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Exploring the Financial Feasibility of a Basic Health Program in California

Basic Health Program Option: Introduction

- The Patient Protection and Affordable Care Act (ACA) includes a provision allowing states to offer a Basic Health Program (BHP) option to provide coverage to some of their residents.
- The BHP option would be an alternative to those individuals receiving coverage through the state's offered Exchange(s).
- This presentation will cover the following:
  - Who would be eligible under a BHP?
  - What are the requirements for a BHP?
  - How is a BHP financed?
  - Is it financially feasible and even potentially beneficial to offer a BHP in California?
  - What potential impacts could offering a BHP have on the California Exchange?
  - Other considerations.

Who Is Eligible for BHP?

- The criteria that individuals eligible for coverage under the BHP must meet are as follows:
  - Income up to 200% of the federal poverty level (FPL)
  - U.S. citizen or lawfully present immigrant
  - Under age 65
  - Not be eligible for coverage under Medicaid (Medi-Cal), Medicare, or CHIP (Healthy Families Program or HFP)
  - 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% of FPL, and
  - Lawfully present individuals with income below 133% of FPL, not eligible for Medi-Cal or HFP because of immigration status

BHP Requirements

- Basic Health Program requirements are:
  - 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 133% to 150% FPL, cost-sharing cannot *exceed* platinum level (10% or 6%)
  - For individuals 151% to 200% FPL, cost-sharing cannot *exceed* gold level (20% or 13%)
  - Plan offered is either a managed care system or offers similar benefits of care management (FFS + PCCM 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

How Is a BHP Financed?

- ACA provides for financing of BHPs in two ways:
  - The federal government will pay states a premium subsidy based on 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

How Is a BHP Financed? (cont'd)

- The premium subsidy available under the Exchange is calculated as follows:
  - The difference between the ACA maximum allowable member premium (based on income, 3% at 133% FPL and 6.3% at 200% FPL) and the second lowest priced silver-level benefit plan offered under the Exchange
  - The subsidy available to states for BHP will be 95% of the amount calculated above
- ACA requires health insurance carriers to offer coverage plans through the Exchange that fall into four levels/tiers corresponding to the level of benefits they provide and their costs, as follows:
  - Bronze = 60% of coverage costs
  - Silver = 70% of coverage costs
  - Gold = 80% of coverage costs
  - Platinum = 90% of coverage costs

How Is a BHP Financed? (cont'd)

- The cost-sharing subsidy that is available to fund the BHP is either 95% or 100% (ACA is unclear) of the cost-sharing subsidy available under the second lowest cost, silver-level plan offered in the Exchange. For conservatism, Mercer uses 95%.
- The cost-sharing subsidy is equal to the difference between a silver-level cost-sharing structure and the gold and platinum levels, as follows:
  - 100 to 150% FPL (94% - 70% = 24%) 24% of total health care costs
  - 150 to 200% FPL (87% - 70% = 17%) 17% of total health care costs
  - 95% of each of the above

Financial Feasibility of Offering a BHP in California

- The following steps outline the overall approach for the feasibility analysis:
  - Estimate the size and demographic characteristics of the uninsured population *eligible* for the Exchange, and the subsets *likely* to enroll in the BHP and Exchange
  - Estimate the silver-level benefits and premiums (second lowest) 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 from 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% FPL through the existing Medi-Cal managed care organizations
  - Calculate the resulting difference between the estimated federal BHP subsidies and the estimated BHP premiums

Estimating the Exchange and BHP Populations

- Utilized the Census Bureau's California-specific Current Population Survey (CPS) data for 2007 – 2009 as the starting point
- Compared components and results to multiple other studies and/or data sources such as the California Health Interview Survey (CHIS) and found very comparable results
- Several key assumptions went into our calculations regarding the size of the potential Exchange and BHP eligible populations, as well as the proportion of those eligible that would likely enroll in both

Total Estimated Exchange and BHP Population

- The estimate of the total Exchange and BHP *eligible* population is 4,565,000
- The table below displays the estimated total Exchange and BHP eligible population estimated to *enroll* in the Exchange and the BHP combined

	Females	Males	Total
Avg. Adult Age	**41.6**	**39.8**	**40.6**
0-18	164,982	194,641	**359,623**
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	**1,218,951**	**1,360,272**	**2,579,223**

Exchange Population: Key Assumptions

- The Exchange risk pool (net of BHP) will consist entirely of adult individuals and families with incomes above 200% FPL
- 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

Estimated Exchange Population (Net of BHP)

- Assume 70% of the 200 – 400% FPL group will enroll and only 25% of greater than 400% FPL will enroll

	200% – 400% FPL		400% FPL and Above		
	Females	**Males**	**Females**	**Males**	**Total**
Avg. Adult Age	40.8	38.9	44.8	43.2	40.6
0-18	142,921	166,379	22,061	28,262	**359,623**
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	**723,512**	**800,105**	**147,169**	**185,019**	**1,855,805**

BHP Population: Key Assumptions

- 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 Healthy Families Program (HFP) or Medi-Cal, and will not be enrolled in the BHP
- Legal immigrants with residency status less than five years below 133% FPL will be eligible for the BHP
- Individuals with existing government-provided health benefits – Medi-Cal, 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
- Virtually all individuals up to 200% of FPL, with privately purchased individual policies, will migrate to the BHP due to the incentives of minimal premiums and low levels of cost-sharing

Estimated BHP Population

- Assume 70% of the BHP eligible population will actually enroll

	< 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**

Estimating Silver-Level Benefits and Premiums

- Priced silver-level Exchange Plan using proprietary Mercer Uninsured Model:
  - Comprised of national commercial large group data adjusted for California specific factors
  - Projected current commercial cost and utilization trends by categories of service (COS) to 2014
- BHP subsidies calculated from second lowest-cost silver plan, which may understate actual risk
- Did not add uninsured risk or pent-up demand factors for conservatism
- Assumed younger ages less likely, and older ages more likely, to enroll for conservatism
- Did not expand average commercial benefits to "Essential Benefits" for conservatism

