CALIFORNIA HEALTHCARE FOUNDATION

The Basic Health Program: What Would It Mean for California?

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This project was developed and funded by the California HealthCare Foundation

Agenda

- Project context and overview
- Profile of the BHP population
- Impact on policy goals
- Concluding thoughts

Definition of the Basic Health Program

The ACA includes a provision that allows states to create a Basic Health Program (BHP) to provide coverage for some of its residents who would otherwise be eligible to obtain coverage through the Health Benefit Exchange (HBE).

Eligibility requirements include:

- Income between 138% and 200% of FPL
- US citizen or lawfully present immigrant
- Under age 65
- Not eligible for other coverage (Medicaid, Medicare, CHIP, military, or Employer Sponsored Insurance [ESI] coverage that meets standards of being comprehensive and affordable)

Program requirements include:

- Benefit design is benchmarked by the essential health benefits (EHB)
- Cost sharing is benchmarked to plans on the HBE by income level

Financing the BHP

The federal government will pay states:

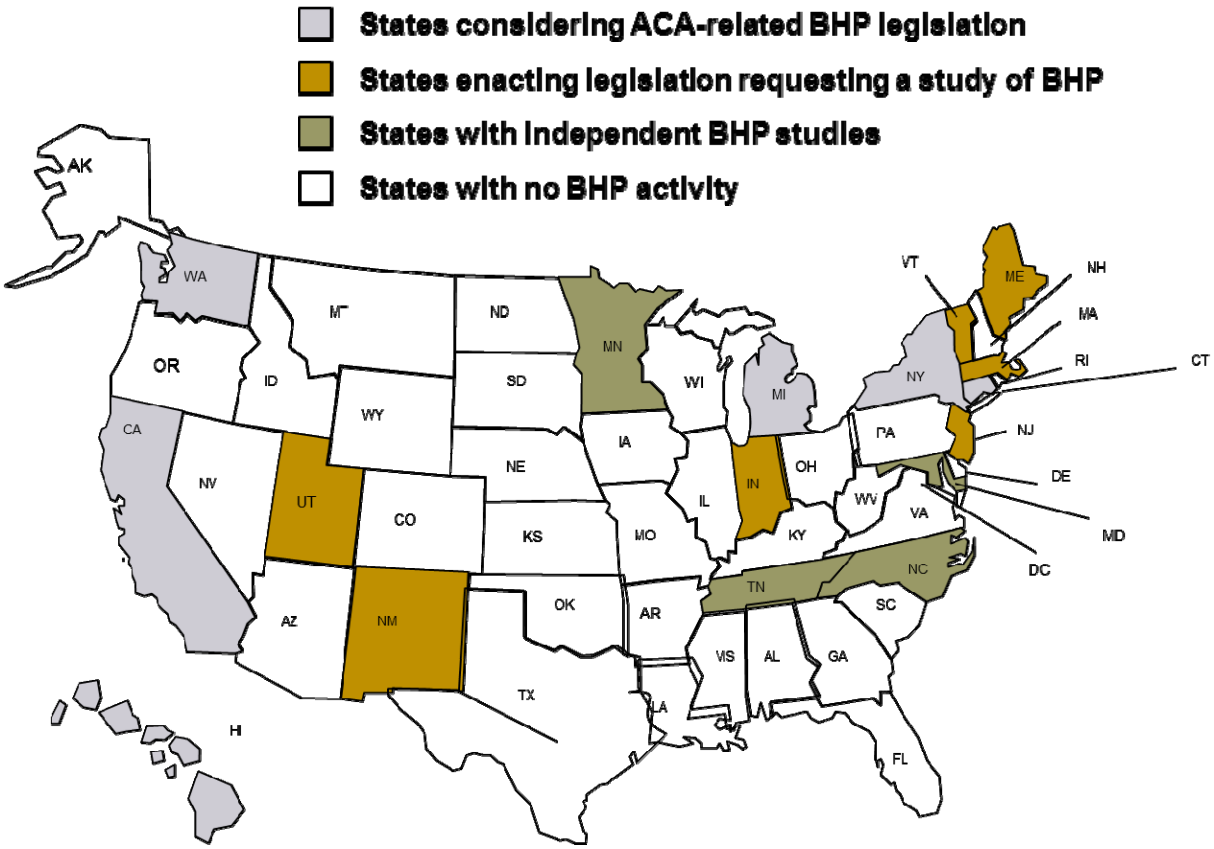
1. A premium subsidy of 95% of what it would have paid for the BHP members (premium credit) under the HBE.
2. The amount of the cost-sharing subsidy that would have been available under the HBE (either at 95 or 100%).

