



# Basic Health Program: Does it Make Sense for Ohio?

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**Microsimulation modeling by Matthew Buettgens, Senior Methodologist, and Caitlin Carroll, Research Assistant, Urban Institute**

# Overview

1. Modeling methodology
2. Modeling results
3. Policy implications



But first

# **A WORD ABOUT AFFORDABILITY**



**Premiums and actuarial value of coverage for a single, uninsured adult, at various income levels qualifying for subsidies under the ACA**

<b>Federal poverty level (FPL)</b>	<b>Monthly pre-tax income</b>	<b>Monthly premium</b>	<b>Actuarial Value (AV)</b>
150	\$1,354	\$54.15	94%
175	\$1,579	\$81.34	87%
200	\$1,805	\$113.72	87%
225	\$2,031	\$145.70	73%
250	\$2,256	\$181.63	73%

*Note: assumes 2010 FPL levels.*



# Examples of health plans at various actuarial value levels

Income	AV	Plan example	Annual deductible	Office visits	Inpatient hosp.	Prescr. drugs
150% FPL	93%	Average HMO plan offered by employers	None	\$20 copays	\$250 co-pay	\$10/\$25/\$45 copays
175% FPL	87%	Federal Blue Cross-Blue Shield	\$250	\$15	\$100 co-payment, then 10%	25% of all costs

*Source:* Congressional Research Service, 2009.



# Perspectives on consumer costs

- The ACA will dramatically lower the cost of coverage and care, reducing uninsurance and improving access to care. According to a 2010 Kaiser survey, single adult policies in the individual market averaged:
  - 3,606 a year in premiums
  - \$924 a year in out-of-pocket costs
- But low-income consumers' costs in the exchange's subsidized individual market will be:
  - Higher than most current public programs
  - High enough to deter enrollment and utilization of essential services for many low-income consumers



# Maximum repayment obligation for tax credit recipients, by income

	Single filer	Joint filer
<b>&lt;200% FPL</b>	\$300	\$600
<b>200-299% FPL</b>	\$750	\$1,500
<b>300-399% FPL</b>	\$1,250	\$2,500



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I.

# MODELING METHODOLOGY



# Our model

- Health Insurance Policy Simulation Model (HIPSM)
  - Built on decades of experience with microsimulation modeling
  - HIPSM is currently being used to provide reports for the Robert Wood Johnson Foundation and technical assistance to HHS and states that include Massachusetts, Missouri, New York, Virginia, and Washington
  - Publicly available methodology: no “black boxes”
- Incorporates state-specific information from March CPS, National Health Expenditure Accounts
  - Adjusts raw CPS data to compensate for the “Medicaid undercount”
  - Determines eligibility using a model of each state’s Medicaid rules
- Via “statistical matching,” incorporates other sources, such as:
  - Health care cost data from MEPS
  - Employer offer data from MEPS, February CPS
- Behavioral models for firms and individuals calibrated to:
  - Empirical observations
  - Health economics literature

# The policy we modeled: building on existing programs to make coverage more affordable



- Basic concept
  - Medicaid look-alike
  - “CHIP for adults”
- One possible approach: a single, integrated program providing all low-income residents with rebranded Medicaid coverage
  - Combine federal funds under Medicaid, CHIP, and BHP—done in the “back room,” invisible to consumers
  - Benefits & cost-sharing:
    - Medicaid level up to 138% FPL
    - Slightly increased cost-sharing and slightly reduced benefits > 138% FPL



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## Subsidy eligibility in Ohio under the ACA, without BHP

	Children	Adults – citizens and immigrants who qualify for federal Medicaid	Adults – lawfully present immigrants ineligible for federal Medicaid
>400% FPL	No subsidies		
200-400% FPL	Exchange		
138-200% FPL	Medicaid	Exchange	
0-138% FPL	Medicaid	Medicaid	Exchange

# Subsidy eligibility in Ohio, under one possible approach to BHP

	Children	Adults
>400% FPL	No subsidies	
200-400% FPL	Exchange	
138-200% FPL	Medicaid	
0-138% FPL		