Estimating Silver-Level Benefits and Premiums (cont'd)

- The *total* health care cost for an adult (non-family) within the Exchange is projected to be **$593** per member per month (PMPM)
- The silver-level **70%** actuarial value represents about **$413** PMPM paid by the plan, plus about **$73** PMPM in administrative costs (assumed at **15%**) – resulting silver-level premium for the year 2014, priced for the estimated demographics of the Exchange, as calculated by the Uninsured Model, is **$486** PMPM
- About **$180** PMPM, or **30%** of the health benefits cost, will be paid by the member via cost-sharing in the form of deductibles, co-insurance, and copayments

Calculation of Federal Subsidies

- Based on the estimated Exchange premium and cost-sharing estimate, the average federal subsidies available for the BHP are as calculated in the table below
- Using this BHP demographic profile, the weighted net federal BHP premium and cost-sharing subsidies are about $487 PMPM

	< 150% FPL	**150% – 200% FPL**
Silver-Level Premium PMPM	$486	$486
- BHP Premium Offset	$53	$91
Net Premium Subsidy	$433	$395
x 95% Premium Subsidy	$411	$375
Health Care Cost	$593	$593
Cost-Sharing Subsidy	$142	$101
x 95% Cost-Sharing Subsidy	$135	$96
Total Est. BHP Subsidy PMPM	$546	$471

Calculation of Estimated BHP Costs

- Utilized Medi-Cal managed care encounter and fee-for-service (FFS) data for adults age 19 through 64 (in ten different age/gender groups) for two Category of Aid (COA) groups
- Blended the data to reflect the projected BHP member demographic mix (included 20% of Disabled COA)
- Kept Medi-Cal maternity experience in the rates
- Assumed increased risk from adverse selection (70% enrollment) and lower risk/utilization (vs. Medi-Cal) due to cost-sharing will roughly offset each other
- Trended the data forward to 2014 and added an assumed administrative loading of 12% (including profit/risk/contingency)

Calculation of Estimated BHP Costs (cont'd)

- Developed weighted estimated gross BHP rates
- Assumed member premiums would be $10 and $20 PMPM for the less than 150% FPL and 150% – 200% FPL respectively, but that only half will ultimately be collected (BHP has a generous 90-day coverage grace period)
- Assumed 2% cost-sharing for the less than 150% FPL income group and 4% cost-sharing for the 150% – 200% FPL (similar to HFP)

	Less than 150% FPL PMPM	150 – 200% FPL PMPM	Weighted Average PMPM
Gross BHP Cost	$405	$406	**$406**
Less Member's Share	$12	$24	**$21**
Net BHP Cost	**$393**	**$382**	**$385**

Financial Feasibility Comparison

- The comparison between estimated federal subsidies and estimated BHP costs are displayed in the table below

	Less than 150% FPL PMPM	150 – 200% FPL PMPM	Weighted Average PMPM
Estimated Monthly Federal Subsidy	$546	$471	**$492**
Net Estimated Monthly BHP Costs	$393	$382	**$385**
Difference Excess	**$153**	**$89**	**$107**

Feasibility Conclusion

- The table on the previous page indicates that a BHP offered at Medi-Cal reimbursement rates would be financially feasible for the State (i.e., no cost to the general fund)
- Based on the estimates developed in our analysis, it appears that the State would be able to offer a BHP at provider reimbursement rates at 20 – 25% above current Medi-Cal rates
- In addition, to the extent the federal government allows BHP subsidies to be used to fund program administration, there appears to be more than adequate excess funding available to cover the cost of program administration if the BHP is offered through an existing program/department
  - Just 1% of BHP subsidy would generate approximately $42.7 million annually (2% = $85.4 million)

Potential Impact on Exchange Population > 200% FPL

- A BHP in addition to the Exchange will reduce the number of individuals covered under the Exchange, thereby reducing the base with which to cover Exchange operating costs (self-sustainability):
  - California's Exchange population is still estimated to enroll over a million residents (even without the BHP group)
- A BHP in addition to the Exchange will impact the risk pool of the Exchange population:
  - Argument that Exchange risk may increase: The less than 200% FPL group has a lower age mix, which typically is less risky
  - Argument that Exchange risk may improve: lower premiums and cost-sharing in a BHP will attract better risk than if the same group (up to 200% FPL) only has the Exchange option (significantly higher premiums and cost-sharing would result in greater adverse selection of this lower income group in the Exchange)

Potential Impact on Exchange Population > 200% FPL (cont'd)

- Improve the policy persistency (i.e., lower the lapse rates) by removing the lowest income population with the least discretionary income
- Reduce complexity of cost sharing subsidy calculations (i.e., do not have to deal with < 150% and 150% - 200% income bands)
- Simplify pricing of silver-level products: If the < 200% group is in the Exchange, they would be purchasing silver-level plans priced at 70% actuarial values, by using services priced at 94% and 87% actuarial values; due to the cost sharing subsidies
- More discussion expected on this topic from the panelists

Other Considerations

- Because of numerous uncertainties about the health care marketplace in 2014, the analysis and conclusions are preliminary and subject to change for many reasons, some of the most significant being:
  - Uncertainties regarding the ACA
  - Key terms and provisions in the law remain undefined/unclear
  - Key terms and provisions of the law conflict
  - Many decisions would have to be made about how the State would structure a BHP and the Exchange
  - Uncertainties regarding health insurance carriers' behaviors under the ACA
  - Uncertainties regarding consumer behavior under the ACA

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