Update to January 2012 Research Brief

Issues in Consideration of a Basic Health Program for Connecticut

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States have the option under the federal Patient Protection and Affordable Care Act (ACA) to create a Basic Health Program (SBHP) for state residents who do not qualify for Medicaid but whose incomes are still relatively low. The SBHP would offer state administered coverage in place of subsidized private insurance purchased through a state Exchange to people with no other source of health insurance whose income is below 200% of the federal poverty level (FPL). In an earlier research brief, we presented the factors that Connecticut should examine in evaluating the potential benefits of a SBHP, and concluded that there was the potential to design a SBHP with comprehensive benefits that was more affordable to individuals and cost neutral to the state.[1] This update presents further issues to consider in assessing the desirability of a SBHP and the optimal timing for implementing it.

1. Comparing Medical Cost Exposure Between Connecticut's State Basic Health Program (SBHP) and the Health Insurance Exchange

The ACA offers both premium and cost-sharing subsidies for low-income individuals purchasing coverage through a health insurance exchange. However, these subsidies are not sufficient to prevent individuals and families from being underinsured. The SBHP likely will provide better protection for individuals and families with income from 138% to 200% of the FPL ("potential SBHP individuals").[2]

Medical Cost Exposure in the Health Insurance Exchange

The ACA offers premium assistance such that SBHP-eligible individuals and families will spend from 2% to 6.3% of their household income on premiums.[3] Likewise, the ACA limits cost-sharing to 6% to 13% of medical expenses for SBHP-eligible families in the Exchange.[4] Table 1 shows Mercer's estimated monthly medical cost exposure for individuals from 138-200% FPL, with the share of household income added in parenthesis.

[1] Center for Health Law and Economics, "Evaluating the State Basic Health Program in Connecticut." Legal Assistance Resource Center of Connecticut, January 2012.

[2] 138% is used because incomes below that level will be covered by Medicaid, given Medicaid's 5% income disregard.

[3] ACA § 1401(b). Based on purchase of the second least expensive silver plan.

[4] ACA § 1401(c). Cost-sharing assistance is only afforded to individuals who enroll in a silver plan

Table 1: 2014 Exchange Premiums and Cost-Sharing (share of household income)[5]

FPL	Premium	Cost-sharing	Total
138%	$45 (3%)	$30 (2%)	$75 (5%)
150%	$60 (4%)	$30 (2%)	$90 (6%)
200%	$130 (6%)	$70 (3%)	$200 (10%)

Underinsurance is defined as lacking financial protection from medical expenses.[6] Researchers have suggested that households with income under 200% FPL are underinsured if their medical cost exposure (premiums and out-of-pocket expenses) exceeds 5% of their income.[7] For those who are underinsured, experiences with the health care system – forgoing needed care because of cost, accessing preventive care, satisfaction and confidence in the quality of care, and having medical bill problems – are similar to the experiences of people without insurance.[8] Table 1 illustrates that many individuals from 138% - 200% FPL will be underinsured by this definition with coverage in the Exchange, even with subsidies.

Medical Cost Exposure in the Connecticut Basic Health Plan

The ACA affords states wide latitude when designing a basic health program, with enrollees' premium and cost-sharing contributions permitted to range from $0 up to the Exchange's levels.[9] Connecticut H.B. 5450 and S.B. 425 both direct the Connecticut Commissioner of Social Services to provide a SBHP "in accordance" with Medicaid, if financially feasible.[10]

In addition to the Medicaid model, Mercer proposed two benefit design models for a Connecticut SBHP. Medical cost exposure for the Exchange (as presented in Table 1) and all three SBHP models are outlined in Table 2.

[5] Health Insurance Exchange Planning Report: The State of Connecticut, 181. Mercer Government Human Services Consulting (January 2012). Mercer estimates the federal poverty level in 2014 to be $12,200/year. Cost-sharing is based on estimates of medical expenditures at the midpoint of the 138-150 and 150-200 income range. This memo uses the lower estimates.

[6] See Cathy Schoen, Michelle M. Doty, Sara R. Collins and Alyssa L. Holmgren. *Insured But Not Protected: How Many Adults Are Underinsured?* Health Affairs (2005)

[7] Ibid.

[8] Ibid.

[9] ACA § 1331(a)

[10] H.B. 5450(b); S.B. 425(b).