There could be gaps between federal payment and state expenditure due to varying rules related to income and reconciliation.

Status of the BHP in California

1. Federal authorization in the ACA
2. Awaiting federal guidance on program rules
3. Pending legislation (SB 703 Hernandez) would establish a BHP in California

BHP Status in Other States



- Six states are considering ACA-related BHP legislation.
- Seven states have legislation in place requiring a BHP analysis.
- **No state has committed to a post-ACA BHP.**

Research Focused on the BHP in California

Source	Focus	Finding (Based on broad assumptions)
Mercer	Financial Feasibility	CA will be able to implement a BHP option at no cost to the state and minimal impact to the Exchange.
Urban Institute	Financial Feasibility & Policy Implications	CA will be able to implement a BHP option at no cost to the state.
Institute for Health Policy Solutions (IHPS)	Income Volatility	Income volatility for the BHP population could create large financial risk to the state.

Comparing a Future With and Without a BHP

And yet, some alternative perspectives were also raised in the interviews…

"If there is a problem with the subsidies, then let's fix that problem rather than creating a whole new government program."

"We should be comparing whether to do a BHP not to the scenario with no intervention, but rather to the next best alternative."

How a BHP Could Affect California Policy Goals

Profile of the BHP-eligible population: Understanding characteristics of those who are eligible for a BHP could impact California's policy goals

Relevant policy goals include:

- Expanding coverage
- Minimizing state financial risk
- Preserving the safety net
- Maximizing continuity of coverage and care
- Minimizing impact to the Exchange

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California Simulation of Insurance Markets (CalSIM)

Characteristics of Californians Eligible for the Basic Health Program under the Affordable Care Act

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April 27, 2012

Demographics of Californians Eligible for the Basic Health Program, 2014

Total	**948,000**	
Age		
0-18 years	12,000	1%
19-29 years	361,000	38%
30-44 years	298,000	31%
45-64 years	277,000	29%
Gender		
Female	520,000	55%
Male	428,000	45%
Income		
0-100% FPL	96,000	10%
101-138% FPL	42,000	4%
139-200% FPL	810,000	85%

Source: UC Berkeley-UCLA CalSIM Version 1.6

Demographics of Californians Eligible for the Basic Health Program, 2014 (cont.)

Total	**948,000**	
Health Status		
Excellent	178,000	19%
Very Good	258,000	27%
Good	315,000	33%
Fair	170,000	18%
Poor	28,000	3%
Family coverage status		
All members uninsured	480,000	51%
1 Source of Coverage	390,000	41%
2 Sources of Coverage	74,000	8%
3 Sources of Coverage	4,000	0.4%

Source: UC Berkeley-UCLA CalSIM Version 1.6

Demographics of Californians Eligible for the Basic Health Program, 2014 (cont.)

Total	**948,000**	
Eligibility Criteria		
Legal Permanent Residents less than 5 years	193,000	
with Income 0-138% FPL	138,000	72%
with Income 139-200% FPL	55,000	28%

Source: UC Berkeley-UCLA CalSIM Version 1.6

Insurance Coverage for the Potentially Eligible BHP Population Based Only on Income, 2014*

Excluding Medi-Cal, Healthy Families, and CHIP enrollees

Total	**3,102,000**	
Uninsured	1,115,000	36%
Employer-Sponsored Insurance	1,541,000	50%
Individual Market	274,000	9%
Insured through Other Public Programs	172,000	6%

* Status for everyone under age 65 with income between 138% and 200% FPL and Legal Permanent Residents less than five years with income less than 138% FPL.

Source: UC Berkeley-UCLA CalSIM Version 1.6

Care Seeking Behaviors for Potentially Eligible BHP Non-elderly Adult Californians, 2009

Total	**3,288,000**	
Currently[1] using the safety net as usual source of care	884,000	27%
Currently[1] using commercial providers as usual source of care	1,035,000	31%
Currently[1] using care, no usual source or source unknown	468,000	14%
Not seeking health care,[2] usual source is safety net	141,000	4%
Not seeking health care,[2] usual source is commercial providers	191,000	6%
Not seeking health care,[2] no usual source or source unknown	567,000	17%

[1] *Currently* is defined as having one or more doctor visits in the past year.

