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State of Arkansas Department of Insurance

Consideration of the Basic Health Plan in Arkansas

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Purpose

The Arkansas Insurance Department requested that PCG develop a report describing the potential advantages and disadvantages of implementing the Basic Health Plan option included in the Patient Protection and Affordable Care Act. This report consists of the following information:

- I. Basic Health Plan Legislation Summary
- II. Factors when considering the BHP option
- III. Advantages and Disadvantages for Arkansas

Basic Health Legislation Summary

The Patient Protection and Affordable Care Act allow states the option to implement the Basic Health Plan (BHP) for the following two groups:

- Adults under age 65 with incomes between 133 and 200 percent of the federal poverty level (FPL); and
- Legally resident immigrants under age 65 with incomes below 133 percent FPL whose immigration status disqualifies them from federally matched Medicaid.

BHP provides states 95 percent of what the federal government would have spent on tax credits and subsidies for out-of-pocket costs in the exchange. In addition, if not all funds are used for the program's expenses, the state is free to use any unspent funds for other purposes within the BHP. These funds cannot be used for non-BHP purposes. Options might include increasing provider rates for services difficult to obtain, offering non covered services that could reduce reliance on emergency room use or inpatient admissions, or lowering enrollee cost sharing.

With respect to **premium costs** by potential enrollees, the law provides two caps on the amount that can be charged an enrollee based on income. Potential enrollees with incomes between 133 and 150% of FPL would be capped at no more than 3% of income and between 151 and 200% of FPL, up to 6.3% of income. In terms of **cost-sharing**, for enrollees with incomes below 150 percent of poverty, the Basic Health Plan would pay for at least 90 percent of the cost of benefits, on average, according to the statute. For enrollees with

incomes between 150 and 200% of the FPL, the Basic Health Plan would pay for, on average, at least 80 percent of the cost of benefits. It is important to note that no cost sharing is allowed for prevention services. If a state elects the BHP option, consumers cannot receive subsidized insurance through the exchange and they may not be charged more than what they would have paid in the exchange.

A BHP can be administered in one of four ways,

- a separate program of its own,
- a Medicaid-like program,
- a CHIP program for adults at the option of the state; or,
- a two way bridge where potential enrollees have a choice between the exchange or the BHP

The state would be required to provide BHP services based on a competitive bid process by contracting with health plans or by implementing a primary care case management approach by contracting directly with primary care providers to provide a medical home and appropriate support services, a model used by many state Medicaid programs. In selecting the BHP, States must provide at least the minimum essential health benefits under ACA, which include:

- ambulatory patient services;
- emergency services; hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and,
- pediatric services, including oral health and vision care.

These same services are also required in the ACA regulations of qualified health plans offered in the individual and small group markets in and out of the exchange.¹

This would suggest that the benefit plans would be comparable unless the state decides to implement the BHP as a Medicaid-like Program or CHIP for adults and provide the same benefit

package. For purposes of this document, when referring to a Medicaid-like program, an assumption is made that the state would provide seamless coverage and use the same administrative infrastructure as the Medicaid program. Regardless of the structure, all sources have been clear that assumptions are based on the reading of the legislation without benefit of government promulgated rules, therefore, some of the content and assumptions in this document could be subject to change.

Factors when considering the BHP option

As Arkansas decides whether or not to implement this voluntary option afforded by the ACA, this document explores the advantages and disadvantages for the state and potential enrollees.

Factors for consideration can be summarized in the following categories:

- Eligibility
- Benefits
- Provider infrastructure
- Impact on the exchange
- Financial

Eligibility

Advantages for implementation:

Eligibility for the BHP is between 133 and 200% of FPL. At this income level it is expected that there will be a fair amount of churning in and out of the Medicaid program as employment status changes in this volatile market. Implementing a BHP as a Medicaid-like program could provide stability for the enrollee and provide less confusion for potential enrollees who change programs frequently. It is also expected that implementing the BHP as a Medicaid-like coverage program improves affordability and continuity of coverage for low income residents.ⁱⁱ

The Children's Health Insurance Program (CHIP) eligibility legislation is scheduled to expire in 2015, the implementation of a BHP, administered as a CHIP plan could provide a safety net for replacement coverage if CHIP funding is not extended in the future at the Federal level.

