

The Federal Basic Health Program: An Analysis of Options for Washington State

I. Introduction

The Patient Protection and Affordable Care Act (ACA) offers states the option to implement a Federal Basic Health Program to citizen adults with incomes between 134 and 200¹ percent of the Federal Poverty Level (FPL) (\$15,000 to \$21,800) and legally resident immigrants with incomes no greater than 133 percent FPL whose immigration status disqualifies them from Federally-matched Medicaid. The Federal government will give states 95 percent of what they would have spent on premium tax credits and cost-sharing reductions² to eligible individuals enrolled in standard health plans in the state if such eligible individuals had been enrolled in a qualified health plan through an Exchange.

The Federal Basic Health Program must include at least the Essential Health Benefits³ under the ACA and consumers may not be charged more than what they would have paid in premiums in the Exchange. In addition, cost sharing must be no greater than a platinum plan (90 percent actuarial value)⁴ for individuals with incomes less than 150 percent FPL or gold (80 percent actuarial value) for individuals with incomes between 150 and 200 percent FPL.

Per the ACA, states selecting to implement a Federal Basic Health Program would need to establish a competitive process for entering into contracts with plans, including negotiation of premiums and cost-sharing and negotiation of benefits in addition to Essential Health Benefits.⁵ Contracts must be with a “managed care system” or a “system that offer(s) as many of the attributes of managed care as are feasible in its local health care market.”⁶ In addition, plans must report on selected performance measures⁷ and must also maintain medical loss ratios of 85 percent or higher. The plans must also include care coordination and case management, incentives for preventive services, maximize patient involvement in health care decision-making and provide incentives for appropriate utilization of health care services.⁸

If states choose to implement a Federal Basic Health Program, eligible individuals cannot receive tax credits through the State’s Health Benefit Exchange. According to the ACA, Health and Human Services will make a single payment to the State at the start of the fiscal year based on best available estimates and will make corrections (if the amount was too high or low) in the next year’s payment.⁹ Since the Federal government has not released its guidance on the Federal Basic Health Program, there remain many unanswered questions about how this payment to states will occur. For example, what estimates about enrollment will be used by the Federal government and if states incorrectly estimate the risk of this population, will they be responsible for under or overpayments?

¹ The ACA expands Medicaid eligibility to 133 percent of the federal poverty line. In addition, S2002(a)(14)(I)(i) adds a five percentage point income disregard which effectively increases Medicaid eligibility to 138 percent FPL. The increased Medicaid eligibility results in eligibility for a Federal Basic Health Program would begin at incomes greater than 138 percent FPL.

² It is unclear whether the “95 percent” qualifier in ACA applies to the cost sharing subsidies as well as the premium tax credits.

³ Essential Health Benefits will be determined by HHS, guidance is expected in 2012.

⁴ Actuarial value is the ratio of benefit costs to allowed cost (i.e., the cost of covered services, prior to member cost-sharing). In other words, the actuarial value represents the portion of the total cost of covered benefits that are paid by a health insurance plan.

⁵ ACA S1331(c)(1)

⁶ ACA S1331(c)(2)(C)

⁷ ACA S1331(c)(2)(D)

⁸ ACA S1331(b)(2)(A)

⁹ ACA S1331(b)(3)(A)

Because Washington State already has a State Basic Health Plan in place that can be used as a platform from which to establish the Federal Basic Health Program, the considerations about whether or not to implement this option are somewhat different from other states.

This issue brief presents a background assessment of Washington State's current programs and eligibility and projections for the population eligible for the Federal Basic Health Program from 134 - 200 percent FPL. A financing and cost estimate for the Federal Basic Health Program is provided here as well as a discussion of the advantages and disadvantages of such a program in Washington State. Where appropriate, insights into the perspective of or the impact upon consumers, employers, insurers, and health care providers in the private and public health insurance markets are discussed. A framework for considering these issues and a recommendation for moving forward is also provided.

This issue brief discusses the following three options for Washington State:

Option 1: Under this option, adults with income less than 134 percent FPL will be eligible for Medicaid, and a standalone Federal Basic Health Program will be established for adults 134 - 200 percent FPL. Children and pregnant women will remain eligible for Apple Health and Medicaid, respectively. Adults with incomes above 200 percent to 400 percent FPL will be eligible for premium tax credits and cost-sharing subsidies in the Exchange.

Option 2: Under this option, adults between 0 - 200 percent FPL will be eligible for coverage through a rebranded Medicaid + Federal Basic Health Program. This new re-branded low-income program will have consistent plans and benefits across income groups but different risk pools. Children and pregnant women would be included in this re-branded program but their cost sharing and benefits would remain unchanged from Apple Health and Medicaid, respectively.

Option 3: Adults with income less than 134 percent FPL will be eligible for Medicaid, and premium tax credits and cost-sharing subsidies will be available in the Exchange for adults 134 - 400 percent FPL (Essential Health Benefits). Children and pregnant women will remain eligible for Apple Health and Medicaid, respectively.

It is important to note that this brief is preliminary in nature because the Federal government has not yet released its guidance for states on the establishment of a Federal Basic Health Program. Nonetheless, it is still important to consider a framework for thinking about these issues now as the timeframe for implementation is very ambitious. If Washington State policymakers were to decide to implement a Federal Basic Health program by January 1, 2014, work would need to be underway by the beginning of 2012.

II. Background

Access to health care for disadvantaged citizens has long been a policy concern among Washington State policymakers. Washington State also has had a relatively long history of support for the use of managed care to control health care expenditures. These two interests came together with the development of the State's Basic Health Plan established in 1987. The legislation creating the State Basic Health Plan also included expansion of Medicaid eligibility, expansion of a State-funded prenatal care program, and creation of a high-risk pool, the Washington State Health Insurance Pool (WSHIP) for the uninsurable. In addition, Washington State children up to 300 percent FPL are

eligible for subsidized coverage regardless of their citizenship status through the State’s Apple Health program. Together, these programs comprise the patchwork of access programs in Washington State before the implementation of the ACA.

Table 1 presents Washington State eligibility for public programs before and after the ACA’s implementation. In addition, several smaller programs are not listed in Table 1. Washington State implemented the Federal temporary high-risk pool for people who have been uninsured for six months or more and who have a pre-existing condition (PCIP-WA). A Health Insurance Partnership (HIP) program, which subsidizes low-income employees (less than 200 percent FPL) who work for small employers (fewer than 50), and a newly launched unsubsidized program called Washington Health, which provides a limited benefits plan for low-income individuals were also established.

Although Washington State has had a history of innovative coverage programs, the State has been hard hit by the most recent recession and consistent funding for these programs has been difficult to sustain. The 2011 Supplemental Budget reduced the State Basic Health Plan’s funding and limited eligibility guidelines. Effective January 4, 2011, the state received a CMS 1115 Medicaid Demonstration Waiver that provided federal matching funds for only those Basic Health enrollees who were determined to be Transition Eligible under the waiver or who are foster parents licensed under chapter 74.15 RCW. Thus, people with incomes above 133 percent FPL and/or without legal residence in Washington State were terminated from the program. The State disenrolled approximately 17,000 members from the State Basic Health Plan effective March 1, 2011 and transitioned about 1,700 children to Apple Health effective April 1, 2011. In addition, the HIP program recently closed its doors to new membership due to the termination of Federal funds.