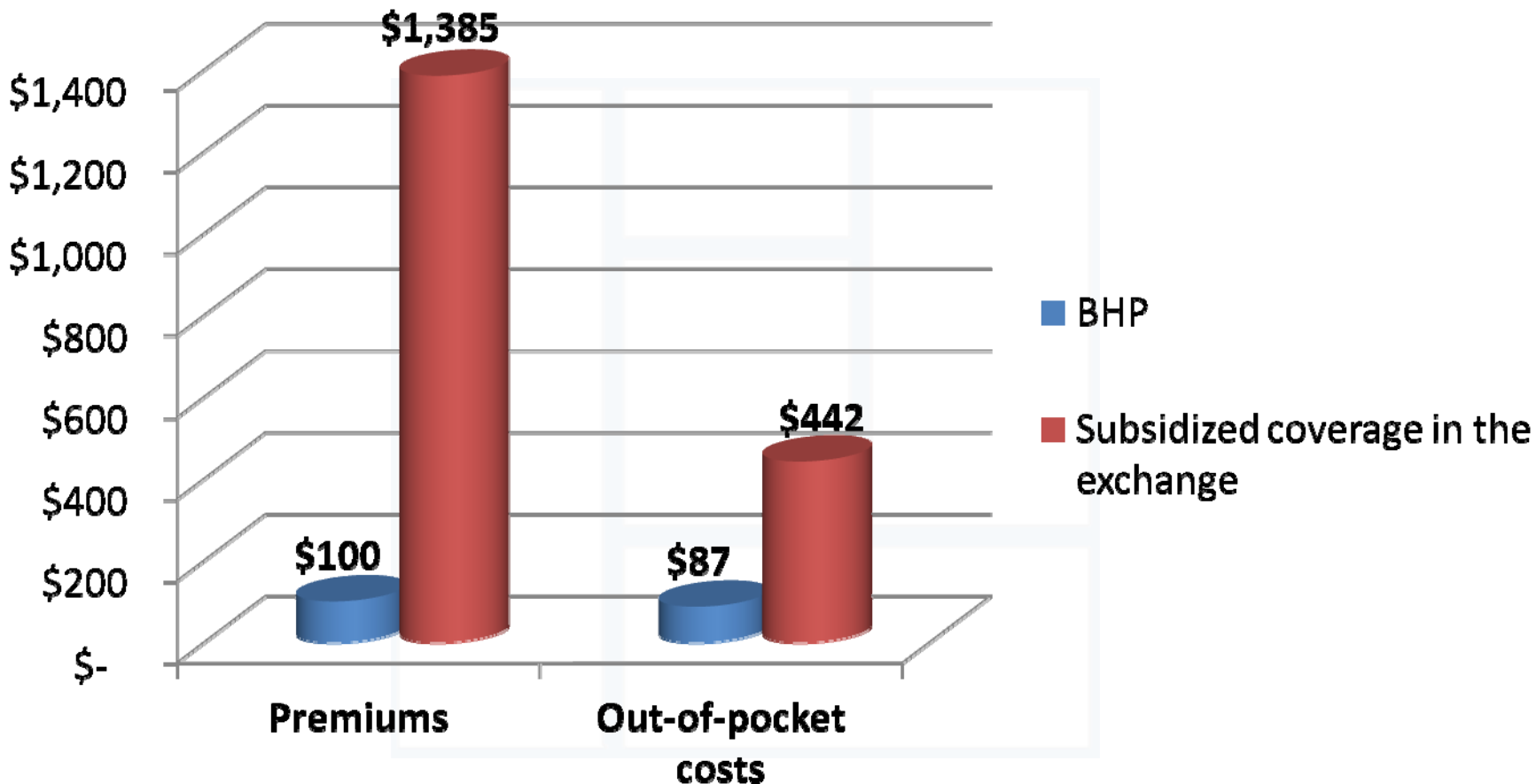
# More detail on the policies we modeled

- Under 138% FPL
  - Implement ACA-required Medicaid up to 138% FPL
  - Use BHP to fund Medicaid look-alike coverage for lawfully present immigrants who are not “qualified,” and so are ineligible for federal Title XIX dollars
- Adults at 138-200% FPL
  - No changes to current eligibility for pregnant women, etc.
  - BHP funds Medicaid “look alike” coverage, modified to impose consumer cost-sharing typical of separate CHIP programs
    - Out-of-pocket cost-sharing: 98% actuarial value
    - Annual premiums of \$50 per child, \$100 per adult
- Private insurance markets
  - Individual and non-group markets remain separate
  - Premiums in exchange = health care costs + 15% administrative load
- Federal BHP dollars = 95% of (tax credits + cost-sharing subsidies)
- Results show effects as if ACA were fully effective in 2011

II.