[2] *Not seeking health care* is defined as having no doctor visits in the past year, regardless of reported usual source of care.

* Non-elderly adults with income between 138% and 200% FPL and non-elderly adult Legal Permanent Residents less than five years with income less than 138% FPL.

Care Seeking Behaviors for Potentially Eligible BHP Non-elderly Adult Californians: Uninsured and Individually Insured, 2009

	Uninsured		Individual Market	
Total	**1,182,000**		**154,000**	
Currently[1] using the safety net as usual source of care	251,000	21%	27,000	18%
Currently[1] using commercial providers as usual source of care	160,000	16%	78,000	51%
Currently[1] using care, no usual source or source unknown	250,000	21%	8,000	5%
Not seeking health care,[2] usual source is safety net	68,000	6%	3,000	2%
Not seeking health care,[2] usual source is commercial providers	65,000	5%	18,000	12%
Not seeking health care,[2] no usual source or source unknown	388,000	33%	21,000	14%

[1] *Currently* is defined as having one or more doctor visits in the past year.

[2] *Not seeking health care* is defined as having no doctor visits in the past year.

* Non-elderly adults with income between 138% and 200% FPL and non-elderly adult Legal Permanent Residents less than five years with income less than 138% FPL.

Questions?

UCLA Center for Health Policy Research

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Our Approach

1. Convened a meeting of leaders in California and experts on the Basic Health Program in December 2011 to gather input on key questions and analytic approach
2. Identified areas for current research
3. Reviewed publicly available state studies for BHP
4. Conducted structured interviews with selected California leaders to explore BHP impact on different consumers and stakeholders
5. Filtered findings by content area to articulate themes across interviews
6. Summarized key goals, controversies, unknowns, impacts, and issues

Because there are a number of unknowns related to policy direction, program definition, and market dynamics, our findings offer insights and raise questions.

Interview Categories

- Health insurance carriers, both with and without Medicaid business
- Providers, including community clinics and medical groups
- Consumer advocacy organizations
- Industry advocacy groups, representing different delivery segments of the industry
- Policy and California health industry experts
- Leaders in state agencies

Coverage

GOAL

The goal is to maximize coverage for lower-income people

Perspectives differ regarding key drivers and obstacles

Driver:
Consumer Contributions

"There is no way that their share of costs in the exchange will be low enough for people under 200% of poverty to afford them. The only way to cover everyone is if coverage costs consumers less."

Driver:
Choice & Access

"There are many people in this income group who can and will pay something; they will have a greater willingness to pay based upon their perceived value of plan and provider choice."

Driver:
*Ease of Enrollment**

"It's true that money is important; but the primary barriers to coverage are obstacles related to enrollment."