Disadvantages for implementation:

An increase in eligibility in a BHP would either create a separate administrative structure as a standalone program from the exchange, or create additional volume for state workers if administering a Medicaid-like Program using the same administrative infrastructure. For the Medicaid-like program, implementing a BHP could lengthen the time it takes to determine eligibility, especially considering the already increased volume from the increase in Medicaid eligibility up to 133% of FPL on the same timeline. A lengthened timeframe could cause a state Medicaid program to be out of compliance with Federal regulations which requires that Medicaid programs determine eligibility within 45 days. If this requirement is not met, states are required to grant eligibility beyond 45 days of application until a decision is reached, using 100% state funds for any service use exceeding 45 days until the eligibility determination is made, a potential risk for the state if this same requirement is implemented by CMS for this population.

As part of enrollment in an exchange consumers receive tax credits based the previous year's income as reported to the IRS. If income changes throughout the year there is a possibility that consumers could owe money to the exchange as a result. Implementation of a BHP avoids this risk for consumers.

Benefits**Advantages for Implementation:**

The essential health benefits required in the BHP are the same as the exchange; therefore, the minimum benefit package would theoretically be comparable in both plans if the BHP were to be set up as a standalone program.

If the state elects to provide BHP coverage as a Medicaid-like program to 200% of FPL, lower income consumers may gain in the area of benefits. Medicaid benefits tend to be more generous than most commercial plans allowing consumers with high, atypical medical needs, not generally served in a comprehensive way by commercial insurers, to be better served by a Medicaid-like program.

The state would also have the flexibility of tailoring the benefit plan of the BHP to service needs specific to this population. This likely would not occur in the exchange. To provide an example, if while the state is monitoring the utilization of services for BHP enrollees, routine emergency department visits are prevalent as a result of non covered services that would be more cost

effective if provided in the community, the state would have the flexibility to add that service to the benefit plan, assuming there is enough funding through BHP proceeds. The same would be true for costly, frequent inpatient admissions or longer hospital stays due to non covered services. Exchange plans, assuming they have a healthier population overall would likely choose additional benefits (over and above the essential health benefits) based on majority needs.

Families at these income levels may have children who are enrolled in the CHIP program. Different benefit plans, cost sharing, and premium payments can be confusing to navigate. If the provision of the BHP is Medicaid-like, families with children enrolled in CHIP could have the same benefits, with the exception of services specifically spelled out for pediatric populations. This would be true if the program is designed to be seamless with the Medicaid program. A seamless Medicaid-like program would reduce confusion for families often resulting in better compliance with rules and regulations for participation.

Lastly, a more stable eligibility environment leads to less transfer amongst health care providers and better continuity of care when enrollees are not forced to change providers due to expected FPL changes.

Disadvantages for implementation:

The implementation of the BHP as a Medicaid-like program may have some disadvantages for states. Many Medicaid programs have tried in recent years to reduce Medicaid benefits due to state financial challenges, only to be prevented from doing so because of pressure from advocacy groups, threat of lawsuits, or MOE provisions. Providing services to potential enrollees as part of the exchange would eliminate the threat of much more stringent Medicaid regulations for BHP enrollees, should Congress decide at a future date to streamline standards between the Medicaid program and the BHP.

For potential enrollees in this income group, aside from possible Medicaid participation, this may well be the first time they have been exposed to or even considered private health insurance plans. The number of plan choices, the comparisons of each, and the possibility of churning in and out of Medicaid, even with the help of navigators, could be overwhelming, resulting in the choice of purchasing no insurance at all.

Provider Infrastructure

Advantages for Implementation:

Although provider participation varies, Medicaid provider networks have more diversity in the types of providers and services available due to the special needs of some Medicaid groups. In studying the needs of childless adults in other states covered through waivers, the needs for this population are more closely related to most Medicaid enrollees. Therefore, if the BHP uses the Medicaid provider network, it may be more prepared to for the provision of atypical services compared to the exchange's qualified health plans, who have traditionally served healthier populations.

