Subsidy	$133	$ 94	**$105**
x 95% = Net Cost-Sharing Subsidy	**$126**	**$ 89**	**$100**
Total Estimated BHP Net Subsidy PMPM	**$494**	**$421**	**$441**

Figures in the table are rounded

Table 7 – Calculation of the Estimated BHP Subsidy (Higher Scenario)

	< 150% FPL	150% – 200% FPL	Combined
Total Projected Health Care Cost	$593	$593	**$593**
- 30% Member Cost-Sharing	$180	$180	**$180**
= 70% Plan Covered Health Care Cost	$413	$413	**$413**
+ 15% Administrative Loading	$ 73	$ 73	**$ 73**
= Silver Level Premium PMPM	**$486**	**$486**	**$486**
- BHP Premium Offset	$ 53	$ 91	**$ 81**
= Gross Premium Subsidy	$433	$395	**$405**
x 95% = Net Premium Subsidy	**$411**	**$375**	**$385**
Gross Cost-Sharing Subsidy	$142	$101	**$112**
x 100% = Net Cost-Sharing Subsidy	**$142**	**$101**	**$112**
Total Estimated BHP Net Subsidy PMPM	**$553**	**$476**	**$497**

Figures in the table are rounded

Estimated 2014 BHP Expenses

Like the Exchange demographic profile, the BHP demographic profile used to estimate the BHP premium and cost-sharing, was developed from the population in the CPS dataset in the up to 200% FPL income levels. Mercer adjusted the BHP demographic profile to a greater extent than the Exchange demographic profile because the lower income level of the BHP population provide greater incentives for younger, healthier individuals to avoid unnecessary expenses on their limited incomes.

While we assume an average of 70% of the BHP eligible population will enroll, we assume that only 50% of the youngest age brackets will enroll, while 90% of the oldest age brackets will enroll. This adjustment increased the average age of the estimated enrolled BHP population by about two years.

The demographic profile of the uninsured BHP eligible population expected to enroll and pay premiums is 52% male with an average age of 41 and estimated to be 0.7 million, as displayed in Table 2 previously.

To estimate the BHP Expenses in 2014 for this population, Mercer used the Calendar Year (CY) 2009 Medi-Cal Managed Care encounters and related FFS experience from the membership of a large subset of Medi-Cal plans that reported the most reliable and complete encounter data. As was done for the Exchange rate assumptions, Mercer developed two different scenarios (lower and higher) to show a range of potential BHP costs.

The following assumptions were used for the higher BHP cost scenario:

- Health status increases with income, as noted previously. Since the BHP eligible population sits just above the Medi-Cal population on the income scale, the BHP health care risk should be slightly better than the Medi-Cal experience
- The Medi-Cal populations that best reflect the health care risk of the BHP eligible population are the adults in the Adult & Family Category of Aid (COA) group and the Disabled Medi-Cal Only (i.e., non-dual eligible) COA group
- Incidence of disability increases as income levels decrease. The current Medi-Cal mix of the adult population is about 80% from the Adult & Family COA group and 20% non “share-of-cost” Disabled Medi-Cal Only COA group. To be very conservative, Mercer assumed the disabled health status risk composition of the BHP eligible population would approach the Medi-Cal mix, so a 15% Disabled blend was used with 85% Adult & Family experience
- The State would establish minimal premium and cost-sharing levels, similar to, or slightly above the current HFP levels, to help maximize enrollment and not discourage access to vital health care services
- Since the current HFP monthly premiums are $4 for the lowest income Category A (up to 150% FPL) and $16 for income Category B (up to 200% FPL), Mercer priced a $10 monthly premium for the less than 150% FPL income group and a $20 premium for the 150% ─ 200% FPL income group
  - Since Mercer calculated the current HFP Category A cost-sharing level to equate to about a 98% actuarial value and the Category B cost-sharing level to equate to about a 96% actuarial value, Mercer priced the less than 150% FPL income group BHP plan with a 98% actuarial value and the 150% ─ 200% FPL income group BHP plan with a 96% actuarial value
- Again, for conservatism, health care cost and utilization trends for the five year period from CY 2009 to the first year of the BHP, CY 2014, will be approximately 1/2% above the upper bound of the range of Mercer estimates used in the pricing of 2011 ─ 2012 Medi-Cal managed care rates

- The administrative loading (including profit/risk/contingency) for the BHPs would represent 12% of the premiums, which is higher than current Medi-Cal managed care payment levels (to be conservative)

After the CY 2009 encounter data for the relevant Medi-Cal managed care health plans were extracted by COA and COS for ten distinct age and gender brackets, they were adjusted for known reporting anomalies. FFS health care costs for benefits not provided by the Medi-Cal managed care health plans, but covered under Medi-Cal FFS (e.g., AIDS and psychotropic drugs) were added to the total to develop complete costs for covering these Medi-Cal members. This was done to better represent the ultimate essential benefits to be defined under ACA.