Table 1: Approximate Eligibility for Washington State Health Insurance Programs for Non-Disabled People < 65, Pre and Post ACA Implementation

Eligibility Group	Current Eligibility	ACA Eligibility
Citizen or legally present non-citizen adults, no children	Countable income ¹⁰ : < 133% FPL and not categorically eligible for Medicaid – State Basic Health Plan (capped enrollment) Legally present non-citizens must serve 5-year wait period.	Countable income: <134% FPL - Medicaid 134-200% FPL - Federal Basic Health Program or Exchange with subsidies 200-400% FPL- Exchange with subsidies Legally present non-citizens can be in a federally-subsidized program like the Exchange while serving 5-year wait period.
Citizen or legally present non-citizen adults with children	Countable income: < 75% FPL – Medicaid 75%-133% FPL – State Basic Health Plan Legally present non-citizens must serve 5-year wait period for Medicaid.	Countable income: <134% FPL - Medicaid 134-200% FPL- Federal Basic Health Program or Exchange with subsidies 200-400% FPL- Exchange with subsidies Legally present non-citizens can be in a federally-subsidized program like the

¹⁰ Countable income has a different meaning under the ACA (i.e. MAGI) than under the traditional Medicaid standard.

		Exchange while serving 5-year wait period.
Pregnant Women	Countable income: < 185% FPL Medicaid >185% FPL Medically Needy 185-200% FPL – State Basic Health Plan	Countable income: <185% FPL - Medicaid 185-200% FPL – Federal Basic Health Program or Exchange with subsidies 200-400% FPL - Exchange with subsidies
Children	Countable income: < 300% Apple Health (above 200% FPL maximum \$30 per child, \$60 per family per month)	Countable income: <300% FPL – Apple Health 300-400% FPL – Exchange with subsidies

The current State Basic Health Plan in Washington is similar in its broad framework to the Federal Basic Health Program outlined in the ACA. That comes as no surprise since Senator Cantwell and her staff were involved in drafting that section of the law. However, there are some distinct differences in the two plans that are discussed below and highlighted in Table 2.

Eligibility

Eligibility for Washington’s Basic Health Plan is currently limited to Washington State resident adults under 134 percent FPL (plus pregnant women when eligible) due to requirements limiting eligibility in order to receive federal matching funds. The Federal Basic Health Program is for citizens and federally-qualified immigrant adults with incomes between 134 and 200 percent FPL and non-qualified but lawfully present immigrants with incomes below 133 percent FPL whose immigration status disqualifies them from Federally-matched Medicaid. Washington’s State Basic Health Plan was, however, originally designed for people up to 200 percent FPL and only recently was pared back due to a new eligibility requirement, as part of the federal waiver, and budget shortfalls.

Premiums and Cost Sharing

Premiums for Washington’s Basic Health Plan are based on income, age, county of residence, and product choice,¹¹ whereas the premiums for the Federal Basic Health Program vary by income only. Prior to the recent cutbacks, the range of premiums for people with incomes between 134 and 200 percent FPL was \$71.08-\$155.49/month in Washington’s Basic Health Plan while the maximum premiums allowed in the Federal Basic Health Program are somewhat lower ranging from \$37.02 - \$116.05 (the expected participant premiums in the Exchange are the maximum allowed in the Federal Basic Health Program).

The State’s Basic Health Plan includes incentives for appropriate utilization of health care services with a deductible of \$250 and 20 percent co-insurance for some services. Some services require modest co-payments instead of the co-insurance, as noted in the table below, and out-of-pocket costs

¹¹ Currently there is no distinction in premiums by plan type but managed care organizations are allowed to offer plans at a higher rate than the negotiated premium and the subscriber who enrolls in those plans pays the additional premium.

(OOP) are capped at \$1500. Generic prescriptions are \$10 and name- brand prescriptions require 50 percent cost sharing. Cost sharing in the Federal Basic Health Program is dependent on income with cost sharing equal or less than that required of a platinum plan in the Exchange for people between 134 - 150 percent FPL and of a gold plan for people with incomes between 151 - 200 percent FPL. The cost-sharing features and amounts will be determined by the qualified health plans but could include a mix of deductibles, co-payments, and coinsurance. OOP costs are capped at \$1983 for both income groups. Examples of possible cost sharing for these plans can be found in Table 2.

Table 2: Comparison of Washington’s State Basic Health Plan and the Federal Basic Health Program

Feature	Washington Basic Health Plan¹²	Federal Basic Health Program
Income Eligibility	< 200% FPL (enrollment capped at 84,000)	134-200% FPL (not eligible if access to affordable employer plan meeting coverage minimums)
Participant Premium	Based on income, age, and insurance product: Between 133-149% FPL - \$71.08 - \$88.85 Between 150-200% FPL - \$108.85 - \$155.49	Premiums can be no greater than what eligible individuals would have paid in the Exchange and are based on % of income only: Between 134-149% FPL- \$37.02-\$54.89 Between 150-200% FPL – \$55.63 - \$116.05
Participant Cost sharing	Deductible of \$250, No co-payments for preventive services or maternity care. \$15 co-payment for office visits, \$100 co-payment for emergency room visits, \$10 copayment for generic Rx and 50% co-payment for brand-name Rx in formulary, 20% coinsurance (inpatient capped at \$300) for other services. OOP capped at \$1500	Cost sharing must be equal or less than that required of a platinum plan in the Exchange (134-150% FPL) or gold plan (151-200%FPL). OOP capped at \$1983. According to one source ¹³ a sample platinum plan would not have a deductible but would include \$20 office visit co-payments, \$250 co-payment for inpatient stays and Rx co-payments of \$10/\$24/\$45. A gold plan could include a modest deductible of \$250, \$15 co-payments, 25% of Rx costs and 10% of other costs.
Funding	Fully state funded until 2010. ACA provided opportunity for federal/state shared funding for citizens with incomes <133% FPL.	State will receive 95% of (second lowest cost silver plan premium + cost sharing subsidies)

¹² In order to show a comparison of program eligibility, benefits and cost sharing are displayed with descriptions prior to 2011 cutbacks

¹³ Peterson, C. Setting and Valuing Health Insurance Benefits, Congressional Research Service, April 6, 2009.

Enrollment	Capped at 84,000, 74% were below 133% FPL (before cutbacks) and will be offered Medicaid in 2014.	Unlimited, as many as 398,000 ¹⁴ estimated between 134-200% FPL
Benefits	Similar to Medicaid but no vision or dental	Essential Health Benefits ¹⁵
Plan Choice	Currently choice of 4 Managed Care plans (not offered in every county): Molina, Community Health Plan of WA, Group Health Cooperative and Columbia United Providers.	Managed Care, at least 2 plan choices, if possible
Provider Reimbursement	Similar to Medicaid rates (enhanced when necessary to ensure access to particular providers)	To be determined

III. Description of Implementation Options Under Consideration

This brief considers three policy options for implementing the ACA to low-income populations up to 200 percent FPL in Washington State. It is important to understand that the options presented here are only part of a wider range of options that could be considered for the Federal Basic Health Program. There are a number of interchangeable elements from each option that can be combined in any number of ways. However, it was necessary to define the specific options being considered here so that cost estimates and advantages and disadvantages across options could be made. Below is a brief summary of each option.