Disadvantages for implementation:

With the exception of atypical provider types, it is expected that commercial insurers who participate in the exchange will have a more abundant choice of providers from whom enrollees may receive services. It is typically true nationwide that Medicaid programs have less choice within their provider networks often due to low rates of payment, although provider participation varies somewhat state to state. If the Medicaid- like program uses the same provider network, provider choice could be less sufficient.ⁱⁱⁱ

Impact on the Exchange

Advantages for states to keep BHP eligible consumers in the exchange:

The BHP population could be served by the Exchange at no cost to the State should the state be unable to pay for BHP services within available funding.^{iv}

More BHP covered lives to state-purchased coverage, could modestly increase such a state's ability to lower prices and improve quality of care. The leverage provided by BHP-eligible covered lives as part of the exchange could reduce state costs for populations currently covered by the Medicaid program that would now become part of the exchange.^v

Disadvantages if the BHP is outside of the exchange:

Serving the BHP eligible population outside of the exchange could have unintended consequences for the exchange:

- Reduces the size of the Exchange - average state's individual market in the Exchange would serve only 6 percent compared to 8 percent of non-elderly residents. As a result the proportion of residents receiving coverage through the exchange would decrease from 16 to 14 percent.^{vi}

- It decreases the number of participants among whom the Exchanges spread fixed administrative costs^{vii}
- It could also decrease the Exchange leverage to improve quality, lower premiums, and achieve goals such as reforming health care delivery, increasing portability, improving consumer information, and holding insurers accountable.^{viii}
- The risk pool in the Exchange's individual market may change as its lowest-income members depart depending on the state's demographics and policy decisions.^{ix}

Financial

States can finance the BHP through four avenues without the use of state money:

- Premium credits from the Federal government capped at 95% of what it would have cost to provide coverage through the exchange;
- Cost sharing subsidies from the Federal government capped at 95% of what it would have cost to provide coverage through the exchange;
- Enrollee premiums; or,
- Enrollee cost sharing.

The Secretary of HHS will determine how much a state receives to operate a BHP based on factors that include, but are not limited to, the income, age, and health status of enrollees, along with geographic differences in health spending. States will be required to establish a trust fund for the money they receive to operate a Basic Health program, and, depending on how their Basic Health program is structured (e.g., benefits offered and provider reimbursement rates), states may not end up spending their full allotment of federal dollars.^x

This document does not provide any financial modeling for Arkansas. If Arkansas AID would like to further consider implementation of a BHP, Phase PCG could provide a detailed financial impact analysis of the program.

Advantages for Implementation of a BHP

For potential enrollees, a BHP implementation removes the fear of owing money to the internal revenue service at the end of the year in the exchange, if their annual income turns out to

exceed what consumers anticipated when health insurance tax credits were paid during the course of the year.^{xi}

There is likelihood that the cost of BHPs will become more favorable over time as BHP costs are likely to parallel increases in Medicaid costs. Experience indicates that commercial costs grow faster than Medicaid costs.^{xii}

Because the Federal government would reimburse states 95 percent of what it would cost to cover a potential enrollee in an exchange, the Federal government would likely pay all costs for BHP coverage in most, if not all, states mostly due to lower rates for provider payments than in the exchange.^{xiii}

Based on the cost of subsidies for private insurance in the exchange, exchange payments for BHP eligible consumers are projected to exceed by 29 percent what it would cost Medicaid to cover BHP-eligible adults in the average state making the BHP the less expensive option for insuring this part of the population.^{xiv}

ACA's tax credits and other subsidies will make coverage much more affordable in an exchange but research suggests that higher cost sharing in the exchange could still deter consumers from signing up for coverage. Furthermore, out of pocket costs could delay or prevent utilization of necessary care, making the exchange less palatable for low income consumers.^{xv}

If the BHP were contracted to a commercial plan the proportion of premium payments that go to health care quality improvement rather than administration (medical loss ratio) cannot fall below 85 percent. Most commercial plans have higher administrative costs than legislation allows for a BHP. Having said that, that has not been the experience of the Massachusetts Health Connector.^{xvi}

Disadvantages for implementation:

The implementation of a BHP would require the state to take on risk it would not otherwise have in the sense that the state may incur financial costs if the BHP is not self sustaining.^{xvii}

A further deterrent to enrollment in an exchange could be consumer fear of owing money to the internal revenue service at the end of the year if their annual income turns out to exceed what consumers anticipated when health insurance tax credits were paid during the course of the year.^{xviii}