# MODELING RESULTS

## Average annual costs for Ohio adults with incomes between 138-200% FPL: BHP vs. subsidized coverage in the exchange



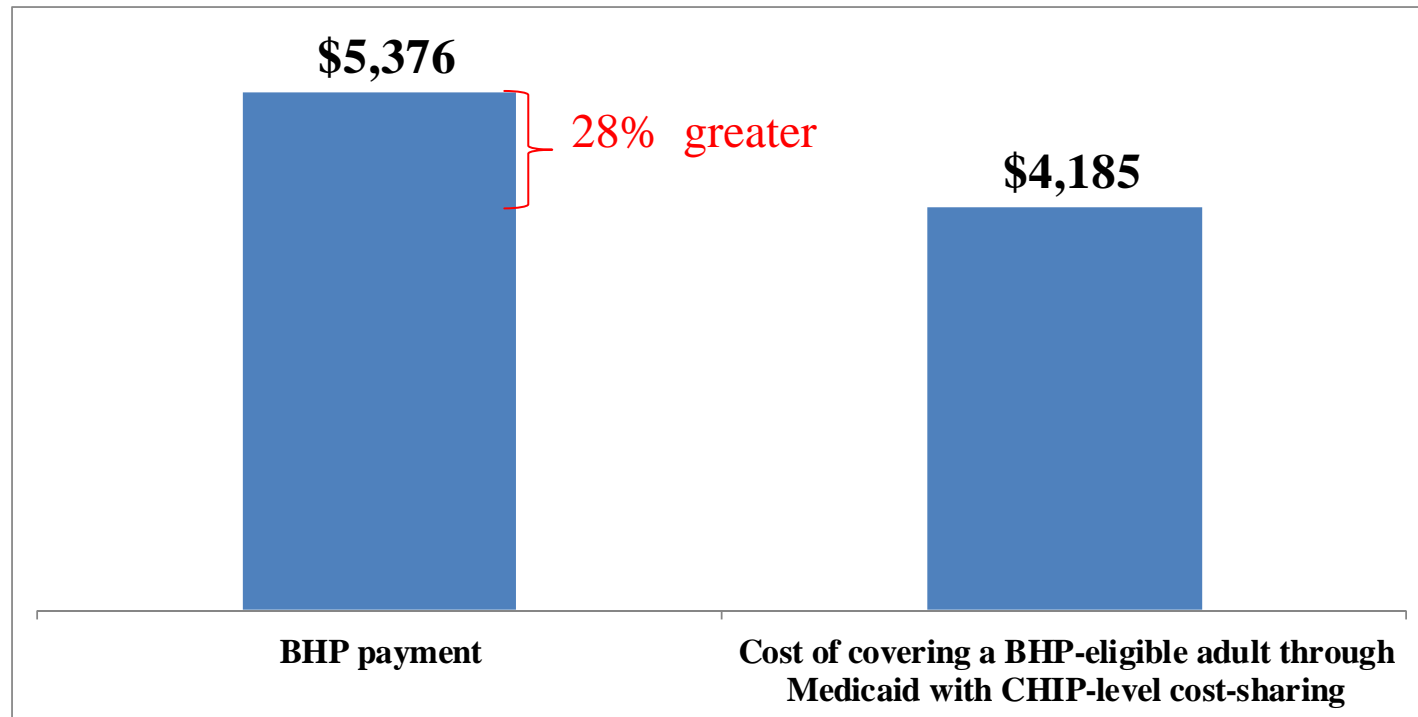
Source: HIPSM, 2011.

# Perspective

- \$1,640 in annual savings for the average BHP consumer in Ohio
- Single adults eligible for BHP have monthly, pre-tax income between:
  - \$1,252 (138% FPL in 2011) and
  - \$1,815 (200% FPL in 2011)



## BHP federal payments vs. the cost to cover BHP adults through Medicaid with CHIP-level cost-sharing: Ohio



*Source:* HIPSM, 2011. *Note:* Assumes exchange premiums generally reflective of current costs and no tobacco-related premium variation. “CHIP-level cost-sharing” refers to 98% actuarial value and \$100 per year in adult premiums.