Option 1: This option would establish a Federal Basic Health Program for citizen adults between 134 and 200 percent FPL who are not income or categorically eligible for Medicaid, as well as for legally resident adults with incomes no greater than 133 percent FPL who are not eligible for Medicaid. Children below 300 percent FPL and pregnant women below 185 percent FPL remain eligible for Apple Health and Medicaid, respectively. The eligibility process will be streamlined via the new eligibility system, making transitions across programs easier. The goal of this option would be to establish a Federal Basic Health Program so that the plans, providers, and program benefits for enrollees would be similar to the Medicaid expansion and Apple Health. As part of implementing the Federal Basic Health Program option, no changes to Apple Health or Medicaid benefits or cost sharing would be made. Premiums and cost-sharing responsibilities would be established on a sliding scale in the Federal Basic Health Program so that transitions to/from Medicaid and to/from the Exchange would be smoother than what is envisioned if people transitioned from Medicaid programs to the Exchange. Plan procurement and provider reimbursement for the Federal Basic Health Program also would be coordinated with Medicaid and Apple Health, although premium and provider rates for each of the programs could be different under this option.

¹⁴ Planning Washington's Health Benefit Exchange: The potential impact of three key decisions, January 27, 2011, Milliman Client Report

¹⁵ States are required to include Essential Health Benefits but are permitted to include other benefits important to this low-income population

This option is similar to the model implemented in Massachusetts under its 2006 reform. While Commonwealth Care (the subsidized program within the Massachusetts Connector Authority) shares an eligibility portal with the Medicaid agency, procurement of plans, enrollment, and customer service are all separate functions operating within the Connector.

Option 2: This option would establish a Federal Basic Health Program as a newly branded program for all low-income legally resident individuals 0 - 200 percent FPL. This rebranded program would include children and pregnant women although their benefits and cost sharing would remain at current levels. In this new program, plan procurement would be done jointly for Medicaid, Apple Health, and the Federal Basic Health Program. Plan and provider rates would be synchronized as much as feasible and allowed by the Federal government as would benefits and cost sharing. Importantly, from the consumer's perspective, everyone up to 200 percent FPL would apply for a single program and would have the same choice of health plan. The risk pool of the Federal Basic Health program enrollees would remain separate from Medicaid and Apple Health

Option 3: This option would not establish a Federal Basic Health Program and would instead assume Medicaid coverage for adults under 134 percent FPL (pregnant women up to 185 percent FPL), Apple Health coverage for children up to 300 percent FPL (below the CHIP cap) and premium tax credits and cost-sharing subsidies in the Exchange for adults 134 - 400 percent FPL (Essential Health Benefits) and children and pregnant women not eligible for Apple Health and Medicaid, respectively. The goal of this option would be to retain coverage for current populations and to enroll new populations into private coverage via the Exchange. Options for smoothing transitions between current public programs and the Exchange are discussed below.

IV. Policy Discussion

There are a number of issues to consider regarding the options described above. This brief will discuss some of the key issues and challenges with each of the options within the following broad categories: 1) coordination with Medicaid and the Exchange; 2) cost comparison; 3) administration issues; 4) health benefit exchange and provider issues; and 5) issues for beneficiaries.

1) Coordination with Medicaid and Exchange

The ACA requires states choosing to establish a Federal Basic Health Program to coordinate the administration of and provision of benefits across its Federal Basic Health, Medicaid, and CHIP programs to maximize the efficiency for such programs and improve continuity of care.¹⁶ Continuity of care is dependent upon continuity of coverage and leads to better health care for most people. Retention of coverage permits continuous relationships between patients and their health care providers and is a fundamental characteristic of "patient-centered medical homes." People experiencing coverage gaps of any length face substantial barriers to accessing affordable, quality care and disruptions in coverage are associated with the underuse of preventive care.^{17 18}

¹⁶ S. 1331(c) (4)

¹⁷ Rosenbach, M et al. National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access. Mathematica Policy Research, Inc. 2007

¹⁸ Shoer, PF. et al. Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem. Commonwealth Fund, pub no. 288. November 2003.

There are a number of reasons why people transition off and on to public programs and experience disruptions in coverage, including income fluctuations, changes in employment, inability to pay premiums, and failure to return paperwork or other necessary documentation. An important issue regarding the policy options under consideration is how, and to what extent, each policy option could be implemented to mitigate coverage discontinuities and churn particularly associated with changes in income.

Not all movement on and off of public programs should be considered churning and therefore a “problem;” some enrollment and disenrollment is a natural consequence of a program where eligibility is based on income. Ensuring that only people eligible for the programs are enrolled is an important component of a program’s integrity, demonstrating appropriate use of State and Federal tax dollars. However, to the extent possible, reducing unnecessary churning can reduce administrative costs and improve the health of enrolled populations.

This issue may be partially addressed by implementing a Federal Basic Health Program, as Washington State could establish the program ensuring similar provider networks, benefits, and cost sharing for the 134-200 percent FPL income group as Medicaid.¹⁹ Although such a strategy addresses transitions due to income fluctuations up to 200 percent FPL, it may create more difficulties for transitions between the Federal Basic Health Program and the Exchange when incomes increase above 200 percent FPL. There are a few specific questions to consider here:

- 1) Where does most of the income fluctuation In Washington State occur?
- 2) Could the Federal Basic Health Program be established in a manner that addresses income fluctuations and transitions between it and the Exchange?
- 3) Are there other options for mitigating the potential harm of income fluctuations and transitions between Medicaid and the Exchange?

While Washington-specific data have not been analyzed for this brief, two recent studies assessing income fluctuations and public program eligibility using national data provide some empirical data that can help policymakers better understand this issue. A study using national survey data found that nearly 40 percent of adults experienced a change in income that would have resulted in a disruption in Medicaid eligibility within the first six months of enrollment.²⁰ In this study, people with incomes at the Medicaid-Exchange income divide (between 100-150 percent FPL) were more likely to experience income fluctuations when compared both with people with incomes below poverty, or above 150 percent FPL. Importantly, this study did not assess fluctuations that would occur specifically in a Basic Health program. A more recent study, using national longitudinal income and health insurance data from the U.S. Census Bureau, found that: “operating separate BH, Medicaid, and Exchange programs substantially increases churning.”²¹ This study also found greater churning overall under an integrated program similar to that proposed under Option 2 (compared to Option 3).

If a Federal Basic Health Program were to be established in Washington State, it would be helpful if it also could be designed to provide a smooth transition between it and the Exchange. The ACA did consider these transitions and the Department of Health and Human Services (HHS) continues to provide guidance to states on how to streamline the eligibility process for these programs. For

¹⁹ Dorn, S; The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States. March 2011.

²⁰ Sommers, B. and Rosenbaum, S. Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges; Health Affairs, 30:2, February 2011

²¹ Graves, J.A., Curtis, R, and Gruber, J.; N Engl J Med 2011; 365:e44 December 15, 2011.

example, recent guidance from HHS confirmed that Modified Adjusted Gross Income (MAGI) will be used as the unified income guideline to ensure a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a Qualified Health Plan (QHP) in the Exchange or any insurance affordability programs (including CHIP, Medicaid, and the Federal Basic Health Program).²² These guidelines also require the Exchange to be the entity that determines all eligibility.

It seems very important that no matter which option Washington State policymakers choose, they will need to consider the alignment of markets and provider networks across all insurance affordability programs. Washington State has begun to make progress towards this goal through its Joint Procurement Project. This seems to be the most critical element for continuity and quality of care for individuals and their families as income changes. Ideally, at least some of the same plans with the same provider networks would participate in the Exchange, CHIP and Medicaid markets whether a Federal Basic Health Program were established or not. This is not only important for transitions between programs but may allow families to be enrolled in the same plans in situations where program eligibility differs. Because program eligibility is different for children and adults, having the same plans available across all insurance affordability programs will allow families to stay together on the same plan. While it may not be possible or desirable to ensure that all of the plans are participating in all of the markets, if there are at least a few plans that cross all markets, continuity of care can be improved for populations susceptible to income volatility.