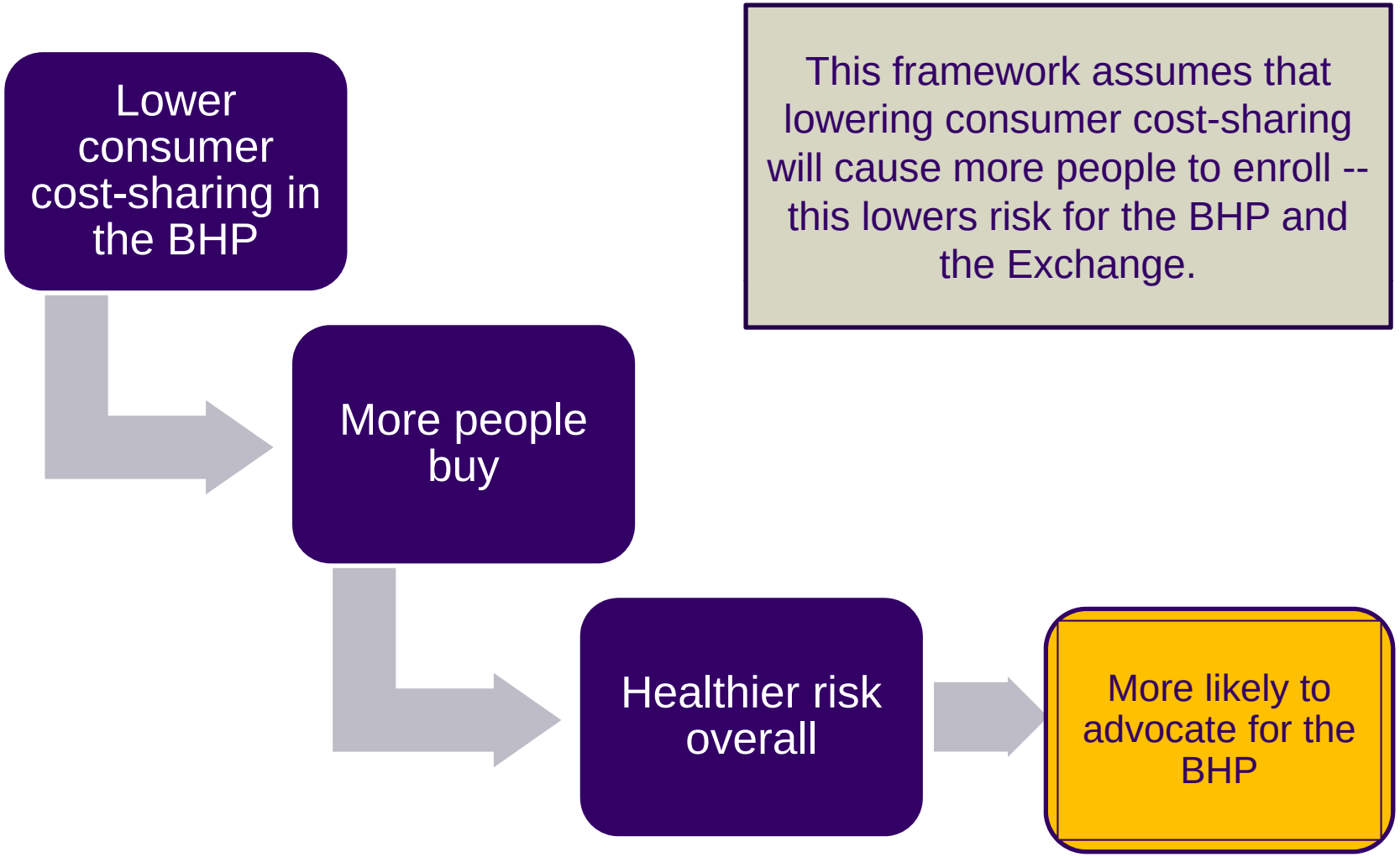
** Many provisions of the ACA are intended to address this bigger issue, so it will not be discussed further here.*