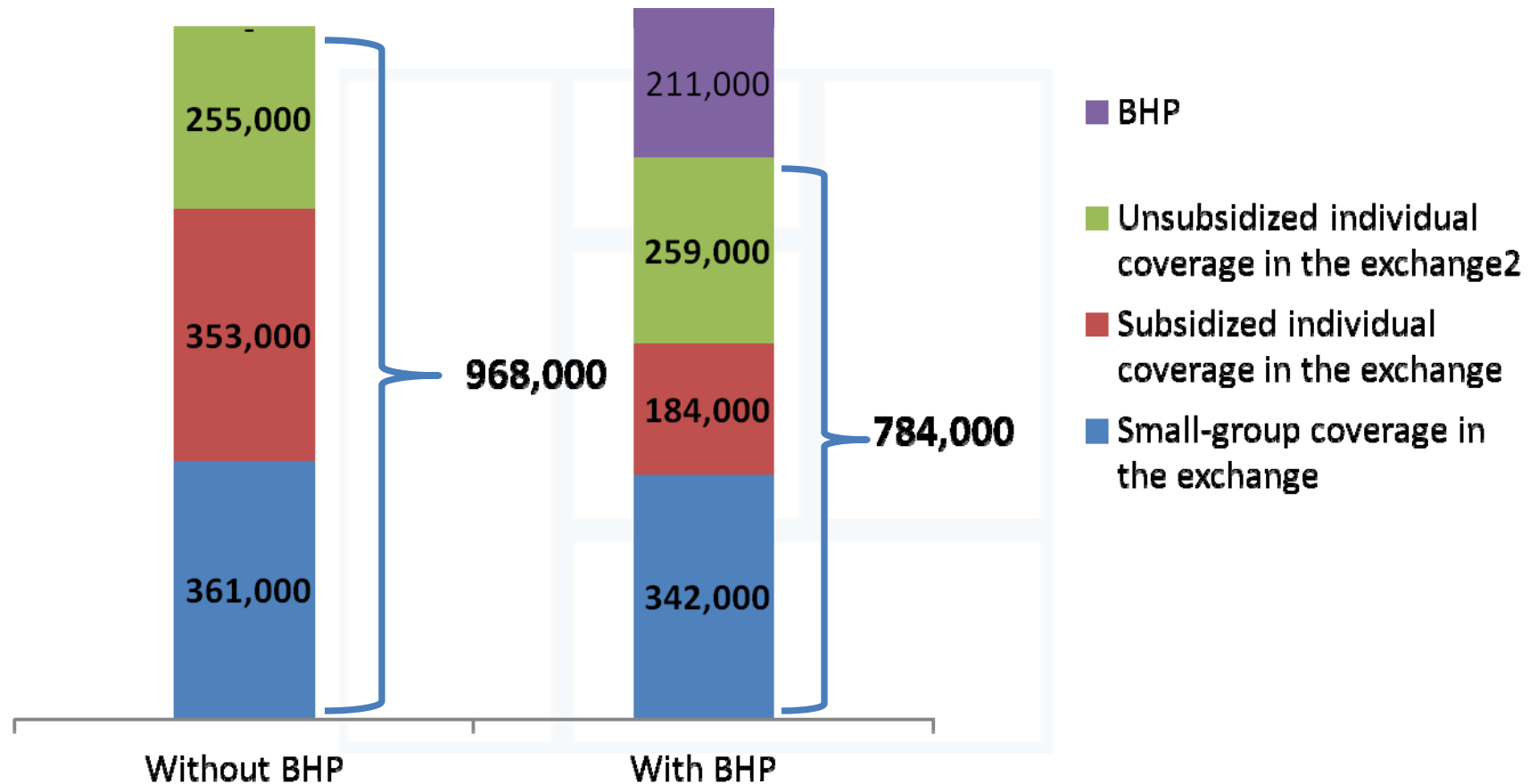
## Number of uninsured under the ACA, without and with BHP

- 600,000 fewer uninsured if all states implement BHP, using the policies we model
- Coverage increases are statistically significant in 34 out of 50 states
  - In Ohio, BHP's lower premiums cause an additional 27,000 uninsured residents to gain coverage



