URBAN INSTITUTE

Basic Health Program: An Webinar for New Mexico

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

Overview

1. Federal law
2. Options
3. Modeling methodology
4. Modeling results
5. 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

Federal poverty level (FPL)	Monthly pre-tax income	Monthly premium	Actuarial Value (AV)
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
<200 percent FPL	$300	$600
200-299 percent FPL	$750	$1,500
300-399 percent FPL	$1,250	$2,500

I.

FEDERAL LAW

Who qualifies for the Basic Health Program (BHP)?

- Requirements
  - Modified adjusted gross income (MAGI) at or below 200 percent FPL
  - Ineligible for Medicaid that covers essential health benefits, Children's Health Insurance Program (CHIP), Medicare
  - Citizen or lawfully present immigrant
  - No access to affordable, comprehensive employer-sponsored insurance (ESI)
- Major groups in 2014, under current law
  - Adults 138-200 percent FPL
  - Lawfully present immigrants 0-138 percent FPL, ineligible for Medicaid and CHIP. E.g.:
    - Green card holders during their first five years
    - Citizens of the Marshall Islands, other COFA nations

What happens to consumers in BHP?

- No subsidized coverage in the exchange
- State contracts with plans or providers
  - All essential benefits must be covered
  - Premiums may not exceed levels that would be charged in the exchange
  - Actuarial value may not fall below specified levels
  - Medical loss ratio may not fall below 85 percent
- **Note: states can provide more generous coverage, such as the coverage furnished by Medicaid today**

BHP dollars

- Federal government pays 95 percent of what it would have spent for tax credits and cost-sharing subsidies if BHP members had enrolled in the exchange
  - Could be > 95%, depending on HHS interpretation
- Federal dollars
  - Go into state trust fund
  - Must be spent on BHP enrollees
- BHP lets states reprogram federal funds to help low-wage workers using strategies that, to state policymakers, make more sense than the ACA
  - New Mexico could control roughly $226 million a year in federal funds

II.

OPTIONS

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

Subsidy eligibility in New Mexico 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		
235-400% FPL	Exchange		
200-235% FPL	Medicaid	Exchange	
138-200% FPL			
0-138% FPL	Medicaid	Medicaid	Exchange

Subsidy eligibility in New Mexico, under one possible approach to BHP

	Children	Adults
>400% FPL	No subsidies	
235-400% FPL	Exchange	
200-235% FPL	Rebranded Medicaid	Exchange
138-200% FPL	Rebranded Medicaid	
0-138% FPL		

III.

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
- On some issues, state samples too small for reliable results