A number of strategies also could be employed under any of the options to mitigate the problems associated with frequent fluctuations in income. In addition to ensuring an alignment of markets and provider networks, Washington State could consider establishing a minimum guaranteed eligibility period with annual redeterminations ensuring a person has continuity of coverage for at least a year. Washington State also could require enrollment in plans through the Exchange to be retroactive to the date of first eligibility for people transitioning from Medicaid, or extend Medicaid coverage until Exchange coverage takes effect. Insuring that beneficiaries have appropriate support for transitions and that these transitions are as seamless as possible for beneficiaries is extremely important.

Navigators also could help educate people who have income that suggests future fluctuations to consider plans that are available across all programs. While establishing a Federal Basic Health Program may seem like the ideal choice to address the issue of coordination among insurance affordability programs, the ACA envisions more coordinated coverage no matter which option a state chooses.

2) Cost Comparison

One of the more fundamental questions for Washington State policymakers to consider is whether the funding the State will receive from the Federal government will be sufficient to cover beneficiaries in a Federal Basic Health Program. Although some national estimates exist, they are not based on Washington-specific data. This section will provide estimates both for the revenues that will be provided to the State and the cost of running the program using Washington-specific data. The analysis that follows includes a number of steps, each of which will be described in some detail. In addition, a number of assumptions are made which will be noted when appropriate.

²² 45 CFR Parts 155 and 157{CMS-9974-P} RIN 0938-AR25

Step 1. Estimating the number of participants

To determine revenue and cost estimates for the Federal Basic Health program it is important to understand who could be enrolling in the program. A recent report estimated that as many as 398,000 Washington State residents were income eligible for the Federal Basic Health Program. However, once access to employer-sponsored coverage and take-up was taken into account, the estimate ranged from 80,000 – 140,000.²³ Another recent estimate found 104,266 would be potentially eligible in the State.²⁴ For the analysis that follows, people uninsured, per the 2010 Washington State household survey, who are income-eligible for a Federal Basic Health Program under the ACA, are included as shown in Table 3 below. Because this estimate does not take into account access to affordable employer-sponsored health insurance or changes in employers' offer of insurance, the actual number may be smaller or larger.

Table 3: Washington State's Population Potentially Eligible for the Federal Basic Health Program by Income

Income Range	Uninsured
134%-150% ²⁵ FPL	37,438
150% - 200% ²⁶ FPL	96,229
Total	133,667

Step 2: Assessing ACA Provisions for Premium Tax Credits in the Exchange

Table 4 displays the ACA requirements by income of people receiving premium tax credits and cost-sharing subsidies in the Exchange. For each income group there is a range of premiums. For people with incomes between 134-150 percent FPL, the range is between 3 and 4 percent of income or participant premiums ranging from \$37.02 -\$54.89. For people with incomes between 151 and 200 percent FPL, the range is between 4 and 6 percent of income or participant premiums range from \$55.63 to \$116.05. There is also an OOP maximum of \$1983 for people under 200 percent FPL.

²³ Planning Washington's Health Benefit Exchange: The potential impact of three key decisions, January 27, 2011, Milliman Client Report

²⁴ Estimate from Stan Dorn's draft report

²⁵ For Basic Health Plan enrollment and disenrollment this category is 140-154% FPL

²⁶ For Basic Health Plan enrollment and disenrollment this category is 155-200%FPL

Table 4: ACA Provisions for Premiums, Actuarial Value and OOP Maximums in the Exchange

Income Range	Premium Range	Est. Income	Est. Premium % of income	[monthly] Income (1 Person)	[monthly] Participant Premium	AV	OOP Max
134-150%	3-4%	134%	3.00%	\$1,234.14	\$37.02	94%	\$1,983
134-150%	3-4%	142.5%	3.50%	\$1,312.43	\$45.93	94%	\$1,983
134-150%	3-4%	149.0%	4.00%	\$1,372.29	\$54.89	94%	\$1,983
151-200%	4-6.3%	151.0%	4.00%	\$1,390.71	\$55.63	87%	\$1,983
151-200%	4-6.3%	175%	5.15%	\$1,611.75	\$83.01	87%	\$1,983
151-200%	4-6.3%	200%	6.30%	\$1,842.00	\$116.05	87%	\$1,983

Note: AV = actuarial rate, OOP = Out-of-pocket maximum

Step 3: Estimating Private Market Premiums for the Second Lowest Cost Silver Plan in the Exchange

It is necessary to estimate the premium of the second-lowest cost silver plan in the Exchange to determine how much revenue Washington State will receive from the Federal government for people enrolled in the Federal Basic Health Program. States will receive 95 percent of the premium tax credits and cost-sharing subsidies that people would have otherwise received had they purchased coverage through the Exchange. Guidance from the Federal government regarding the definition of Essential Health Benefits and actuarial requirements has not yet been released and therefore this part of the analysis will need to be revisited at a later date.

Two strategies for estimating the second lowest cost silver plan premium are used here. The first estimate begins with a base premium from the current State’s Basic Health Plan and the second estimate begins with a base premium from the current average premium in the individual market. Each of these approaches makes numerous assumptions. Because this part of the analysis is critical, it was decided to use two different methods for deriving the silver premium from which Federal revenues will be based.

Method 1: Starting with the Basic Health Plan Premium

Using the premium from Washington’s State Basic Health Plan as a baseline is reasonable since the population served by the State’s Basic Health Plan will be similar to the one served by the Federal Basic Health program (i.e. low income without access to employer-sponsored insurance). Accounting for differences in health status among populations and the affect on premiums is a difficult task. By using State Basic Health premiums as a baseline, it is not as important to adjust the premiums for health status differences.

However, the following adjustments will need to be made to account for differences in premium between the State’s Basic Health Plan and a silver plan in the Exchange.

- 1) Carrier administrative costs: The current State Basic Health Plan’s administrative costs are assumed to be lower than what would be expected in a commercial plan in the Exchange. For this analysis, it is estimated that the difference in administrative load between the State

Basic Health Plan and a commercial plan in the Exchange is 5% (State Basic Health Plan has an estimated administrative load of 10 percent while commercial loads are estimated to be 15 percent).²⁷

- 2) Provider rates: Provider rates are lower in plans contracting for services for State Basic Health Plan beneficiaries versus the privately insured. For this analysis, an adjustment of 25 percent is added to claims cost to account for these differences in provider rates.²⁸
- 3) Actuarial value: It is assumed that the actuarial value of the State Basic Health Plan is richer than a future silver plan in the Exchange. The State Basic Health Plan is estimated to have an actuarial value of between 78 – 80 percent so a small decrease in the premium is made to account for differences in actuarial value. (Silver plans will have actuarial values of 70%)

In addition to the above adjustments, several other assumptions are made in this analysis. First, the benefits covered by the existing State's Basic Health Plan are similar to what would be covered by a silver plan in the Exchange in 2014. In addition, premiums are not inflated from their 2011 base for any of the calculations presented here.

The most recent data available from the Washington Health Care Authority (HCA) notes that premiums in the State's Basic Health Plan program are \$251.99/month for the period January – June 2011. Taking the baseline premium and rounding up to \$252/month, of which 10 percent is assumed to be carrier administrative costs, a claims premium of \$227/month is determined. This premium is increased by 25 percent (to account for provider rate differences) to arrive at a claims premium of \$284. Out-of-pocket cost sharing is then estimated at \$71 for a plan with an actuarial value of 80 percent. The premium is then adjusted down to account for the difference in actuarial values (from 80% to 70%) and administrative costs of 15 percent are added back in. The final premium derived by this method is \$285.52/month or \$3426/year.