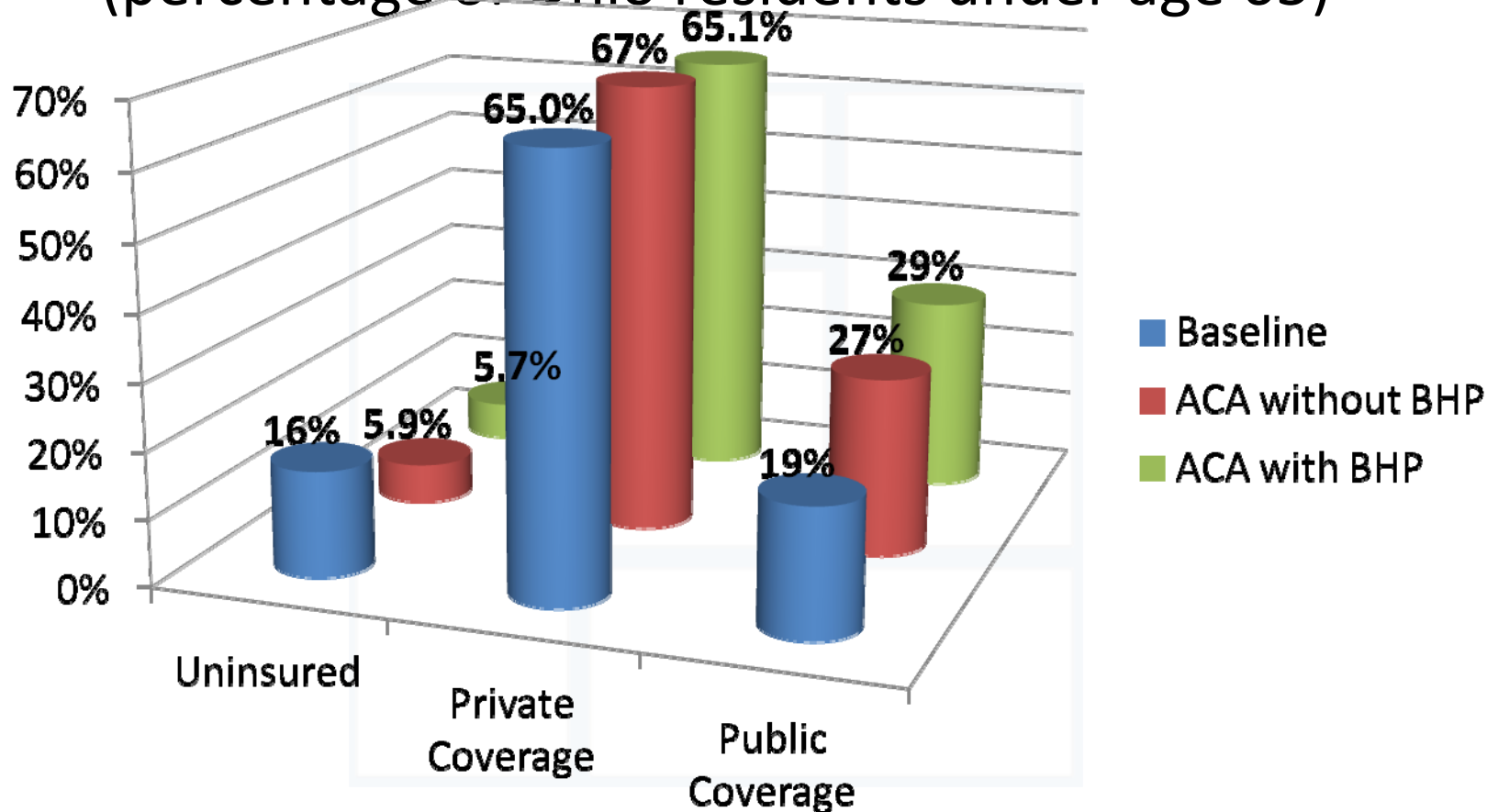
*Source:* HIPSM, 2011. *Note:* Does not take into account increased coverage under BHP resulting from the absence of risk of owing money to the Internal Revenue Service if annual income turns out to exceed estimated levels.