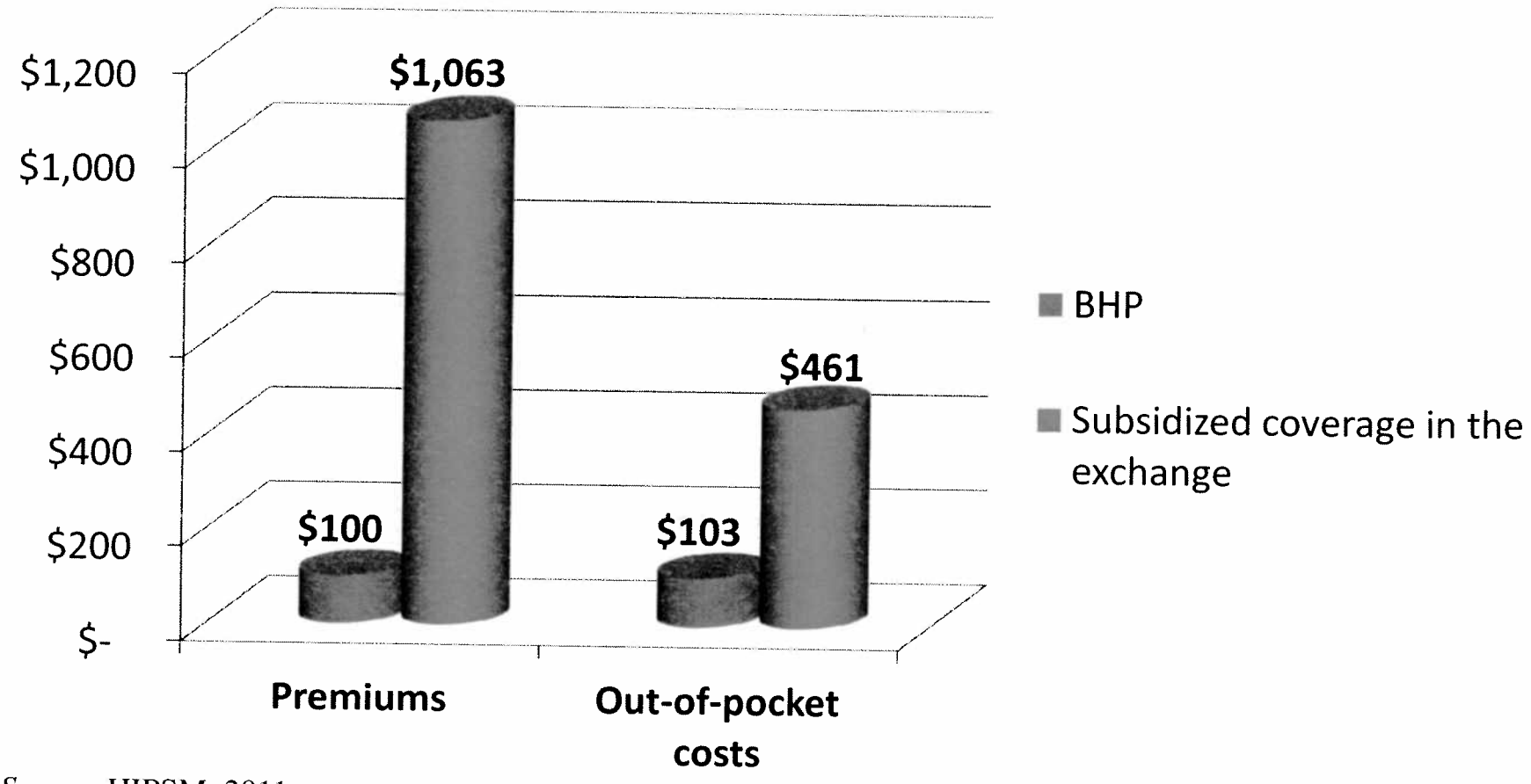
What policies did we model?

- 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
  - Eliminate Medicaid 1115 and 1931 coverage, retain other Medicaid
  - 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

IV.