Table 2: 2014 Connecticut Exchange and Basic Health Models with Total Medical Cost Exposure[11]

		Connecticut SBHP Options		
FPL	Exchange	Medicaid model	Option 1 (low cost)	Option 2 (high cost)
0-138% (Medicaid)	$0 (0%)	$0 (0%)	$0 (0%)	$0 (0%)
138%	$75 (5%)	$0 (0%)	$20 (1%)	$35 (2%)
150%	$90 (6%)	$0 (0%)	$20 (1%)	$35 (2%)
200%	$200 (10%)	$0 (0%)	$40 (2%)	$100 (5%)
201% (Exchange)	$270 (13%)	$270 (13%)	$270 (13%)	$270 (13%)

As the table illustrates, for SBHP-eligible individuals, medical cost exposure ranges from 0% to 5% of household income in proposed SBHP models, compared to a range of 5% to 10% in the Exchange without a SBHP option.

2. Disruptions in coverage from fluctuating income: "Churning"

In a 2011 Health Affairs article, Sommers and Rosenbaum found that the incomes of adults below 200 percent of the federal poverty level (FPL) fluctuate frequently.

- For those starting out below 133% FPL, and who would therefore be eligible for Medicaid as of 2014, almost 40% moved above 133%, at least temporarily, in the first six months; 54% percent moved in first year. Of those, almost a third (16% of entire cohort) went back below the 133% line during the year.
- For those who start out initially ineligible for Medicaid but below 200% FPL, 30% moved below 133% in the first 6 months, and 43% did so in the first year.
- After three years, a vast majority of adults – almost three-quarters (73%) – with income below 200% FPL moved across the 133% threshold in one direction or another, many multiple times. Over half (56%) crossed the threshold at least twice, 41% at least three times, and 29% at least four times.[12]

This income volatility can disrupt continuity of coverage and access to care as adults move in and out of Medicaid eligibility. There is also an administrative cost of this churning to the state: estimates over the last several years of the cost of enrolling people into public programs range from $180 per person per enrollment in California, to $198 in Massachusetts, to $280 in New York.[13]

[11] Monthly medical cost exposure (premiums + average cost-sharing) are shown, with share of household income in parenthesis. Data taken from the Connecticut Mercer report, supra. note 3.
[12] Benjamin D. Sommers and Sara Rosenbaum. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." *Health Affairs*, 30, no. 2 (2011): 228-236.
[13] Robert Seifert, Garrett Kirk and Margaret Oakes. "Enrollment and Disenrollment in MassHealth and Commonwealth Care." Massachusetts Medicaid Policy Institute, April 2010.

The churning phenomenon offers a strong argument for a SBHP that offers the same or similar benefits, cost sharing and provider networks as Medicaid. The state could administer the two programs so that they would appear seamless to recipients, thus minimizing the churning-related coverage and care disruptions around the 133% FPL income level.

However, this might have the effect of simply moving the churning point further up the income scale. A study published in the New England Journal of Medicine, using the same data source as Sommers and Rosenbaum but a different methodology, found that the frequency of churning would be similar at a threshold of 200% FPL.[14] In other words, in a state with a Basic Health Program that is integrated with its Medicaid program, these authors estimate a similar degree of movement between the SBHP and a subsidized Exchange coverage as there would be between Medicaid and the Exchange in a state without a SBHP.

The policy decision facing a state, then, regarding the question of churning and a SBHP, is not at what level churning would be minimized, but whether the effects of the churning would be more of a concern at the lower income level.

Affordability: Though adults entering the Exchange at 200% FPL would be responsible to pay more of their incomes for premiums and cost sharing than those entering the exchange at 133% FPL (see Section 1), people with lower incomes tend to be more sensitive to price and have less disposable income than those with higher incomes. Studies done in the early years of Washington's Basic Health program found that increases in premiums of just $10 or $15 per month significantly reduced the likelihood of enrollment among the eligible population (who were in the same income range as the current SBHP option).

Better benefits: The benefits in a Medicaid or Medicaid-like program are often superior to those in a private insurance plan, particularly in some areas that disproportionately affect lower income populations, such as behavioral health care.