This is somewhat higher than the \$231/month Washington State average individual market premium for 2011.²⁹ However, there are several explanations for this difference. First, the actuarial value of the current average individual plan is likely lower than a silver-level plan. Second, the health status of people currently enrolled in the individual market is better than the health status of people enrolled in the State's Basic Health Plan.

Method 2: Starting with the Individual Market Premium

The individual market premium is also used as the baseline to estimate the value of a silver plan in the Exchange. The following adjustments will need to be made to account for differences between the average individual plan premium and a silver plan in the Exchange.

- 1) Health Status Adjustment: Milliman recently reported that the average healthcare expenditure index for people purchasing individual coverage was .79 compared to 1.03 for the uninsured.³⁰ Since both populations will be enrolling in silver plans in the Exchange, some average of these two populations must be used here. The current individual plan premium is adjusted up by a factor of 15 percent to adjust for an estimated sicker population enrolling in coverage in 2014 versus now.

²⁷ Conversations with Washington HCA staff.

²⁸ Ibid.

²⁹ Mapping Premium Variation in the Individual Market, Kaiser Family Foundation issue brief, August 2011.

³⁰ Milliman Client Report. Planning Washington's Health Benefit Exchange: The potential impact of three key decisions. January 27, 2011

- 2) Actuarial Value: It is assumed that the actuarial value of an average individual plan in Washington State is closer to a bronze level plan (60%) so a small adjustment is made to increase the premium reflecting this difference in actuarial value.

Beginning with a premium of \$231, administrative costs of 15 percent are subtracted to arrive at a claims premium of \$196.35. An increase of 15 percent is made to adjust for health status. The actuarial value is adjusted and then administrative costs of 15 percent are added back to arrive at a monthly premium of \$302.95/month or \$3635.40/year. No adjustments to benefits (from existing benefits) or annual inflation are accounted for.

The two estimates presented above both contain numerous assumptions but both arrive at similar premiums for a silver plan in the Exchange of \$285.52 - \$302.95. As guidance from the Federal government becomes available, in particular regarding the definition of Essential Health Benefits, these analyses may need to be revisited.

Step 4: Estimate Cost-Sharing Subsidies

It is somewhat unclear from the ACA language whether states will receive 95 or 100 percent of the cost-sharing subsidy amount; for this analysis 95 percent is used. To calculate the amount of cost-sharing subsidy Washington State will receive from the Federal government in lieu of people receiving cost-sharing subsidies in the Exchange, the average amount of cost sharing in a typical silver plan is first estimated. The average cost sharing in a silver plan with an actuarial value of 70 percent is estimated here to be 30 percent of the current claims cost. The ACA requires that cost sharing be reduced for people with incomes between 134 and 150 percent to a platinum plan (94% actuarial value) and to a gold plan (87% actuarial value) for people with incomes between 151 and 200 percent FPL. It is therefore estimated that annual cost-sharing reductions to out-of-pocket costs are approximately \$798/year for people under 151 percent FPL and \$558/year for people between 151-200 percent FPL for the estimate beginning with State Basic Health Plan premiums. (\$873/year and \$618/year for the estimate beginning with individual plan premiums).

Tables 5a and 5b provide a summary of the estimated total revenue that would be provided to Washington State per person enrolled in a Federal Basic Health Program based on the two methods for calculating a silver-level premium. It is clear from these tables that as the income of the enrollee increases, the amount of revenue provided by the Federal government decreases. The estimated revenue amounts provided in Tables 6a and 6b do not account for the age of the enrollees. Premiums also will vary based on the age of the enrollee, and so will the revenue provided by the Federal government. Thus, it is important to not only consider the average income of the population but also the age of the population expected to enroll in the Federal Basic Health Program, when assessing the overall revenue that will be available.

Table 5a: Estimated Premium and Cost Sharing Revenue/Month for People Enrolled in a Federal Basic Health Program -- Starting with the Basic Health Plan Premium

Point estimate Income %FPL	Participant Premium	Premium for Silver plan ³¹	Premium Subsidy	Cost Sharing Subsidy	Total Monthly Subsidy @100%	Total Monthly Subsidy @95%
	(a)	(b)	(b – a)	d	(b – a) + d	.95 (b – a) + d
138%	\$37.02	\$285.52	\$248.50	\$66.53	\$315.03	\$299.28
142.5%	\$45.93	\$285.52	\$239.59	\$66.53	\$306.12	\$290.81
149%	\$54.89	\$285.52	\$230.63	\$66.53	\$297.16	\$282.30
151%	\$55.63	\$285.52	\$229.89	\$46.54	\$276.43	\$262.61
175%	\$83.01	\$285.52	\$202.51	\$46.54	\$249.05	\$236.60
200%	\$116.05	\$285.52	\$169.47	\$46.54	\$216.01	\$205.21

Table 5b: Estimated Premium and Cost Sharing Revenue/Month for People Enrolled in a Federal Basic Health Program – Starting with the Individual Market Premium

Point estimate Income %FPL	Participant Premium	Premium for Silver plan ³²	Premium Subsidy	Cost Sharing Subsidy	Total Monthly Subsidy @100%	Total Monthly Subsidy @95%
	(a)	(b)	(b – a)	d	(b – a) + d	.95 (b – a) + d
138%	\$37.02	\$302.95	\$265.93	\$72.71	\$338.64	\$321.71
142.5%	\$45.93	\$302.95	\$257.02	\$72.71	\$329.73	\$313.24
149%	\$54.89	\$302.95	\$248.06	\$72.71	\$320.77	\$304.73
151%	\$55.63	\$302.95	\$247.32	\$51.51	\$298.83	\$283.89
175%	\$83.01	\$302.95	\$219.94	\$51.51	\$271.45	\$257.88
200%	\$116.05	\$302.95	\$186.90	\$51.51	\$238.41	\$226.49

Step 5: Costs of Operating the Federal Basic Health Program

In 2011, per member per month (pmpm) costs for the State’s Basic Health Plan are \$251.93. This rate includes a 10 percent administrative load and has an actuarial value of 78-80% percent. Provider rates are reportedly similar to Medicaid except in some cases where small increases are made to assure access to certain providers. Under the Federal Basic Health Program, it is assumed that plans would be required to do more care management, patient engagement and reporting and therefore plan administrative costs will likely be higher than the 10 percent included here. It is estimated that these

³¹ This estimate began with the current State Basic Health Plan premium

³² This estimate began with the current average individual plan premium

additional responsibilities will add 5% to the administrative costs. In addition, actuarial values must be no lower than that of a platinum plan (actuarial value = 90 percent) for people 150 percent FPL and below, and a gold plan (actuarial value = 80 percent) for people between 151 - 200 percent FPL. Therefore, a plan's base premium cost will increase for people in the lower income category to account for this actuarial difference. Since many of the people eligible for the Federal Basic Health Program will be in the higher income category an adjustment of 5% is made to the claims premium. The total minimum Federal Basic Health Program premium is therefore estimated to be \$277.12/month.

In addition, there is a cost to the State for establishing and operating a Federal Basic Health Program. Current State administrative costs for the State's Basic Health Plan provide a reasonable starting point for estimating the on-going costs of operating a Federal Basic Health Program. According to the Health Care Authority, State costs for operating the State Basic Health Plan were \$7.2 million and \$6.7 million in 2010 and 2011 respectively. This is an average per member per month administrative fee of approximately \$8.83.