Comparative Costs for Adult Coverage Through the Exchange or the BHP

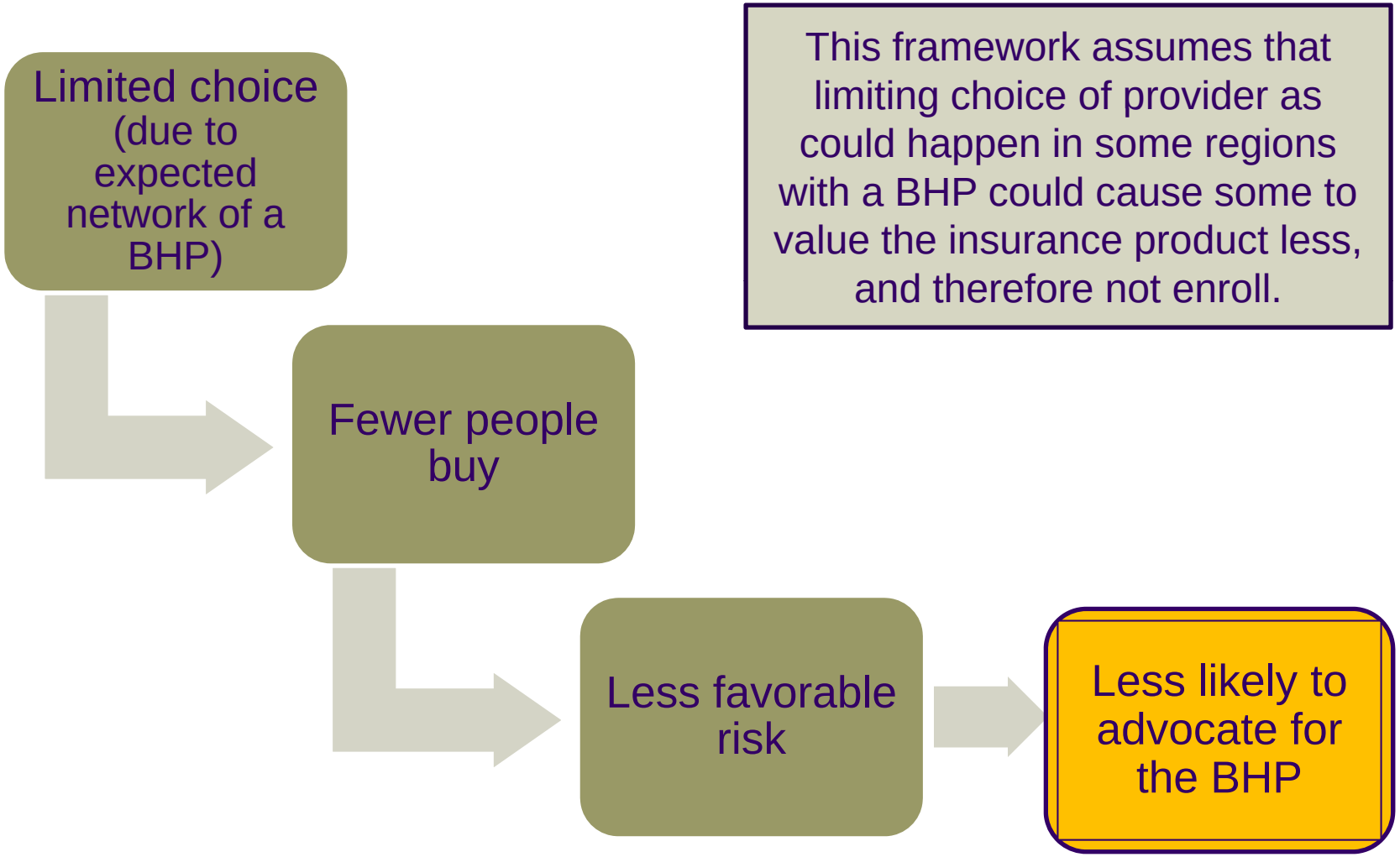
Income Level*	Annual Income	Monthly Income	Estimated Exchange Monthly Premium*	Assumed BHP Premium**
150% FPL	$16,248	$1,354	$54.14	$10
200% FPL	$21,660	$1,805	$113.72	$20

* Based on Urban Institute California analysis.
** Based on Mercer California BHP analysis.

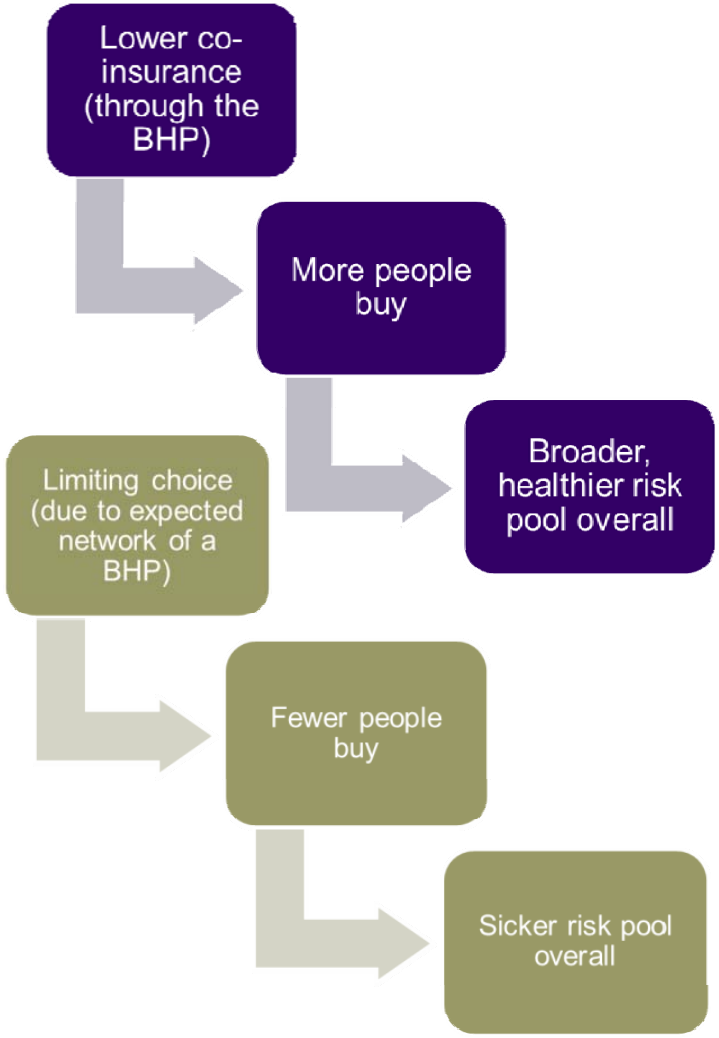
Coverage: Assuming *Consumer Cost-sharing* as a Primary Driver