Continuity of care: Allowing adults to remain enrolled in Medicaid, or in a public program that mimics Medicaid in important respects, improves access to and continuity of care not only for those adults but for their children as well. Many studies have documented the benefits that accrue to children of having their parents enrolled in coverage from the same source, with the same network of providers, using the same eligibility redetermination and other administrative processes.[15]

[14] John A. Graves, Rick Curtis and Jonathan Gruber. "Balancing Coverage Affordability and Continuity under a Basic Health Program Option." *N Engl J Med* 2011; 365:e44, December 15, 2011.

[15] These studies are reviewed in Leighton Ku and Matthew Broaddus, "Coverage of Parents Helps Children Too." Center on Budget and Policy Priorities, October 2006.

3. **Tax Liability**

The ACA allows premium tax credits to be advanced to eligible recipients to ease the purchase of coverage through the Exchange. The advance credits are based on the prior year's income (as reported on that year's tax return) or on current income if it can be verified by pay stubs.

The actual amount of the tax credit is calculated on taxable income for the current year, as reported on an individual's tax return. There is a reconciliation process when a recipient of the advanced credits files a return. If the advanced credits exceed the credit for which the recipient is ultimately eligible, the individual must repay the overpayment, at least in part. The repayment amount is capped in 2014 at $300 for an individual with income up to 200% of FPL, $750 for incomes between 200% and 300% FPL, and $1,250 for incomes between 300% and 400% FPL. These maximum amounts are double for family rather than individual filers, and will be indexed for inflation. There is no cap if taxable income for the year exceeds 400% FPL.[16] Though the caps may mean that the entire overpayment may not need to be repaid, the reconciliation might still cause a reduction in an expected tax refund, or an outright tax liability, for people who may not have much discretionary income.

A Kaiser Family Foundation study estimated that 6 percent of adults with 2004 income between 138% and 200% FPL saw their income increase beyond the subsidy range in 2006 – that is, to over 400% FPL.[17] Had the ACA been in effect in this period, these people would have been subject to full recoupment of the tax subsidies, likely totaling thousands of dollars. Other tax credit recipients whose income increased to a lower level might also need to repay some of the subsidies, subject to the caps.

Two examples from the Kaiser study illustrate the risks of the reconciliation process:

> A family with a working spouse making $35,000 begins the year receiving coverage within an Exchange. Midway through the year, the second spouse begins a job making $60,000 annually (or $30,000 over the remainder of the year) that also provides employer-sponsored coverage for the family. The family leaves the Exchange at the end of June and stops receiving advanced payments. The family received $5,371 in advance payments for the six months they were enrolled in coverage in the Exchange, based on their $35,000 annual income during that time. However, with the second job, the family's actual annual income is $65,000, which qualifies them for a tax credit of only $3,190 for the six months. The family received excess advanced payments of $2,182, but the repayment would be limited to $1,500 with the current caps in place. A moderate income family such as this may not have the resources to pay this unexpected cost.
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> Another family with two working spouses makes $90,000 per year. Because the head of this family is older (55 years old), the family faces a premium of nearly $20,000 per year in the Exchange. With advance payment subsidies of $933 per month, the family pays $713 a month toward the premium. At the end of December, one spouse receives a $5,000 bonus. This bonus pushes the family's annual income above 400% of the poverty level and above the eligibility threshold for the subsidies. During the reconciliation process, the family is determined to have received $11,200 in excess payments (the full amount of the subsidies

[16] The ACA as passed set lower caps for reconciliation. The caps have been increased twice to reach the current levels, as offsets to revenue losses resulting from the passage of other laws in 2010 and 2011. An earlier version of the repayment schedule capped repayment amounts up to 500% of FPL.

[17] Kaiser Family Foundation, "Focus on Health Reform: Reconciliation of Advance Payments for Health Insurance Subsidies." February 2011.

> received)… [T]he family would have to pay back the full $11,200. Even for a family with greater means, having to repay sums of this magnitude would be financially burdensome.[18]

To minimize the risk of owing repayment of overpaid tax credits, newly issued Exchange regulations require that recipients of tax credits report any changes in eligibility within 30 days, and encourage Exchanges to send periodic electronic reminders of this obligation to report. Exchanges will also re-determine eligibility annually. Still, the prospect of repayment of advance credits could deter participation in the Exchange, reducing the number of low income people with coverage relative to a SBHP.