Once the CY 2009 Medi-Cal MCO data were completed and adjusted to the statewide levels used for rate setting and the FFS costs were added, the resulting data were projected forward five years, using the current Medi-Cal unit cost and utilization trends to develop estimated CY 2014 health care costs for both the Adult & Family and Disabled COAs. These costs were then loaded with a 12% factor for administration, profit and risk/contingencies to develop final, estimated statewide MCO premiums for females and males in each of five age brackets for both COAs.

The adult female Medi-Cal membership in the 19-44 age brackets significantly overrepresent maternity costs due to Medicaid eligibility rules. In many cases, women become eligible for Medicaid, not only because of their income, but because of a combination of their incomes and pregnancy status. Consequently, the female age 19-44 Medi-Cal health care risk is much higher than the normal, commercially covered populations, where the incidence of pregnancies is not unnaturally inflated. Under current Medi-Cal eligibility rules, almost all pregnant women below 200% FPL are eligible for coverage. As an added measure of conservatism, Mercer calculated the projected BHP health care costs with 25% of the Medi-Cal pregnancy experience included. It is important to note that if actual BHP maternity experience is greater than what was included in the cost base, it will mean that the State is achieving corresponding savings by removing the maternity experience from Medi-Cal. Therefore, we believe this 25% figure is very conservative.

The resulting premiums by age bracket were then combined in the ratio of 85% Adult & Family COA and 15% Disabled COA to develop blended rates. The projected membership by age and gender for both BHP income categories were then multiplied by the estimated BHP demographic mix to develop a weighted, estimated gross BHP rate of $373 PMPM.

Mercer then calculated the impact of the $10 and $20 member premiums for the less than 150% FPL and 150% – 200% FPL income brackets, respectively, assuming that only 50% of the premiums will ultimately be collected (to be conservative). Added to this, Mercer applied the 2% cost-sharing paid by the less than 150% FPL income group and the 4% cost-sharing paid by the 150% – 200% FPL income group, to reduce the $373

PMPM gross BHP rate to a net cost to the State of $353 PMPM for the BHP, as shown in Table 8, below.

Table 8 – Estimated BHP Premium Rates (Higher Scenario)

Pregnancy Costs Included	< 150% FPL	150% ─ 200% FPL	Combined
Gross MCO Premium	$369	$374	**$373**
Gross Member Contribution	$10	$20	**$17**
Collection Offset Percentage	50%	50%	**50%**
Net Member Contribution	$5	$10	**$9**
Member Cost-Sharing	$6	$13	**$11**
Net MCO Cost to State	**$358**	**$351**	**$353**

Figures in the table are rounded

Because this scenario reflects compounded conservatism of several assumptions, Mercer developed an alternate lower cost scenario that has a higher probability, with the following adjustments:

- The Medi-Cal mix of the population will be 90% Adult & Family and 10% Disabled, instead of the 85%/15% mix used in the most conservative scenario
- Health care cost and utilization trends for the next five year period from CY 2009 to the first year of the BHP, CY 2014, will be at the midpoint of the range of the Mercer estimates used in the pricing of 2011 ─ 2012 Medi-Cal managed care rates
- The administrative loading for the Medi-Cal MCOs operating similar BHPs would represent 10% of the premiums, instead of 12%
- Only 10% of the pregnancy costs will be included in the premium rates, instead of the 25%
- 75% of the premiums will be collected, instead of the 50% assumption

This lower scenario produces a weighted, estimated gross BHP rate of $316 PMPM. The impact of the same member premiums and cost-sharing referenced above, reduces the $316 PMPM gross BHP rate to a net cost to the State of $294 PMPM for the BHP, as shown in Table 9, below.

