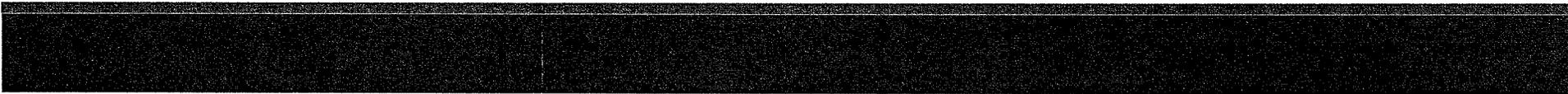


Basic Health Program Update

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MICHAEL HELY, STAFF ATTORNEY, LEGISLATIVE COUNCIL
SERVICE



Basics of the Basic Health Program (BHP)

Sections 1331 and 10104(o) of the federal Patient Protection and Affordable Care Act (PPACA) provide that states may establish a health insurance program for low-income individuals who do not qualify for Medicaid. These individuals include:

- Adults with incomes 138-200% of the Federal Poverty Level (FPL); and
- Legal resident immigrants who:
 - have incomes 0% to 200% FPL; and
 - are in the five-year "waiting period" that excludes them from Medicaid eligibility.

The federal government has banned implementation of BHPs until 2015.

Financing a BHP

Sources of financing:

- The federal government gives states that create a BHP 95% of what it would have spent on:
 1. tax credits;
 2. subsidies for out-of-pocket costs; and
 3. unspent federal health insurance exchange grant funds (Minnesota reallocated \$5 million of its unspent funds).
- State matching funds.
- Enrollee premiums.

SHP Requirements

At least two standard health plans (SHPs) must be offered

Contracts for SHPs must be in place by January 1, 2016.

Premiums cannot exceed:

- the premium a person would pay if that person were enrolled in the second-lowest-cost silver plan;

Cost-sharing cannot exceed:

- the cost-sharing under a platinum-level plan (actuarial value 94%) if the household income is below 150% FPL; and
- the cost-sharing under a gold-level plan (actuarial value 87%) if the household income is >150% and <200% FPL.

Some Considerations About BHPs

A good comparison for value and cost to the state might be the CHIP program, which in NM covers children 6-19 years old up to 240% FPL and children 0-5 years old up to 300% FPL.

The value for enrollees will be contingent on the type of package a state devises, i.e., what actuarial value a BHP has. NB: A BHP must offer plans that will cost enrollees less than a qualified health plan on the exchange.

Risk is pooled in a BHP-specific pool, excluded from individual and group risk pools.

How to Establish a BHP

1. The state must devise a "Blueprint" that outlines the state's plan.
2. The state must get public comment and tribal consultation on the Blueprint
3. The governor, or the governor's designee, must submit the Blueprint to the secretary of the federal Department of Health and Human Services for approval.
4. The state must establish a BHP trust fund, which will only be used to receive federal matching dollars and state contributions. The fund may NOT be used for any other purpose.
5. Federal funds may not be used for administration of the BHP.

Standard Health Plans— Essential Health Benefits

A standard health plan offered under a state BHP must cover, at a minimum, the "essential health benefits", as specified by the federal PPACA, including:

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

Recommended Features of Standard Health Plans

Standard health plans should:

- include innovative features, such as care coordination, care management and incentives for use of preventive services;
- provide for adequate access to care in rural, frontier and urban settings;
- use a managed-care model; and
- establish performance measures for plans, focusing on quality of care and improved health outcomes.

Minnesota's BHP "Look-Alike"

Minnesota has implemented a BHP look-alike plan through its existing MinnesotaCares program.

MinnesotaCares Versus Qualified Health Plan (QHP) Enrollee Costs

<u>A MNCares enrollment @ 170% FPL</u>	<u>A QHP enrollee @ 170% FPL</u>
\$33 premium per month	\$80 premium per month, with subsidy
\$2.75 monthly deductible (\$33 annually)	\$750 deductible annually
\$3 copay per primary/specialty office visit	\$10 primary/\$30 specialty copay per visit
<u>A MNCares enrollee @ 140% FPL</u>	<u>A QHP enrollee @ 140% FPL</u>
\$21 premium per month	\$46 premium per month, with subsidy
\$2.75 monthly deductible (\$33 annually)	\$750 deductible annually
\$3 copay per primary/specialty office visit	\$10 primary/\$30 specialty copay per visit

MinnesotaCares Versus Qualified Health Plan (QHP) Enrollee Costs

<u>A MNCares enrollee @ 200% FPL</u>	<u>A QHP enrollee @ 200% FPL</u>
\$50 premium per month	\$121 premium per month, with subsidy
\$2.75 monthly deductible (\$33 annually)	\$750 deductible annually
\$3 copay per primary/specialty office visit	\$10 primary/\$30 specialty copay per visit

New Mexico Facts

- The average monthly premium on the New Mexico Health Insurance Exchange (NMHIX) for a QHP is \$232.
- The monthly premium depends on insurance plan (including actuarial value) + enrollee's age + location + smoking status.
- New Mexico used to cover "childless adults" with incomes below 200% FPL with the State Coverage Insurance program, though there were usually waiting lists for coverage. Under the BHP, no waiting list is allowed, nor are enrollment caps.
- NMHIX has 32,400 enrollees in QHPs to-date. We do not know the effect that a BHP would have on the NMHIX population, which presumably includes individuals with incomes between 138% FPL and 200% FPL (those eligible for BHP).

Why Have a BHP?

- Possibly reduce "churn" by having seamless coverage transition between Medicaid and BHP if the Human Services Department administers it;
- Lower cost coverage for the individuals in 138-200% FPL income group; and
- Coverage (and thus lower uncompensated care costs) for legal permanent residents with incomes below 200% FPL.

Risks of BHP

- Difficult to project what the state's federal match will be from year to year.
- Some state funds must be allocated to keep premiums below the lowest QHP premiums.
- May have an impact on NMHIX enrollment.
- As with any federal program, it is difficult to administer due to complicated requirements.
- No state has yet implemented a BHP (because of federal ban until 2015), so we do not know what the effect has been for other states.
- Unless it is well-integrated with the Medicaid system or the NMHIX, "churn" could be exacerbated.
- No actuarial study has been performed.
- Possibility for "downward death spiral": the BHP is its own risk pool.

Sources

This presentation depends heavily on data and analysis provided and permitted by Stan Dorn, Senior Fellow, Urban Institute.

Section 1331 of the Federal Patient Protection and Affordable Care Act.

42 C.F.R. Part 600.

45 C.F.R. Part 144.

7-8 Fed. Reg. 42160 (July 15, 2013) and 78 Fed. Reg. 54070 (Aug. 30, 2013).

Guidance from the federal Centers for Medicare and Medicaid Services.

Basic Health Program Workgroup (presentation), October 30, 2013, Office of Health Insurance Programs, New York State Department of Health.

Testimony of Amy Dowd, Chief Executive Officer, New Mexico Health Insurance Exchange, September 22, 2014 Legislative Health and Human Services Committee (LHHS) hearing, Elephant Butte, New Mexico.

Testimony of John Franchini, Superintendent of Insurance, September 21, 2014 LHHS hearing, Elephant Butte, New Mexico.