Unlike exchange planning grants it is unclear if there is any money set aside to pay states for the establishment of the BHP whether that means a new program or creating a DHHS Medicaid-

like program. For example – expanding call center functions, amending the MMIS to accept new eligibility, etc.^{xx}

In a scenario where tax credits are pegged to the premium charged in the silver plan (the lowest metal plan required of qualified health plans in the exchange), with a 70 percent actuarial value, costs for providing care for BHP potential enrollees are higher in an exchange than in a Medicaid-like program. The average cost of covering a BHP-eligible adult through Medicaid payment is \$3,624. The average federal BHP is \$4,680.^{xx}

States also have the flexibility of implementing a "two-way" bridge between public programs and the Exchange as consumers change FPL levels. If selecting this option, states would need to guard against adverse selection and compensate plans for the difference between BHP payments and subsidies in the Exchange.^{xxi}

Summary of Advantages and Disadvantages for Arkansas

<i>State Considerations</i>		
<i>Categories</i>	<i>Advantages</i>	<i>Disadvantages</i>
Eligibility		For the Medicaid-like program, implementing a BHP could lengthen the time it takes to determine eligibility, especially considering the already increased volume from the increase in Medicaid eligibility up to 133% of FPL on the same timeline. A lengthened timeframe could cause a state Medicaid program to be out of compliance with Federal regulations which requires that Medicaid programs determine eligibility within 45 days. If this requirement is not met, states are required to use 100% state funds for each eligibility determination exceeding 45 days.
Benefits	The state would also have the flexibility of tailoring the benefit plan of the BHP to service needs specific to this population.	Many Medicaid programs have tried in recent years to reduce Medicaid benefits due to state financial challenges, only to be prevented from doing so because of pressure from advocacy

		groups, threat of lawsuits, or MOE provisions. Providing services to potential enrollees as part of the exchange would eliminate the threat of much more stringent Medicaid regulations for BHP enrollees, should Congress decide at a future date to streamline standards between the Medicaid program and the BHP.
	A seamless Medicaid-like program would reduce confusion for families often resulting in better compliance with rules and regulations for participation.	
Provider Infrastructure	if the BHP uses the Medicaid provider network, it may be more prepared to for the provision of atypical services compared to the exchange’s qualified health plans, who have traditionally served healthier populations.	With the exception of atypical provider types, it is expected that commercial insurers who participate in the exchange will have a more abundant choice of providers from whom enrollees may receive services.
Impact on the HBE	The BHP population could be served by the Exchange at no cost to the State should the state be unable to pay for BHP services within available funding. ^{xxii}	Reduces the size of the Exchange - average state's individual market in the Exchange would serve only 6 percent compared to 8 percent of non-elderly residents. As a result the proportion of residents receiving coverage through the exchange would decrease from 16 to 14 percent.

	The leverage provided by BHP-eligible covered lives as part of the exchange could reduce state costs for populations currently covered by the Medicaid program that would now become part of the exchange.	It decreases the number of participants among whom the Exchanges spread fixed administrative costs.
		It could also decrease the Exchange leverage to improve quality, lower premiums, and achieve goals such as reforming health care delivery, increasing portability, improving consumer information, and holding insurers accountable.
		The risk pool in the Exchange's individual market may change as its lowest-income members depart depending on the state's demographics and policy decisions.
Financial	There is likelihood that the cost of BHPs will become more favorable over time as BHP costs are likely to parallel increases in Medicaid costs. Experience indicates that commercial costs grow faster than Medicaid costs.	The implementation of a BHP would require the state to take on risk it would not otherwise have in the sense that the state may incur financial costs if the BHP is not self sustaining
	Because the Federal government would reimburse states 95 percent of what it would cost to cover a potential enrollee in an exchange, the Federal government would likely pay all costs for BHP coverage in most, if not all, states mostly due to lower rates for provider payments than in the exchange.	Unlike exchange planning grants it is unclear if there is any money set aside to pay states for the establishment of the BHP whether that means a new program or creating a DHHS Medicaid-like program. For example – expanding call center functions, amending the MMIS to accept new eligibility, etc