MODELING RESULTS

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

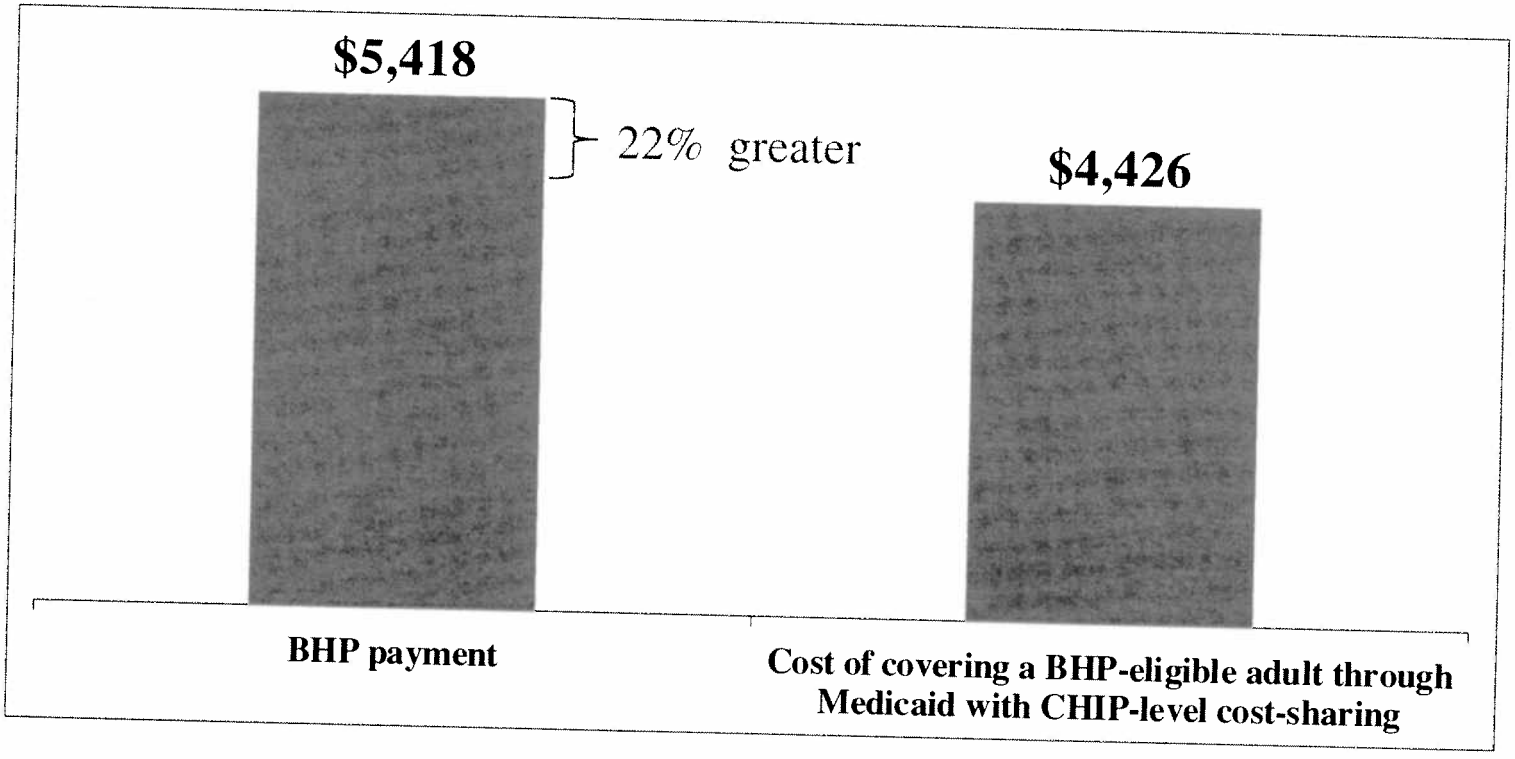


Source: HIPSM, 2011.

Perspective

- $1,321 in annual savings for the average BHP consumer in New Mexico
- 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 (average for Mountain Division states–**may be much different for NM)**



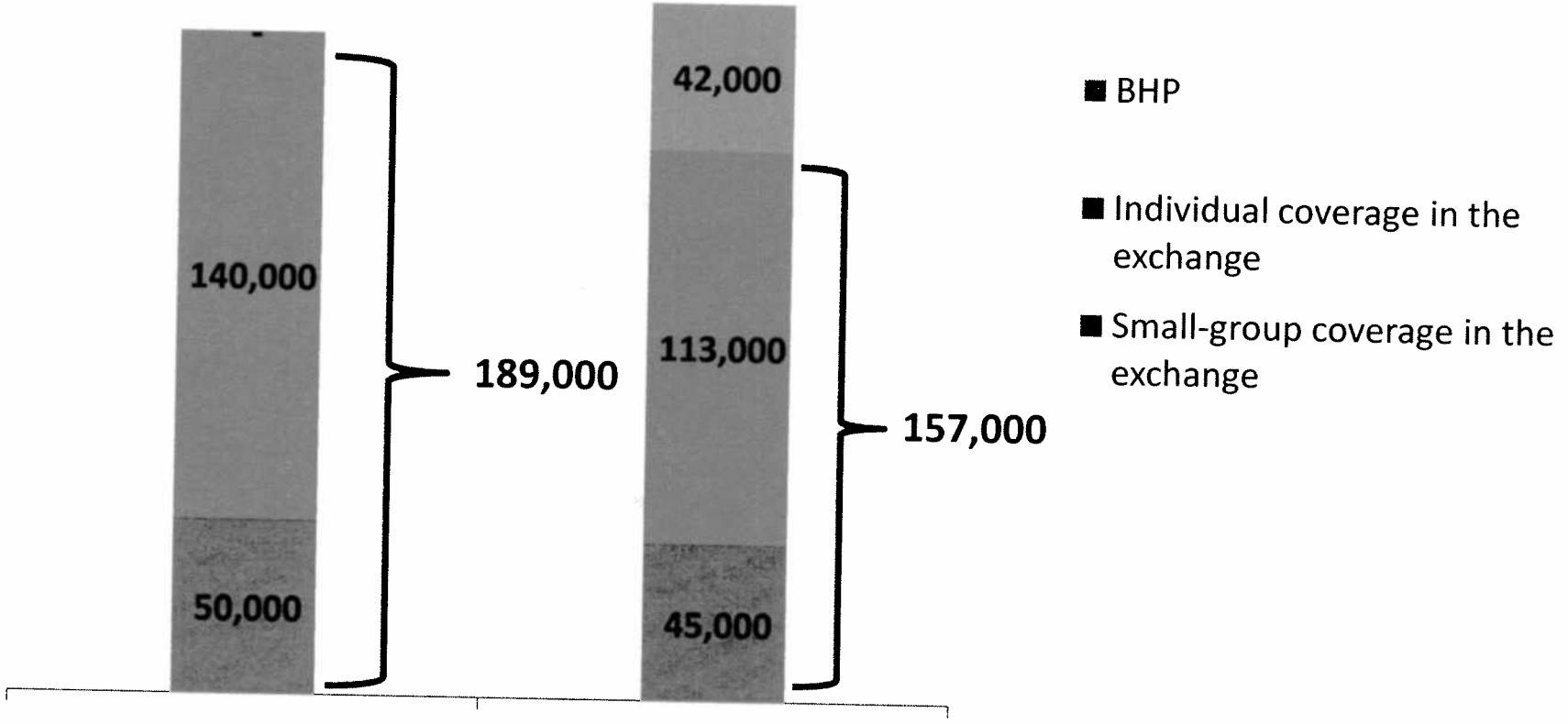
Source: HIPSM, 2011. *Note*: Assumes exchange premiums generally reflective of current costs and no tobacco-related premium variation. "CHIP-level cost-sharing" refers to 98% actuarial value and $100 per year in adult premiums.