Estimates for establishing a Federal Basic Health Program are difficult to predict as they somewhat depend on guidance that has yet to be provided by the Federal government. However, it is important to keep in mind that start-up costs are not supported by Federal Exchange Establishment grant funds. It is also unclear whether the Federal government will allow states to use any Federal reimbursement to operate the program.³³ Probably the largest start-up costs of a Federal Basic Health Program would be the procurement of new IT systems. To the extent the IT system from the Exchange could be used for the Basic Health Program, these costs would be reduced.

Although the Federal government requires that a single eligibility portal be established and that all of the insurance affordability programs be coordinated, there will still be allocation costs for determining eligibility for the Federal Basic Health Program. To the extent that Option 2 could be achieved, resources dedicated to operating the Medicaid program potentially could be redirected to run this rebranded program. This arrangement would require approval from the Federal government and would likely present challenges for the State regarding accounting of costs and other reporting for the different populations.

Step 6: Determining the Breakeven Point for the Federal Basic Health Program

The estimate of Federal revenue that will be received by Washington State ranges from \$205.21–\$299.28 pmpm dependent on enrollee's income using the State Basic Health Plan premium as the base for the silver-level premium and \$226.49 - \$321.71 using the current average individual plan premium in Washington State as the base.

The cost of the State Basic Health Plan averages between \$13 and \$36 pmpm lower than the average revenue that would be provided by the Federal government (see yellow highlighted boxes in Tables 5a and 5b) for lower income people. However, for people at the highest income level the cost of covering the enrollee is greater than what would be provided by between \$20 and \$41 pmpm. It is estimated that nearly three quarters (71%) of the expected population who would enroll in the Federal Basic Health Program in Washington State are in the higher income categories (Table 3).

However, the figures provided in Tables 5a and 5b do not include any payment of premiums by the enrollee. It is expected that Washington State would charge participants premiums for the Federal

³³ S1331 (d)(2) states that "amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State."

Basic Health Program, although it is not yet known what these premiums would be. Tables 6a and 6b below incorporate participant premiums at the highest level allowed (the same level as required in the Exchange) as an example. Although policymakers may want to consider lower premiums, the maximum allowed premiums are used here to allow for discussion of the breakeven points for managing a Federal Basic Health Program in Washington State. The columns labeled “Difference” in Table 6a and 6b provide the estimated amount of total revenue Washington State would have per enrollee for coverage in a Federal Basic Health Program if enrollees paid premiums equal to those they would have paid in the Exchange.

The small estimated difference could be used to incorporate one or more of the following enhancements although the available funding is likely not sufficient to significantly improve the program in all three areas.

- Reduce premiums and/or cost sharing below what is expected in the Exchange
- Increase provider rates from their near Medicaid-levels,
- Cover any additional benefits not included in the definition of Essential Health Benefits

Table 6a: Maximum Estimated Revenues Available to Cover People Eligible for Exchange Subsidies Under 200% FPL in the Federal Basic Health Program -- Starting with the State Basic Health Plan Premium

Point estimate income %FPL	Total ACA Subsidy Method 1	Maximum Premiums Allowed	Total Maximum Basic Health Revenue	Minimum Basic Health Cost (from above)	Difference
	(a)	(b)	(a + b)	(d)	(a + b) - d
138%	\$299.28	\$37.02	\$336.30	\$277.12	\$59.18
142.5%	\$290.81	\$45.93	\$336.74	\$277.12	\$59.62
149%	\$282.30	\$54.89	\$337.19	\$277.12	\$60.07
151%	\$262.61	\$55.63	\$318.24	\$277.12	\$41.12
175%	\$236.60	\$83.01	\$319.61	\$277.12	\$42.49
200%	\$205.21	\$116.05	\$321.26	\$277.12	\$44.14

Table 6b: Maximum Estimated Revenues Available to Cover People Eligible for Exchange Subsidies Under 200% FPL in the Federal Basic Health Program – Starting with the Individual Market Premium

Point estimate income %FPL	Total ACA Subsidy Method 2	Maximum Premiums Allowed	Basic Health Revenue	Minimum Basic Health Cost (from above)	Difference
	(a)	(b)	(a + b)	(d)	(a + b) - d
138%	\$321.71	\$37.02	\$358.73	\$277.12	\$81.61
142.5%	\$313.24	\$45.93	\$359.17	\$277.12	\$82.05
149%	\$304.73	\$54.89	\$359.62	\$277.12	\$82.50
151%	\$283.89	\$55.63	\$339.52	\$277.12	\$62.40
175%	\$257.88	\$83.01	\$340.89	\$277.12	\$63.77
200%	\$226.49	\$116.05	\$342.54	\$277.12	\$65.42

Summary of Analysis

The analysis provided here finds that Washington State may be able to cover its enrollee costs under a Federal Basic Health Program option if premiums were kept at levels similar to what is required by people in the Exchange. These estimates suggest some small savings that could be used to lower participant cost sharing, add benefits, or increase provider rates. There are, however, significant assumptions made throughout this analysis. Importantly, the risk profile of those who enroll in program is not known, and Essential Health Benefits are not yet defined. It is also unclear how Washington State would find the revenue to cover the start up or development costs of this program, which could be significant.

Another recent financial analysis of the Federal Basic Health Program found that average Federal payments to Washington State would exceed the costs of furnishing CHIP-like coverage in a Federal Basic Health Program by 11.4 percent.³⁴ Although the methodology, assumptions, and conclusions differ from those provided here, the revenue-cost differential of 11.4 percent is one of the smallest across all states, and significantly lower than the US average. This result suggests that Washington State would have less revenue and flexibility to increase benefits, reduce cost sharing, or enhance provider rates than would other states.

3) Administration Issues

A number of administrative issues arise with each of the options under consideration. Options 1 and 2 involve establishing and administering a new Federal Basic Health program that would require significant infrastructure and on-going operational costs.

Option 1 assumes a different operating infrastructure from both the Exchange and Medicaid and one that is similar to what is in existence today within the Health Care Authority. Some operational tasks

³⁴ Dorn, S, Burgess, M and Carroll, C; Using the Basic Health Program to Make Coverage More Affordable to Low-income Households: A Promising Approach for Many States. September 2011.

could be coordinated with Medicaid for efficiencies and to ensure coordination across all programs. If the program were housed in the Health Care Authority, certainly building off of the current infrastructure and sharing some of the administrative functions with Apple Health and Medicaid would be recommended. However, the programs would still remain distinct under this option and some redundancy in functions across the various programs and the Exchange would likely persist. In addition, the administrative costs of running this wholly separate program would need an on-going revenue source. The Federal government's guidance on the Federal Basic Health Program has indicated that user fees can be used as a revenue source.³⁵

Option 2 envisions a new, single branded program for low-income individuals that would incorporate Medicaid and the Federal Basic Health program and likely would be operated within the Medicaid office. Procurement of plans, enrollment, customer service, etc. could be streamlined within the Medicaid program. The Federal government is unlikely to allow the merging of risk pools so some disaggregation of the programs would be necessary. In addition, a cost allocation system for the administrative functions that could be streamlined would be necessary, as the Federal government will want these costs separated out from Medicaid's administrative costs. This option would certainly reduce administrative costs from that of Option 1, although there would remain some obvious redundancy in functions between the Federal Basic Health program and the Exchange. Unfortunately, this is an issue that is not easily remedied as states will continue to manage CHIP and Medicaid programs, and the ACA requires states to establish Exchanges.