	Based on the cost of subsidies for private insurance in the exchange, exchange payments for BHP eligible consumers are projected to exceed by 29 percent what it would cost Medicaid to cover BHP-eligible adults in the average state making the BHP the less expensive option for insuring this part of the population.	The average cost of covering a BHP-eligible adult through Medicaid payment is \$3,624. The average federal BHP is \$4,680.
	If the BHP were contracted to a commercial plan the proportion of premium payments that go to health care quality improvement rather than administration (medical loss ratio) cannot fall below 85 percent. Most commercial plans have higher administrative costs than legislation allows for a BHP. Having said that, that has not been the experience of the Massachusetts Health Connector.	States also have the flexibility of implementing a "two-way" bridge between public programs and the Exchange as consumers change FPL levels. If selecting this option, states would need to guard against adverse selection and compensate plans for the difference between BHP payments and subsidies in the Exchange.

<i>Consumer Considerations</i>		
<i>Categories</i>	<i>Advantages</i>	<i>Disadvantages</i>
Eligibility	Implementing a BHP as a Medicaid-like program could provide stability for the enrollee and provide less confusion for potential enrollees who change programs frequently. It is also expected that implementing the BHP as a Medicaid-like coverage program improves affordability and continuity of coverage for low income residents. ^{xxiii}	

	The Children’s Health Insurance Program (CHIP) eligibility legislation is scheduled to expire in 2015, the implementation of a BHP, administered as a CHIP plan could provide a safety net for replacement coverage if CHIP legislation is not extended in the future at the Federal level.	
Benefits	If the state elects to provide BHP coverage as a Medicaid-like program to 200% of FPL, lower income consumers may gain in the area of benefits. Medicaid benefits tend to be more generous than most commercial plans allowing consumers with high, atypical medical needs, not generally served in a comprehensive way by commercial insurers, to be better served by a Medicaid-like program.	
	A more stable eligibility environment leads to less transfer amongst health care providers and better continuity of care when enrollees are not forced to change providers due to expected FPL changes.	
	The number of plan choices, the comparisons of each, and the possibility of churning in and out of Medicaid, even with the help of navigators, could be overwhelming, resulting in the choice of purchasing no insurance at all.	

Provider Infrastructure	Provider infrastructure could be better for members who require atypical services more prevalent in Medicaid provider infrastructures.	With the exception of atypical provider types, it is expected that commercial insurers who participate in the exchange will have a more abundant choice of providers from whom enrollees may receive services.
Impact on the HBE	None applicable to consumers	None applicable to consumers
Financial	ACA's tax credits and other subsidies will make coverage much more affordable in an exchange but research suggests that higher cost sharing in the exchange could still deter consumers from signing up for coverage. Furthermore, out of pocket costs could delay or prevent utilization of necessary care, making the exchange less palatable for low income consumers.	As part of enrollment in an exchange consumers receive tax credits based the previous year's income as reported to the IRS. If income changes throughout the year there is a possibility that consumers could owe money to the exchange as a result. Implementation of a BHP avoids this risk for consumers.

ⁱ *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1331

ⁱⁱ *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn*, <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

ⁱⁱⁱ *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn*, <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{iv} Families USA.org. The Basic Health Plan Option

^v *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn*, <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{vi} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn*, <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{vii} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn*, <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{viii} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn*, <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{ix} *for State Coverage Initiatives by the Urban Institute by Stan Dorn*, <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^x Families USA.org. The Basic Health Plan Option

^{xi} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn*, <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{xii} Palmer, Jeremy. Milliman. “Healthcare Reform and the Basic Health Program Option – Modeling Financial Feasibility.” April 2011. <http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf>

^{xiii} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn,*
<http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{xiv} ^{xiv} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn,*
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^{xv} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn,*
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^{xvi} Palmer, Jeremy. Milliman. “Healthcare Reform and the Basic Health Program Option – Modeling Financial Feasibility.” April 2011. <http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf>

^{xvii} Palmer, Jeremy. Milliman. “Healthcare Reform and the Basic Health Program Option – Modeling Financial Feasibility.” April 2011. <http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf>

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^{xix} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn,*
<http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{xx} Health Insurance Policy Simulation Model (HPSM), Urban Institute, 2011

^{xxi} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn,*
<http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf>

^{xxii} Families USA.org. The Basic Health Plan Option

^{xxiii} *Prepared for State Coverage Initiatives by the Urban Institute by Stan Dorn,*
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