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 New Mexico, BHP's lower premiums cause 7,400 uninsured residents to gain coverage

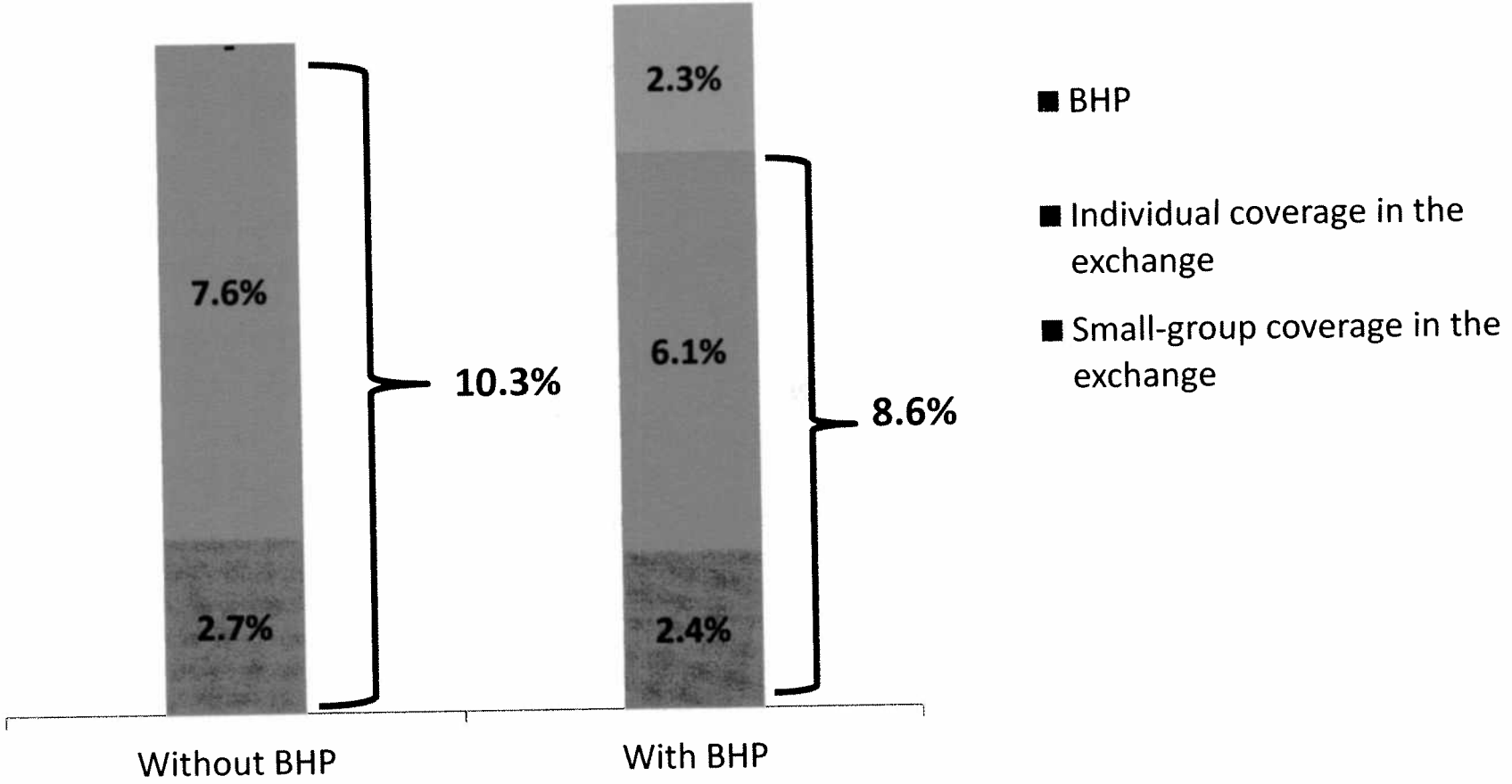
Source: HIPSM, 2011. *Note*: Does not take into account increased coverage under BHP resulting from the absence of risk of owing money to the Internal Revenue Service if annual income turns out to exceed estimated levels.