Coverage: Assuming *Choice and Access* as Primary Drivers



Coverage: A Diverse Population



Because the BHP population includes a blend of individuals with a range of circumstances, values, and needs, it is difficult to know which set of dynamics will dominate.

State Financial Risk

GOAL

The goal is to minimize financial risk to California

Minimizing the financial risk to California involves identifying the potential costs and savings as well as the level of uncertainty associated with these.

Very rough estimates

State Financial Risk: Costs

The estimated budget of the BHP program is $3,064 M.[1] The table below highlights some of the financial uncertainties in the context of this number.

Cost	Amount	Source of Resolution
Cost of administering the BHP program (assuming same admin 4.5% as Medi-Cal)	$137 M[2]	*Policy determination*
Cost of administering the BHP program (as estimated in state-level analyses)	$300 M[3]	
Whether the federal reimbursement includes 95% or 100% of the co-payment subsidy *(ambiguity in the ACA)*	$61 M	*Federal clarification*
Potential reduction in federal BHP payment due to income variation	$100 - $550 M[4]	*Program experience*

[1] Calculated based upon Mercer analysis.
[2] Based upon Kaiser Family Foundation analysis from 1997.
[3] Most state analyses estimate administrative costs to be 8-12% of program budget. This figure is based on 10% of total estimated BHP payment in the Mercer analysis.
[4] IHPS conservative estimate.

Churn Could Create Considerable Financial Risk for California

Federal BHP Payment

The federal BHP payment is based on annual income: If an individual's annual income either increases or decreases out of the BHP range, the federal BHP payment could be less than initially expected.

BHP Costs

If individuals can enroll in the BHP when their income falls into the BHP range (as under Medi-Cal and Healthy Families), they may be similarly unlikely to dis-enroll when their income rises again.

The difference between these two methodologies of calculating BHP costs could imply that the state could receive a federal BHP payment that is significantly lower than the state's BHP liabilities.

Very rough estimates

State Financial Risk: Savings

Opportunities for budget savings are focused on **state-only Medicaid** programs

States that cover an expansion population under Medicaid with state-only funds could benefit from establishing a BHP, under which those populations would newly qualify for federal funding.

For California, the greatest potential here is to capture federal tax-credit funding to cover recent immigrants (<5 years) who are ineligible for the federal Medicaid match due to the waiting period.

In 2011, approximately 80K Californians were enrolled in state-only funded Medi-Cal due to their immigrant status, at an estimated cost of $225M.[1]

[1]Based upon per-individual Medi-Cal spending for non-disabled adults ($2819), California Health Care Almanac, Medi-Cal Facts and Figures, September 2009, CHCF.

Safety-Net and Medi-Cal Providers

GOAL

Ensure that there is an adequate safety net for those who may need it

Providers who serve Medi-Cal, underinsured, and uninsured are **diverse**:

- Region
- Geography
- Patient demographics
- Patient coverage mix

Examples include :

- Federally Qualified Health Centers (FQHCs) and community clinics
- Public hospitals
- Private providers that serve Medi-Cal and uninsured patients

Safety-Net and Medi-Cal Providers: Stability

Providers who serve a blend of public and commercial consumers could face uncertain changes in revenue due to a BHP; the net outcome would vary across providers.