## BHP implementation and exchange size under the ACA (Number of Ohio residents under age 65)



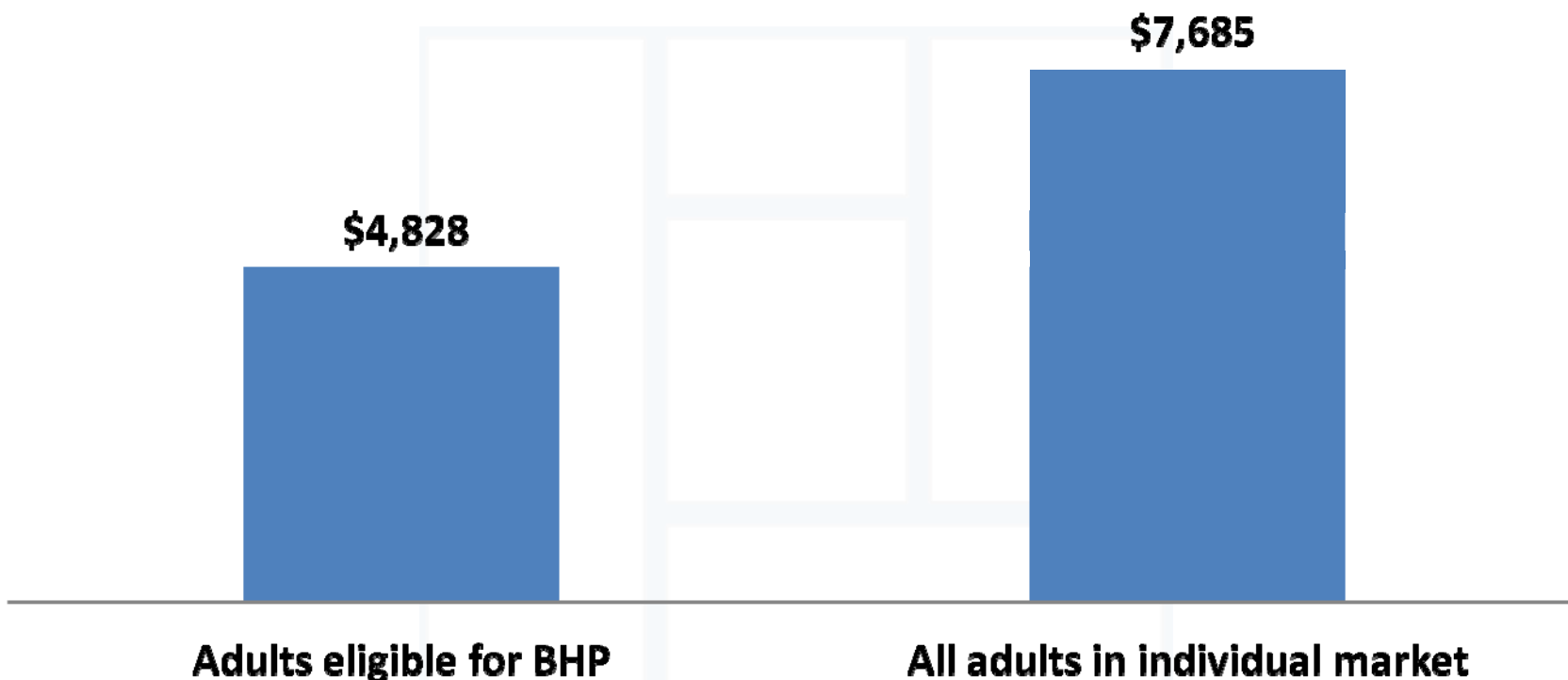
Source: HIPSM, 2011. Totals may not add because of rounding.

## Uninsured, privately insured, and publicly insured residents : baseline vs. ACA without and with BHP (percentage of Ohio residents under age 65)



Source: HIPSM, 2011. Note: Public coverage, in this chart, consists of Medicaid, Medicare, and BHP. Private consists of ESI and individual insurance, within and outside the exchange.

## Under the ACA, average health care costs of BHP-eligible adults in the exchange vs. all adults in individual market: OH



*Source:* HIPSM, 2011. *Note:* Costs include those covered by insurance, plus out-of-pocket payments for care. Does not include effects of possible Medicaid eligibility cutbacks or cost reductions other than for 1115 waivers and coverage under Social Security Act Section 1931.

III

# POLICY IMPLICATIONS



# Implications of the approach we modeled



# BHP from the perspective of low-income consumers

- Advantages
  - Certain Medicaid beneficiaries retain something like current coverage
    - Adults with MAGI > 138% FPL
    - Legally resident but not qualified immigrants < 138% FPL
  - Other low-income adults >138% FPL also receive much more affordable coverage than will be offered in the exchange
  - No risk of owing money to IRS at the end of the year
  - More stability of coverage
  - More access to safety-net plans
- Disadvantages
  - More limited provider networks, even though could probably raise provider fees and capitated payments above Medicaid levels
  - Less access to commercial plans
  - Separate systems of coverage and care for low-income and other residents
- The key consumer trade-off: for this particular population, what is the more significant impairment of access?
  - Higher costs in the exchange; or
  - Smaller provider networks in BHP