BHP implementation and exchange size under the ACA (Number of New Mexico residents under age 65)



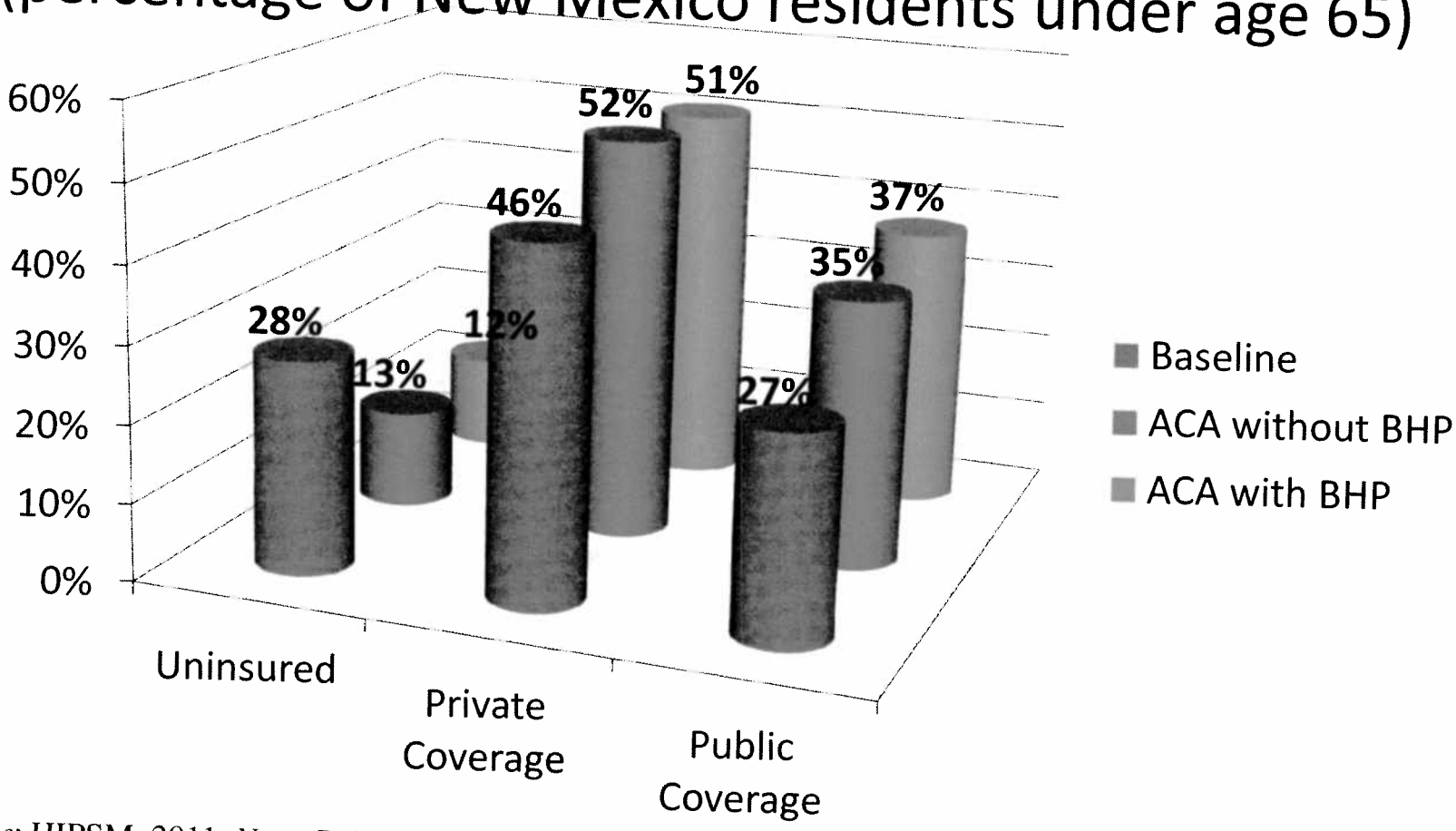
Source: HIPSM, 2011. Totals may not add because of rounding.