Option 2 would, however, require greater start-up costs than Option 1. The complexity of merging these programs and determining which features could be synchronized is not straightforward. Moreover, there are likely some features that would require approval from the Federal government particularly if any changes in benefits or cost sharing are desired. Funding of the initial start-up costs for Options 1 or 2 could prove problematic in this tight State fiscal environment especially since the Federal government is not allowing the use of Exchange Establishment grant funds to finance the development costs of the Federal Basic Health program. Moreover, it is unclear what level of risk the State is responsible for regarding costs exceeding Federal reimbursement on a year-to-year basis for this program (The ACA states that the Federal government will adjust rates for subsequent years if the rates were too high or too low).

Option 3 would not require any new infrastructure (beyond the establishment of an Exchange) and would maintain Apple Health and Medicaid as distinct programs. As with the other options, duplication of certain administrative tasks already handled by the Health Care Authority for Apple Health and Medicaid such as customer service, Federal reporting, plan procurement and certification, quality monitoring, etc. and the Exchange is unavoidable.

The administrative issues discussed here provide little guidance regarding whether Washington State should pursue one option over another. Option 2 reduces duplication of functions compared to Option 1 by integrating most of the existing public programs, however, even with this option some duplication of functions remains across the Health Care Authority and the Exchange and this option may prove too complex to implement in the necessary timeframe.

³⁵ Centers for Medicare & Medicaid Services, "State Exchange Implementation Questions and Answers." November 29, 2011.

4) Health Benefit Exchange and Provider Issues

In considering the options discussed above, Washington State policymakers will want to assess the potential impact each option would have on the private insurance market, the Exchange, and providers. The following issues related to the private insurance market and providers are discussed here: 1) the impact on the size of the Exchange; 2) the impact on the risk pool of the Exchange; and 3) the impact on provider reimbursement and cost shifting.

One of the more significant concerns regarding establishing a Federal Basic Health program under Option 1 or 2 is the resultant size of the Exchange. The size of the Exchange is important for at least two reasons. First, the larger the Exchange, the greater the number of insured lives over which to spread administrative costs. Second, a larger Exchange will likely have a better chance of attracting and engaging plans to its distribution channel, as well as greater opportunity to move the market regarding quality improvement efforts. A recent report estimated the range of the number of individuals in Washington State who could enroll in health insurance through the Exchange as 140,000 – 410,000. If all individuals who would be eligible for the Federal Basic Health Program, if established, are removed the individual Exchange enrollment drops by at least a third. In Massachusetts, where individuals are subsidized to 300 percent FPL, most subsidized individuals currently covered through the Exchange are under 200 percent FPL (84 percent). Thus, establishing a Federal Basic Health program could reduce Exchange enrollment below a critical level that is required for the Exchange to be self-sustaining. A full discussion of this issue was provided in the report prepared earlier in the year by Milliman.³⁶

Not a lot is understood about the difference in risk between people who will be eligible for the Federal Basic Health program with incomes between 134 and 200 percent FPL and those who will be eligible for premium tax credits and cost-sharing subsidies through the Exchange with incomes between 201 and 400 percent FPL. However, generally speaking, lower income is associated with poorer health status. There also is some evidence that Washington State's Basic Health Plan suffered from some risk selection in the past as the estimated HealthCare Expenditure Index for State Basic Health Plan members is 1.06 compared to the general individual market index of 0.79.³⁷

The ACA addresses risk selection in the insurance market with several mechanisms; however, it is not clear how the Federal Basic Health Program will interact with these mechanisms. Risk will be pooled across the individual market inside and outside the Exchange in the commercial market, but the ACA and subsequent proposed regulations on risk adjustment are silent on whether the Federal Basic Health program could be included in this pooling mechanism. The primary concern is that the Federal Basic Health program's population risk is greater than the risk of the population in the Exchange. Because reimbursement is based on the premiums of those in the second lowest cost silver plan in the Exchange, if the risk was much lower in the Exchange, the premiums from which the Federal Basic Health reimbursement is based would be lower while the population actually requires more services. The cost analyses presented earlier does not adequately account for any potential differences in health status of the populations in the Federal Basic Health program and the Exchange. Guidance from the Federal government is forthcoming and may include information on how these risk adjustment mechanisms will interact with the Federal Basic Health program.

³⁶ Milliman Client Report. Planning Washington's Health Benefit Exchange: The potential impact of three key decisions. January 27, 2011

³⁷ *ibid.*

The ACA extends Medicaid coverage to all legal residents up to 133 percent FPL. In Washington State, the State Basic Health Program already extended coverage to a proportion of residents in that income group. However, according to one report an additional 189,463 previously uninsured Washington residents will become eligible for Medicaid coverage in 2014.³⁸ This will create added pressure on Medicaid provider rates in order to ensure access to providers for all the newly insured. It may be unrealistic to expect that providers can absorb all of these newly insured individuals at current Medicaid reimbursement rates. However, establishing a Federal Basic Health Program under Option 1 or 2 could exacerbate this problem. The State partially addresses the issue of low provider rates in its State Basic Health Plan by occasionally increasing provider rates when it is necessary to ensure adequate access. Washington State policymakers would likely need to use much of the potential surplus in revenue provided by the Federal government to increase rates to managed care organizations so that provider rates could be enhanced in the Federal Basic Health program, leaving little funding for decreasing beneficiary cost sharing or enhancing benefits.

If policymakers choose Option 3 and do not establish the Federal Basic Health program, then the population from 134 - 400 percent FPL receiving coverage through the Exchange would be covered by private insurance and providers would be reimbursed at commercial rates. This would likely be preferable to providers and it would be at the expense of the Federal government. This removes the State from the rate negotiations with providers for this sizeable population.

It is also logical to expect that some providers will see a decrease in uncompensated care and will be able to absorb lower reimbursement through a Federal Basic Health program. However, this is a difficult argument to make when these providers are fiscally quite vulnerable with slim financial margins. Moreover, in Massachusetts, providers experienced significantly less uncompensated care as an outcome of their reform, but provider reimbursement issues remain a problem.

5) Issues for beneficiaries

Washington State policymakers also will want to assess the potential impact each option would have on consumers. The following discussion covers several of the consumer issues that have been identified but it may be necessary to talk with potential consumers in order to ensure that their preferences are included in any decision making.

Three consumer concerns are discussed here: choice, access, and cost. The consumer would have the greatest choice if Option 3 were implemented. The Exchange will have more options available to consumers at the metallic tiers with varying levels of cost sharing and provider networks. In addition, consumers will have a choice of the same private health insurance plans and will not have the stigma of being enrolled in a public plan.

Consumers' access to providers would also be the best under Option 3 because provider reimbursement would be at commercial rates. Although policymakers could increase provider reimbursement above the Medicaid level, it is unlikely they will be able to increase rates to commercial levels. Consumer choice, however, must be balanced with cost.

One potential advantage to establishing a Federal Basic Health Program is that premiums and cost sharing could be lowered (from what is expected in the Exchange) for the population between 134 -

³⁸ Holahan, J and Headen, I. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, Kaiser Commission on Medicaid and the Uninsured. May 2010.