# State cost savings: the big picture

- By shifting adults' health costs from Medicaid to BHP, the state saves money without forcing these adults to pay significantly more
- Could also save money by putting these adults in the exchange, but that would greatly raise consumers' health costs without increasing state savings
- Either way, some Medicaid adults are offered ESI that will disqualify them from both BHP and federally-funded subsidies in the exchange

Scenario	What happens to Medicaid adults >138% FPL?	Impact on Medicaid adults	State fiscal effects
1.	They stay in Medicaid	No increased costs	No savings
2.	They move into the exchange	Major cost increases	Savings
3.	They move into BHP, with CHIP-level cost-sharing and premium payments	Nominal cost increases	Same savings as #2

# Savings from moving people from Medicaid to BHP

- Lawfully present immigrants with MAGI < 138 percent FPL who now receive coverage with state-only dollars
- Over 138% FPL, Medicaid adults outside 1115/1931 eligibility (pregnant women, women diagnosed with breast and cervical cancer)
- Children over 138% FPL, if maintenance of effort requirements are repealed or CHIP allotments end after 2015



# Savings, for states and employers

- Lower administrative costs from reduced movement between Medicaid and the exchange
- Lower cost of state benefit mandates
  - ACA requires state to pay increased costs in the exchange that result from state requirements to cover services that go beyond federally-specified minimum essential benefits
  - BHP implementation eliminates the need to pay such costs for adults at 138-200 percent FPL
- Employer penalties largely disappear (depending on how HHS interprets the statute)
  - Employers pay penalties if their workers obtain coverage funded by tax credits, not BHP



# What about the exchange?

- Some state policymakers may prefer state residents in state-designed coverage, rather than the exchange
- Exchange size somewhat smaller
  - Large enough for viability and attracting good plans
  - Fixed administrative costs spread across a smaller population
- Federal BHP payments will likely exceed baseline costs, allowing increased reimbursement, but:
  - Inherent uncertainties in any new federal program
  - Exchange administration will affect federal BHP funding
    - A very low “reference premium” cuts tax credit amounts, hence



# Effect of BHP implementation on exchange risk

- What counts is effect of BHP implementation on the *entire individual market*. ACA insurance rules base premiums on the risk level of the entire market, not enrollees in a particular plan or set of plans:
  - Plans pool all individual enrollees together, inside and outside the exchange
  - Risk-adjustment, reinsurance equalizes risk levels between plans
- Death spirals highly unlikely to result from increased individual premiums
  - In the past: increased risk in exchange raised premiums in the exchange; healthy enrollees left for similar coverage sold elsewhere at much lower prices, further raising risk in exchange, further raising premiums, triggering further departures, etc.
  - Under the ACA:
    - High risk levels within specific plans do not cause a major premium increase. Premium based on overall market risk, not risk level of plan enrollees.
    - Little or no reason for healthy individuals to leave. Similar coverage not available outside the exchange for much lower premiums.
- General premium increases in the individual market:
  - Will affect the federal government and unsubsidized enrollees
  - Will not have a major impact on subsidized enrollees

## A hypothetical: Tommy Tax Credit

- A single guy, Tommy has income at 250% FPL
- If Tommy picks the plan with the reference premium, he pays 7% of income, or \$160 a month

Tommy's plan	Factor	What happens if all the premiums in the exchange are low?	What happens if all the premiums in the exchange are 20% higher?	What's the difference?
<b>Plan with reference premium</b>	Monthly premium	\$400	\$480	\$80
	Tommy's cost	\$160	\$160	\$0
	Tax credit	\$240	\$320	\$80
<b>A more costly plan</b>	Monthly premium	\$500	\$600	\$100
	Tommy's cost	\$260 (\$160 + the \$100 excess over the reference premium)	\$280 (\$160 + the \$120 excess over the reference premium)	\$20
	Tax credit	\$240	\$320	\$80

# State policy options that affect risk in BHP and the individual market

- If Medicaid for pregnant women and other high-cost groups is cut back above 138 percent FPL, BHP implementation may improve the remaining risk pool or leave it largely unaffected, on balance
- If allowed by HHS, the state could share risk between BHP and the individual market
  - Include BHP in reinsurance, risk adjustment mechanisms serving the individual market
  - If a BHP plan is state-licensed, require the insurer to pool BHP risk with individual market members