BHP implementation and exchange size under the ACA (Percentage of New Mexico residents under 65)



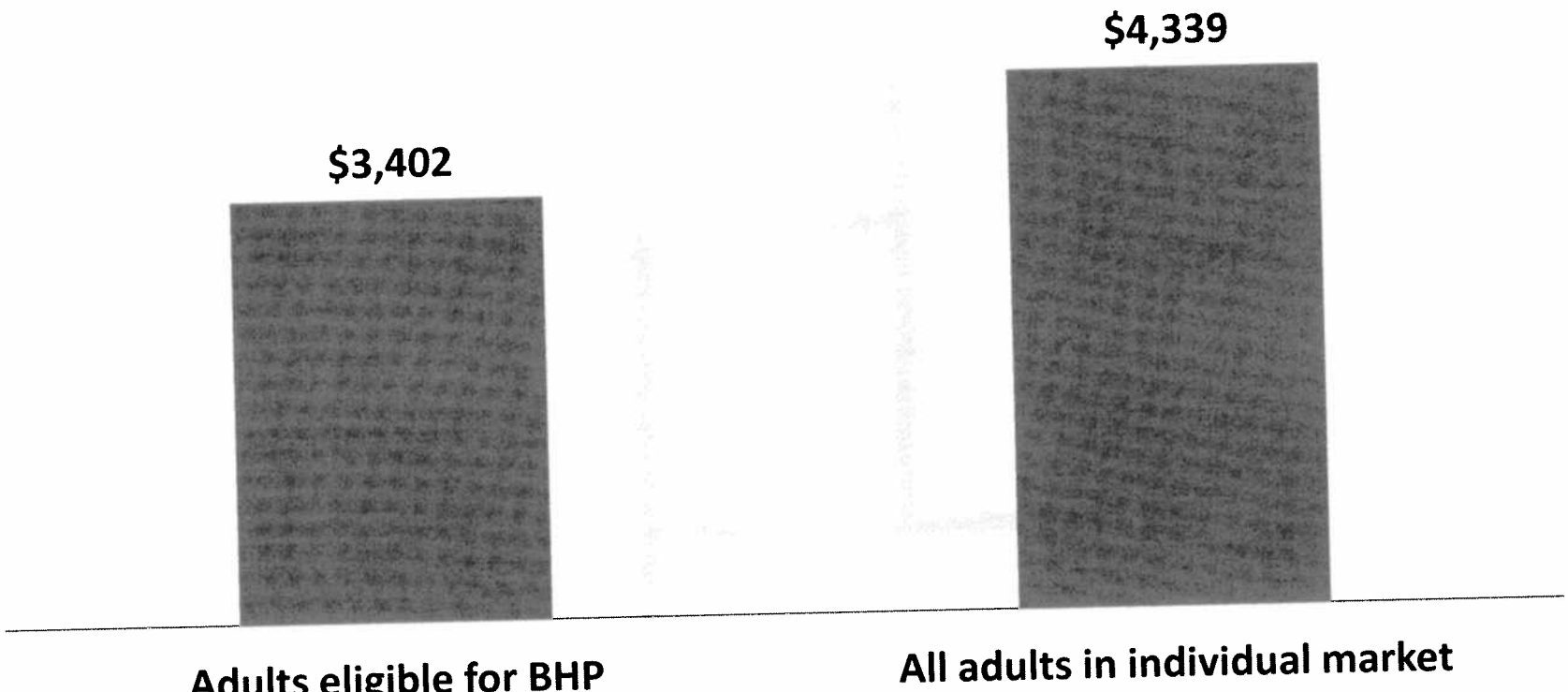
Source: HIPSM, 2011. Totals may not add because of rounding.