200 percent FPL. For people in this income category, the ACA requires them to pay between \$37.02 and \$116.05 per month in premiums in the Exchange. In addition, they will be responsible for some cost sharing typical of a platinum plan (if between 134-150 percent FPL) and a gold plan (if between 151-200 percent FPL) in the Exchange. While platinum plans likely will have no deductible, and gold plans only a modest one, they will be cost sharing in the form of co-payments or co-insurance similar to what is found in many employer plans.³⁹

Washington State has some experience understanding what is affordable for its low-income population because of extensive experience operating its State Basic Health Plan. For people at similar income levels (as those who would be eligible for the Federal Basic Health program), recent premiums and cost sharing have been somewhat higher in Washington State's Basic Health Plan than what is expected in the Exchange. Washington State's experience suggests that these levels of premiums and cost sharing largely have not deterred people from enrolling in the State's Basic Health Plan or in seeking necessary care. In fact, there has always been a long waiting list for the State's Basic Health Plan. However, it should be noted that over time enrollment in Washington's State Basic Health Plan has declined in the higher-income categories as premiums increased.⁴⁰

Therefore it is possible that the level of premiums and cost sharing expected in the Exchange will deter some people from enrolling in Exchange plans. If policymakers in Washington State are interested in lowering premiums and cost-sharing requirements to ensure greater take-up of coverage, they also need to be mindful that lowering premiums for this income group will create a larger increase in premiums and cost sharing when people transition from the Federal Basic Health Program to the Exchange above 200 percent FPL. There are also State cost considerations of reducing premiums from those required in the Exchange.

Policymakers should also consider the effects of cost on take-up rates. If cost sharing could be significantly reduced under a Federal Basic Health Program, then greater take-up of this insurance may be likely. However, it is difficult to assess what consumers value more, choice or affordability, and which option would ensure greater take-up of coverage. One issue related to take-up is that consumers are required to pay back the Federal government some portion of any overpayment of tax credits received via the Exchange. It is possible that this pay-back feature could dissuade eligible individuals from participating in the Exchange. Establishing a Federal Basic Health Program likely would be implemented without this pay-back feature. Choice, overall cost, and ease of enrollment will also be important factors to consider regarding the take-up rates of the various options.

V. Framework for Considering a Federal Basic Health Program in WA State

There are clearly many issues facing policymakers regarding whether they should establish a Federal Basic Health Program in lieu of Exchange subsidies for people with incomes up to 200 percent FPL. It may be difficult for policymakers to weigh the competing goals with the advantages and disadvantages of the options presented here. This section presents a table summarizing the issues discussed in this brief and provides a framework for policymakers to consider these issues moving forward. In Table 7, each of the policy options are presented and scored on their effectiveness in addressing the issues described in this paper. A score of A, B, and C are assigned to each of the three options (A is assigned to the options that can most easily address that particular "Issue for the State," B

³⁹ Peterson, C. Setting and Valuing Health Insurance Benefits, Congressional Research Service, April 6, 2009.

⁴⁰ 16% of BHP enrollees were in the 125-200%FPL range according to the most recent BHP report

is assigned to options where the issue is likely to remain, and a C is assigned to the options that exacerbate the issue). While these assignments are somewhat subjective, they may provide guidance in considering the issues in the context of each option.

Table 7: Framework for Assessing Issues Best Addressed by the Various Options

<i>Issues for the State</i>	<i>Option 1</i>	<i>Option 2</i>	<i>Option 3</i>
Exchange sustainability	C	C	A
Complexity of insurance affordability programs	B	C	A
Federal Funds to support establishment and on-going operation	C	C	A
Adequate take-up of insurance coverage	A	A	A
<i>Issues for Consumers</i>			
Affordability (premiums and cost sharing)	B	A	C
Access to providers	B	C	A
Choice of Plans and Providers	B	C	A
Complexity navigating the system	C	A	B
<i>Issues for other stakeholders</i>			
Provider stability and cost-shifting	B	C	A

VI. Summary

The Federal Basic Health Program option is one that Washington State policymakers are considering. This brief provides a discussion of two options for implementing this program and compares it to covering income-eligible people in the Exchange on a number of dimensions. The discussion was focused on issues related to: 1) coordination with Medicaid and the Exchange; 2) cost comparison; 3) administration issues; 4) health benefit exchange and provider issues; and 5) issues for beneficiaries. While all of these issues are important, there are a few questions that are critical and should be the primary focus of the policy discussion.

First, will the revenue provided by the Federal government be sufficient to cover individuals enrolled in a Federal Basic Health Program? The analysis provided here presented two estimates of revenue projections, both making numerous assumptions. While these estimates provide some level of

assurance that costs can be covered (particularly for people at lower incomes), the available revenue is likely not sufficient to address all of the issues of interest to policymakers such as cost-sharing levels, benefits, and provider rates. The second critical question is what is the risk that the establishment of a Federal Basic Health Program causes the resulting Exchange to be unsustainable? Preliminary estimates and experience from Massachusetts suggest that the establishment of a Federal Basic Health Program may indeed limit enrollment in the Exchange to a point where the Exchange is not sustainable. A third key question is the availability of State funds to develop and administer a new Federal Basic Health Program when the federal government has not, to date, indicated financial support for the program.

Additionally, a \$2.0 billion deficit has been forecasted for Washington State. To help address this, the Governor has proposed eliminating the State Basic Health Plan. If the Legislature follows through and cuts the current program as part of budget reductions, the state would have to consider the Federal Basic Health Program without an existing program to build from.

The answers to these questions start with the estimates in Tables 6a and 6b. Whether starting with the State Basic Health Plan or individual market premium, the analysis arrives at similar estimates of total revenue: roughly \$320-\$360 per participant per month if Exchange-level premiums are charged to participants. That estimate of total revenue is roughly \$40-\$80 above the projected monthly premium of covering a participant in the Federal Basic Health Program. An important discussion for Washington State is whether that gap is large enough to alleviate the risks associated with implementing the Federal Basic Health Program.

That gap does not include the administrative expenses, which must be funded by the State, of operating the Federal Basic Health Program. This issue brief identifies additional administrative functions primarily in the area of coordination with other public programs and private markets that are not performed by the current State Basic Health Plan. Washington State would have to fund the development and operation of those administrative functions. Also, if the current State Basic Health Plan is eliminated, then Washington will lose some or all of the advantage of building the federal program upon an existing administrative base and attracting individuals back to a plan that had just been dissolved may also prove difficult.

The gap between estimated revenue and premiums in the Federal Basic Health Program could be overwhelmed by outcomes different than the assumptions in this issue brief. If the second lowest-cost silver plan has a lower premium than expected, then federal subsidies, and thus, total revenues will be lower. The health status of the participants could be worse than expected and drive up the cost of coverage compared to the second lowest-cost silver plan. If more participants from the lower end of the income scale enroll, then total participant premiums will be less than expected. Finally, health care providers will likely argue for higher reimbursement rates leaving less funding to lower premiums or enhance benefits. A difference in any of these assumptions could place the state at risk of funding coverage in the Federal Basic Health Program because the participants cannot be turned away or placed on a waiting list.

Adding to these concerns, HHS has not yet specified how the estimate of capped federal funding will be calculated for each state. To generate any interest in the Federal Basic Health Program, HHS will need to provide funding on a per participant basis. States also need to know if HHS intends to dynamically alter the funding estimate throughout the year based on, for example, the age or income of the program's population.

The final key question for policymakers to answer is what are the specific goals for this low-income population? As this brief presents, none of the issues discussed point to a particular policy choice but rather suggest that each option will have implementation and operational challenges that will need to be addressed in order to achieve the desired goals.

While states are awaiting further guidance from the federal government on the establishment of a Federal Basic Health Program, and the definition of Essential Health Benefits, this analysis can be used as a starting point for the 2012 legislative session discussion.