# Continuity of coverage and care

- BHP could move the transition point between Medicaid plans and the exchange from 138 to 200 percent FPL. This improves continuity, since, at lower income levels:
  - More subsidy recipients
  - More income fluctuation
- Why continuity matters
  - Continuity of provider is clinically significant
  - Coverage can be temporarily lost in a shift between programs
  - Churning raises public-sector administrative costs
  - Continuity increases plans' incentive to invest in members' long-term wellness

# Children and parents could join the same plan and program

- No research shows benefits from such family unity
  - When parents receive coverage and essential care, their children benefit in various ways
  - No evidence of benefit when parents are covered through the *same plan* as their children, rather than a different plan
- Nevertheless, joint coverage would probably help some children
  - Parents need to learn only one health plan's procedures for accessing care, which could increase access to care
  - Parents must meet just one government program's requirements for getting and keeping coverage, which could increase enrollment
  - Some parents and children have co-located or common providers
    - Staff-model HMOs , community health centers, and family practitioners
    - Could sometimes allow a common visit for preventive care or a family-wide illness
    - Greater provider knowledge of the entire family could sometimes improve care
    - Unknown: how many parents and children share providers
  - For political viability, health reform needs to make sense to consumers
    - Splitting families among programs reduces credibility – but by how much?
    - Massachusetts uses different programs for children and parents, and reform is very popular



# Other possible approaches to BHP



# Medicaid reimbursement

- Option: raise reimbursement by further increasing consumer cost-sharing or reducing benefits
- Option:
  - Pay baseline Medicaid levels
  - After the end of the year, pay bonuses to providers who serve BHP consumers, based on final federal BHP payments to state



# BHP as 2-way bridge



- BHP consumers can choose between Medicaid and the exchange
- Advantages
  - Continuity
  - Consumer choice
- Challenges to address
  - 5% shortfall in BHP payments to plans in the exchange
  - Instability potentially resulting from a small group of BHP enrollees in particular plans
  - Potential consumer confusion
  - Risk selection

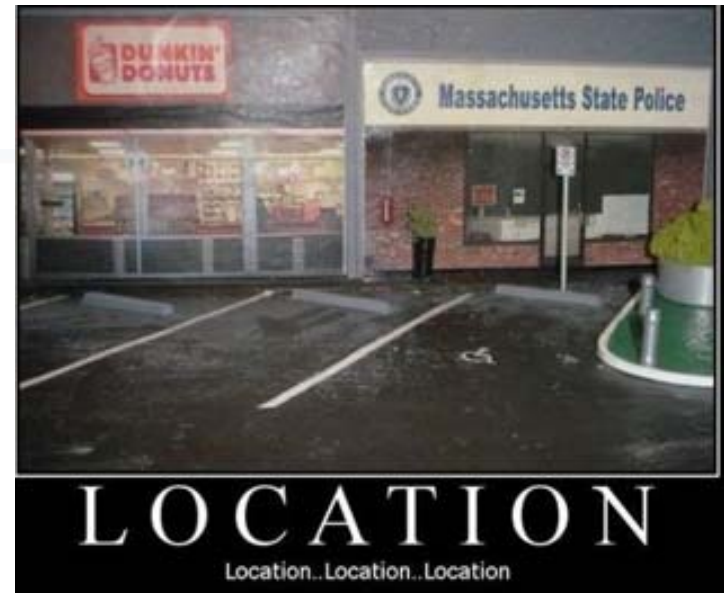
# BHP as “in between” program

- Consumer costs, covered benefits, provider reimbursement between Medicaid and commercial coverage in the exchange
- Appeal: An “in between” program for an “in between” population
- Disadvantages:
  - Fragmentation and discontinuity
  - The administrative challenges of creating a brand-new program while implementing the rest of ACA



# Where should BHP be put?

- Medicaid or exchange?
- Where do you want the leverage to go?
  - Medicaid: State-purchased health care
  - Exchange: federal government and unsubsidized enrollees
- Which entity has the relevant expertise and necessary administrative resources?



# Conclusion

- Implemented to build on existing Medicaid models, BHP could greatly improve affordability for low-income consumers, including some Medicaid adults who might otherwise be moved to the exchange
- BHP allows state Medicaid savings without imposing major cost increases on Medicaid beneficiaries
- Trade-offs
  - For consumers: smaller provider networks
  - For exchange: fewer covered lives and the potential for higher individual market premiums
  - For providers: less financial gains from the ACA, since smaller increase in private and larger increase in public coverage
- Key obstacle: waiting for CMS guidance