Table 9 – Estimated BHP Premium Rates (Lower Scenario)

Pregnancy Costs Removed	< 150% FPL	150% ─ 200% FPL	Combined
Gross MCO Premium	$312	$318	**$316**
Gross Member Contribution	$ 10	$ 20	**$ 17**
Collection Offset Percentage	75%	75%	**75%**
Net Member Contribution	$ 8	$ 15	**$ 13**
Member Cost-Sharing	$ 5	$ 11	**$ 9**
Net MCO Cost to State	**$299**	**$292**	**$294**

Figures in the table are rounded

Surplus/(Deficit) of Estimated Federal BHP Subsidies over BHP Premiums

In calculating the CY 2014 BHP premium subsidy and BHP cost estimates, Mercer employed conservative assumptions on both sides. The actual Exchange subsidies may be higher due to the risk profile of the likely actual Exchange enrolled population and the pent-up demand this previously uninsured population will bring with it. Similarly, the risk profile of the likely BHP enrolled population should have lower average costs than the current Medi-Cal enrolled population, and should have a lower incidence of disability and pregnancy than was used in the BHP cost estimates.

In order to reflect the most conservative scenario, Table 10, below, calculates the difference between the lowest estimated BHP subsidy and the highest cost BHP estimate. This reflects the minimum potential difference (excess) of BHP subsidy and BHP cost estimates. The table also reflects the maximum potential difference resulting from the subsidy and cost estimates.

Table 10 – Calculation of the Estimated BHP Subsidy Surplus/(Deficit)

	Minimum Difference PMPM	Maximum Difference PMPM
Estimated Monthly Federal Subsidy	$441	$497
Net Estimated Monthly BHP Costs	$353	$294
Difference = Excess	$ 88	$203

The $88 PMPM gap between the estimated premium subsidy and BHP costs for the most conservative scenario represents about 25% of the $353 Net BHP costs, which allows for a large margin of error in these estimates and assumptions. For the more aggressive scenario, the $203 PMPM gap represents almost 70% of the Net BHP costs. The size of these gaps should not be affected by the actual number of Californians with incomes less than the 200% FPL level and eligible for the BHP, although it will be affected by the relative risk profile of the percentage that decides to enroll.

Another factor worth noting is that the federal BHP subsidies do not include state mandated benefits, which must be funded entirely by the states. By using the actual Medi-Cal costs to develop the estimated BHP rates, the current California mandated benefits are already included on the cost side of the ledger. Given that California has one of the larger sets of state mandated benefits, an expansion of the definition of Essential Health Benefits could have the impact of increasing the federal BHP premium subsidies without adding any costs to the BHP rates, as these benefits may already be included in the current Medi-Cal costs.

Conclusion on Financial Feasibility

Under any scenario based on the estimated subsidy and costs modeled in this analysis, the result is that it would be financially feasible for California to offer a BHP option at Medi-Cal provider reimbursement levels, with no costs to the State. These results are consistent with estimates and projections included in other papers written on the BHP option that were not specific to California (e.g., Milliman, the Urban Institute, and CCS).

Since the ACA does not allow a state to retain or use excess funding for anything but the BHP, there appears to be room under each scenario to offer a BHP at reimbursement rates above current Medi-Cal levels. The following bullets offer a point of reference for the current Medi-Cal reimbursement levels for the three most significant COS (Hospital Facility, Physician, and Pharmacy).

- An analysis of data from the 2008 California Office of Statewide Health Planning and Development (OSHPD) Hospital Annual Disclosure Reports estimates Medi-Cal managed care hospital per diem reimbursement rates to be approximately 89% of Medicare reimbursement levels. Based on this same data source, Medi-Cal managed care per diem rates are approximately 43% of Commercial inpatient rates
- A 2009 CHCF nationwide survey of Medicaid physician reimbursement rates found California physician fees to be approximately 56% of the Medicare fee schedule. Based on Mercer's experience, commercial physician reimbursement tends to run anywhere from 100% to 130% of Medicare. Taking the average of this range (115%) would put Medi-Cal physician reimbursement at approximately 49% of commercial reimbursement levels
- Based on Mercer's experience, Medi-Cal managed care prescription drug reimbursement levels are roughly equivalent to Medicare and commercial levels

For purposes of this discussion, we will assume that these three COS are representative of all reimbursement levels for Medi-Cal. That is to say, we will assume that all COS roll up to one of these three, broad COS (Hospital ─ Facility, Physician – Professional and Pharmacy). On a weighted basis, this would mean that current Medi-Cal reimbursement levels are approximately 81% of Medicare rates (the weighting of 89% facility, 56% professional and 100% pharmacy).