Uninsured, privately insured, and publicly insured residents : baseline vs. ACA without and with BHP (percentage of New Mexico 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 (average for Mountain Division states)



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.

V

POLICY IMPLICATIONS

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
    - Note: In 2008, New Mexico Medicaid paid 7% > than Medicare—3rd highest ratio in US
  - Less access to commercial plans
- 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

- Modeled: Adults eligible under 1115 waivers and Social Security Act Section 1931
  - Annual state savings of $2.7 million in New Mexico
- Unmodeled:
  - 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, people diagnosed with breast and cervical cancer, etc.)
  - Children over 138% FPL, if maintenance of effort requirements are repealed or CHIP is allotments end after 2015

More unmodeled savings, for states and employers

- Lower administrative costs from reduced movement between Medicaid and the exchange
- To the extent that BHP leverage yields cost savings, the state, rather than the federal government benefits
- 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?

- Exchange size somewhat smaller
  - Large enough for
    - Viability
    - Attracting good plans
  - Fixed administrative costs spread across a smaller population
  - Leveraging health care delivery reforms? With or without BHP:
    - Can leverage some changes
    - For earthshaking reforms, may need to negotiate on behalf of multiple payers at once: the exchange, state-purchased coverage, Medicare, and large employers that voluntarily participate
- Federal BHP payments will likely exceed baseline costs, 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 BHP funds
    - If premiums are risk-rated for tobacco use, tax credits, so federal BHP funds, do not include the tobacco charge; but BHP must pay tobacco-related costs
  - What about tax reconciliation? It may help the state.

Why tax reconciliation helps the state

- Federal BHP amount is based on the subsidies the consumer would have received in the exchange
- Calculation includes effect of reconciliation
  - IRS repayments to consumers are ***uncapped***
  - Low-income consumer repayments to IRS are ***capped***

A hypothetical: Unlucky Uma and Lucky Luisa

	Income change	Resulting change in what the tax credit should have been	Transaction with IRS
Unlucky Uma	-$10,000	+$1,000	+$1,000
Lucky Luisa	+$10,000	-$1,000	-$300 (because of cap)

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

Another 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?
Plan with reference premium	Monthly premium	$400	$480	$80
	Tommy's cost	$160	$160	$0
	Tax credit	$240	$320	$80
A more costly plan	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

How important is it to cover children and parents in the same health plan?

- The research says: no evidence that it matters
  - Children benefit when their parents have coverage
  - No evidence of benefit when parents are covered through the *same plan* as their children, rather than a different plan
- Factors outside the research
  - *Why it may not be so important*: Children and parent may use different provider networks
  - *Why it may be important*
    - Parents need to
      - Learn only one health plan's procedures for obtaining care
      - Comply with only one program's requirements for enrollment and retention
    - In staff-model HMOs and with family practitioners
      - Parents and kids can be seen in one visit if they're in a common plan
      - Providers can get to know the family, may improve care delivery
    - For long-term political viability, a reformed health care system needs to make sense to consumers. It might make more sense to some consumers if children and parents can enroll in the same plan.

Conclusion

- Implemented to build on existing Medicaid and CHIP 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 somewhat 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