BHP Encouraging Stability

- Broader insurance participation could lead to less uncompensated care
- BHP payments could be higher than Medicaid payments (a program-level decision)

BHP Challenging Stability

- Increased demand for services among newly covered populations could strain provider capacity
- Some individuals will migrate from commercial to BHP coverage with lower payment rates

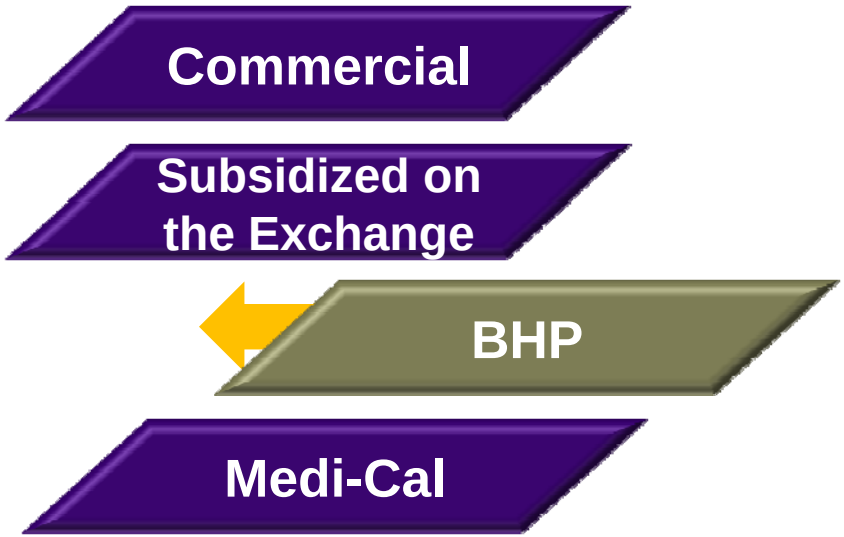
PPS rates could be in flux in the market; it is difficult to assess them specific to this inquiry.

Continuity of Coverage and Care

GOAL

Minimize disruption of coverage and care delivery as individuals' financial status changes

Source of Coverage



The BHP inserts an additional source of coverage for people with a relatively narrow band of income. It would require significant coordination among Medi-Cal, the BHP, and the Exchange to ensure continuity of coverage and of care.