Under the most conservative scenario, there is an excess of approximately 25% funding (i.e., 25% higher estimated subsidy than the estimated net BHP costs). Therefore, even under this scenario, our model projects that there is enough room to raise BHP reimbursement levels from current Medi-Cal (assumed to be 81% of Medicare) to 100% of Medicare for Facility and Pharmacy and 90% for Physician/Professional services.

Under the less conservative scenario, there was an excess of approximately 70% funding (i.e., 70% higher estimated subsidy than the estimated net BHP costs). If this scenario plays out, there would appear to be enough room to raise BHP reimbursement levels to 110% of Medicare for Facility, 100% for Pharmacy and 125% for Physician/Professional.

5

BHP Impact on the Exchange

This section of the report addresses some of the potential impacts that adopting a BHP option could have on the Exchange in California. Specifically, the following potential areas of impacts are discussed:

- Impact on Exchange risk
- Impact on Exchange self-sustainability
- Impact on the Exchange's ability to selectively contract

Finally, we close with a host of "Other Considerations" related to the analyses performed and included in this report.

Impact on Exchange Risk

As illustrated by the Health Care Cost Relativities graph in the previous section, the BHP population in the up to 200% FPL income group (BHP group) should represent a less healthy (and more costly) risk profile than the remaining Exchange population above 200% FPL. In addition, the level of premiums and cost-sharing in a BHP and in an Exchange population (with or without a BHP option) will have a direct impact on the risk of the population that enrolls. Specifically, higher premium and cost-sharing levels increase the level of adverse risk and lead to higher enrolled population risk. With the assumption that a BHP option would only be implemented with reduced premiums and cost-sharing (as compared to what would be available under the Exchange for the same BHP-eligible subgroup), it is reasonable to conclude that the risk of the enrolling population, up to 200% FPL, would be better under a BHP than the risk of the same population subgroup that would enroll under an Exchange.

It is impossible to be sure how the risk of the remaining Exchange population above 200% FPL would compare to the less than 200% FPL group under an Exchange.

However, one could argue that with less disposable income at the lower income (FPL) levels, the impact of adverse risk would be greater at the lower income levels. If that holds true, Exchange risk may actually improve with the implementation of a BHP. On the other hand, at higher income levels the subsidy is considerably lower than at lower income levels. Therefore, the motivation to participate within the Exchange versus the outside market is much lower for the healthiest segment of the Exchange population. Plan participation, consumer choice and risk dynamics for the Exchange population are complicated and beyond the scope of this analysis.

Impact on Exchange Self-Sustainability

All Exchanges must be self-sustaining by January 1, 2015. There will be no federal funds available for states to use for the ongoing operations of the Exchanges after this date. Therefore, it is reasonable to be concerned about removing some Exchange eligible members from the pool of members from which the Exchange may be funded. Based on the population estimates included in the previous section, the BHP population is approximately 723,000 members. However, the estimate of Exchange membership (net of BHP) is approximately 1.8 million. This net number for California is likely to be larger than any other state's gross Exchange enrollment (California's total population is 48% larger than the next closest state – Texas). From a purely fiscal perspective, the somewhat reduced Exchange population should not pose a significant issue with respect to being able to achieve self-sustainability.

Impact on The Exchange's Ability to Selectively Contract

California's Exchange enabling legislation has authorized the Exchange to use selective contracting. While the details regarding how this selective contracting will occur are still under development, ultimately it means that not every willing health plan will be allowed to participate in California's Exchange. This was most likely set up this way to create some level of competition among licensed health plans for a place in the Exchange. Such competition can be used to drive higher quality and potentially lower costs (or improved efficiency). Therefore, it is reasonable to be concerned as to whether removing some Exchange eligible members from the pool will lower the "demand" (i.e., competition) to be part of the Exchange.

As mentioned previously, the estimate of Exchange membership (net of BHP) is approximately 1.8 million. This net number is approximately twice the size of California's HFP population. MRMIB currently has 24 licensed health plans under contract and competing for the HFP membership of less than 900,000. A group of 1.8 million people constitutes a large pool of potential membership. We cannot speak to the specific size that will ultimately attract the State's desired level of demand for participation in the Exchange. However, if the estimate of Exchange enrollment net of BHP is reasonable,

the somewhat reduced Exchange population should not create a dramatic difference with respect to being able to drive competition for selective contracting.

Other Considerations

As illustrated in Table 5 in the previous section, the income band spanning 138% and 200% FPL is a rather narrow range of only $7,562 annually. Sommers and Rosenbaum, in the February 2011 issue of Health Affairs, published a study which showed that over the course of a year, approximately 50% of the people at this income level will experience earnings fluctuations which will move them above or below the 138% FPL BHP eligibility threshold, rendering them ineligible for the specific coverage they have, and requiring them to re-enroll in the coverage for the income category they move to. This churning of coverage will also likely exist above or below the 200% BHP upper income eligibility threshold, requiring them to disenroll from the BHP and enroll in the Exchange (or vice versa). We did not attempt to model this phenomenon and have not made any adjustment to our analysis to account for this.

By using the Medi-Cal provider reimbursement rates in the CY 2009 data, we have not modeled the increased reimbursements for primary care providers (PCPs) to the Medicare levels mandated by the ACA for CY 2013 and CY 2014. As the law currently stands, these PCP reimbursement rates will revert to their current levels starting in 2015, however, some states are contemplating leaving the PCP reimbursement rates intact after 2014.

The ACA currently requires Exchange participating health plans to offer Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as part of their provider networks. In addition, payment for these FQHCs and RHCs is to be at the prospective payment rates used by the states' Medicaid programs. In California, these payment rates tend to be significantly higher than regular physician Medi-Cal and even commercial payment levels. As the ACA stands today (before regulations are published), these requirements do not exist for a BHP option. Mercer did not make any adjustment to the estimated BHP or Exchange health care costs to account for this requirement.

All estimates in this report are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any estimates or projection must be interpreted as having a likely range of variability from the estimate. Mercer has prepared these projections exclusively for the California HealthCare Foundation. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. The estimates and projections included in this report are not a guarantee of results which might be achieved.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the ACA and Health Care Education and Reconciliation Act (HCERA) have been issued, including clarifications and technical corrections and without

guidance on complex financial calculations that may be required. Accordingly, these estimates are not Actuarial Opinions. The State of California is responsible for all decisions related to the policy direction of the Exchange and a BHP option. Such decisions should be made only after the State's careful consideration of alternative future financial conditions and legislative scenarios and not solely on the basis of the estimates illustrated here.

Because of numerous uncertainties about the health care marketplace in 2014, the analyses and findings contained in this report are preliminary and subject to change for many reasons, including, but not limited to:

- Uncertainties regarding the ACA
  - Key terms and provisions in the law remain undefined, or not yet fully defined, more than a year after it was enacted, such as the definition of the "Essential Health Benefits" that will be required for all products offered in the Exchange, and which will drive the BHP premium and cost-sharing subsidies
  - Key terms and provisions of the law conflict. For example, Section 1331(a)(2)(A)(ii) defines the BHP cost-sharing subsidies to be a minimum of Platinum-Level benefits (90% actuarial value) for individuals between 100% – 150% FPL and Gold-Level benefits (80% actuarial value) to individuals between 150% – 200% FPL, while Section 1402(c)(2) defines the additional cost-sharing subsidies to be a minimum of 94% actuarial value for individuals between 100% – 150% FPL and 87% actuarial value to individuals between 150% – 200% FPL
  - Key terms and provisions of the law are unclear, such as the precise definition of "actuarial value" and the formula for the BHP cost-sharing subsidy (100% or 95%)
- Decisions about how the State would structure a BHP, such as the premiums and cost-sharing levels, which will impact the risk profile of those who enroll, and how the state decides to legislate and regulate the health care marketplace under the ACA
- Uncertainties regarding consumer behavior under the ACA, for example:
  - What will be the level of compliance with the federal insurance mandate?
  - Will those above 400% FPL, not eligible for premium subsidies, purchase health care in the Exchange, or migrate to other products outside it, leaving the Exchange with a potentially lower income and less healthy risk pool?
  - How will the 90-day grace period for non-payment of premiums and the lack of a penalty for re-enrollment affect coverage persistency and premium payments in a BHP and/or in the Exchange?

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