Exchange: Impact

GOAL

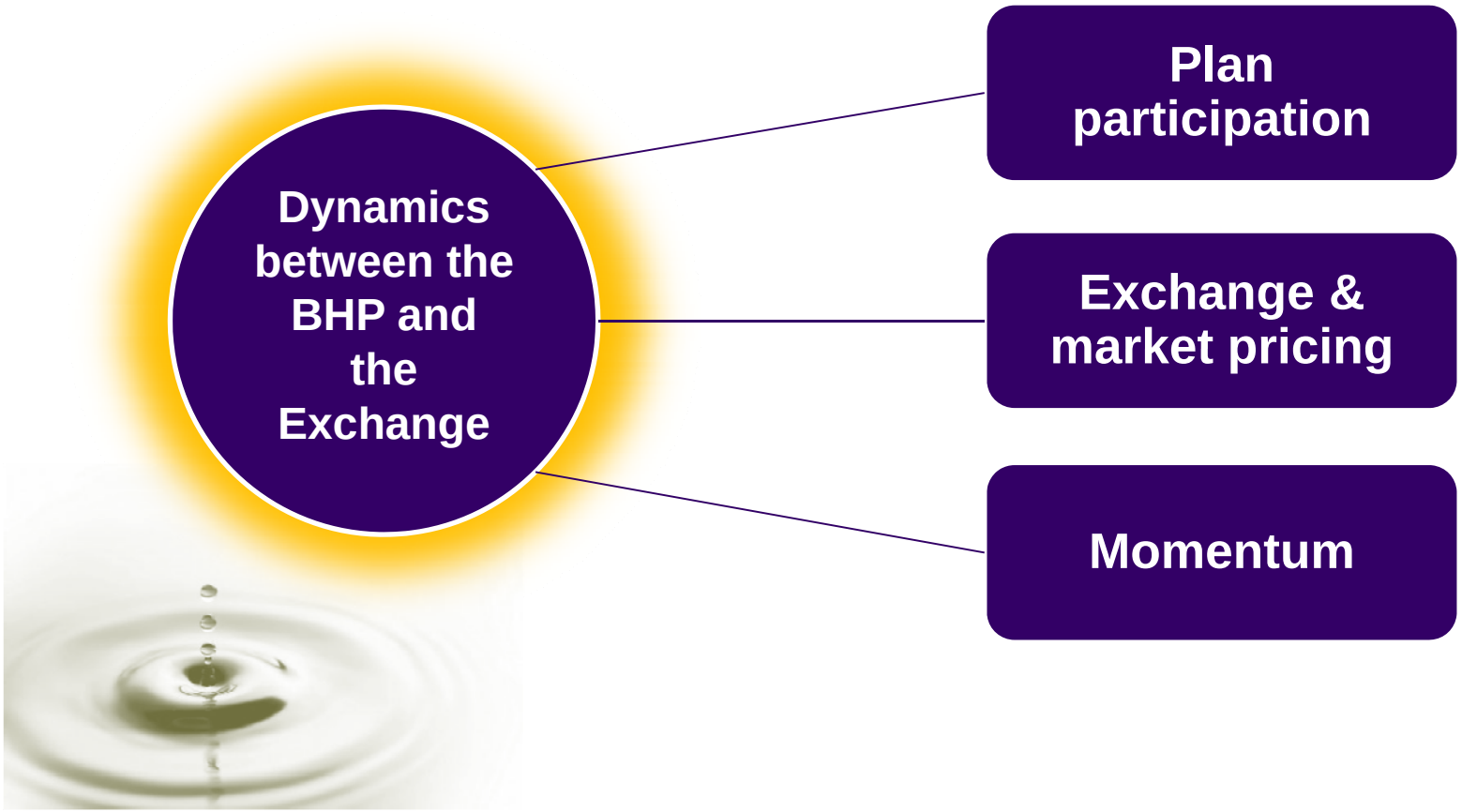
Ensure a viable Exchange that provides stable coverage and serves as a catalyst for delivery system improvement

The most often cited impacts were to the volume and risk mix of the exchange – with varying perspectives

	Potential BHP Impact on the Exchange
Volume	• Operating costs distributed across smaller membership • Potentially reduced negotiating power for prices, quality standards, and innovation • Some carriers may be less willing to invest in exchange readiness with a smaller pool of consumers
Risk Mix	Removing the BHP population from the exchange could either: A. Lower risk on the exchange (assuming they are sicker due to lower income); or B. Raise risk on the exchange (assuming they are younger and healthier, needing less care)

Exchange: Additional Dynamics

The impact to the Exchange – and the broader market – could move beyond the immediate issues of volume and risk



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Uncertainties

Many sources of uncertainty limit this analysis.
Some variables will be defined and others will emerge from complex market and individual dynamics

Near Term Expected Clarifications

- Federal policy decisions:
  - Mechanisms for state reconciliation
  - Reimbursement level for cost-sharing (95 or 100%)
  - Availability of federal support for BHP administrative costs
- State-level decisions:
  - Where the BHP is housed
  - Premium, cost-sharing, and benefit design for the BHP product

Will Emerge Over Time

- How many consumers actually enroll in which types of coverage over time
- Health status and other characteristics of enrolled consumers
- Actual price for the second lowest silver plan – which will determine the federal BHP payment level

Scoring the Impact of a BHP on California

The qualitative findings from this analysis suggest that the BHP's impact varies by policy goal

Best-Case Scenario	
Area of Impact	Rating
Coverage	++
Continuity	+ / -
Safety net	+ / -
State financial risk	+ / Neutral
Exchange	+ / Neutral

Worst-Case Scenario	
Area of Impact	Rating
Coverage	+
Continuity	+ / - -
Safety net	+ / -
State financial risk	- -
Exchange	- -

Highlights and Closing Thoughts

- Beyond the financial threshold questions addressed in many state analyses, there are significant ways that a BHP could impact California's policy goals.
- There is no definitive answer for how these could play out with so many lingering unknowns.
- Any significant change in the insurance coverage for a large block of California's population will affect not just that group in isolation but also other consumers and stakeholders.