With a SBHP, this risk of tax reconciliation will not be present for people in the 138-200% FPL income range, because they would not receive individual subsidies. Rather, the state will receive 95 percent of the aggregate tax credits and cost sharing subsidies this population would have received, calculated using a method yet to be determined. A process for the year-end reconciliation of this aggregate amount between the state and federal governments has also not yet been spelled out.

4. **Likely effects of a SBHP**

On health care providers

The state of Connecticut could design a SBHP so that health care providers receive approximately the same total revenues that they would receive if the potential SBHP population were enrolled in the Exchange instead.

If low income individuals purchase insurance through the Exchange, providers would be paid for their care at private insurance rates, which are generally much higher than Medicaid rates. However, these individuals will be responsible for up to 13% of the cost of their care out-of-pocket; it will very difficult for providers to collect such large amounts from this low-income population. Some of these individuals will go without needed care because of the cost.

Moreover, because the out-of-pocket cost requirements are higher in the Exchange, fewer low income individuals are likely to enroll. Mercer estimates that 50% of potential SBHP individuals (approximately 37,000) are likely to enroll in an Exchange, but 70% of these individuals (approximately 51,000) are likely to enroll in a SBHP.[19] The potential SBHP individuals who remain uninsured will likely continue to receive charity care from health care providers or their accounts may result in bad debt.

For these reasons, the total revenues that providers receive under an Exchange scenario probably would be only slightly higher than the revenues they would receive from a SBHP. The state could make up the difference by using surplus funds generated by a SBHP to enhance provider rates paid under a SBHP.

[18] Ibid.

[19] Mercer Government Human Services Consulting. Health Insurance Exchange Planning Report for the State of Connecticut, January 19, 2012, p.30.

On the Exchange
Mercer's analysis concluded that "the risk of enrolling the population up to 200% FPL would be better under a [S]BHP at lower member premium levels, than the risk of the same population subgroup that would likely enroll under an Exchange at higher member premium levels."[20] That is, the SBHP eligible population is likely to be higher risk (i.e. they have greater health care needs) than the population over 200% FPL enrolled in the Exchange. Thus, the risk in the Exchange likely will be *lower* if the 138-200% FPL population were separately covered in a SBHP.

Mercer also estimated the assessment that the Exchange would need to charge on premiums in order to cover the Exchange's operating costs. Mercer estimated that the Exchange would need to charge a 3.0% assessment if only individuals over 200% FPL enrolled in the exchange, but it could lower its assessment to 2.8% if the SBHP eligible population were included in the Exchange. [21] In effect, including this population in the Exchange would require these very low income individuals to subsidize Exchange costs for all of the higher income individuals enrolled in the Exchange.

5. Why should a decision about a SBHP be made now?

The Exchange and Exchange plans will make a number of decisions based on whether the population 138-200% FPL is included in the Exchange.

First, the Exchange staffing, budget, and administrative assessments will likely be based at least in part on the number of expected enrollees.

Second, individuals with incomes 138-200% FPL may differ from higher income populations enrolled in the Exchange in terms of their:

- Health status,
- Geographic location,
- Level of education,
- Expertise in using the health care system, and
- Primary spoken language.

The Exchange will need to target a number of services differently to ensure that the Exchange and participating health plans best meet the needs of this population. These Exchange services may include:

- The system for rating health plans and the quality measures chosen to ensure plans provide appropriate support services for this population;

[20] Ibid.
[21] Ibid

- Outreach efforts to encourage eligible individuals to enroll using trusted intermediaries in the geographic areas where they live;
- Educational and marketing materials that in multiple languages that do not require high literacy levels;
- Call center that supports a higher volume of calls and multiple languages;
- Billing and collections services that require more communication and produce lower returns.

The insurers that anticipate offering health plans through the Exchange will also make different decisions depending on whether the 138-200% FPL population is included in the Exchange. Health plans calculate premiums based on a number of factors including the expected number of enrollees, geographic area, age, family status, and health status; all of these factors will vary depending on whether low-income individuals are enrolled in a SBHP or in the Exchange. If this population is included in the Exchange, health plans will also need to develop or expand certain targeted services, such as care coordination and clinical care management. And like the Exchange, health plans will need to ensure that written materials are available in multiple languages and do not require high literacy levels and that call centers can support a higher volume of calls and multiple languages.

Others have advocated for first enrolling this low income population in the Exchange and then, sometime in the future, creating a SBHP. This approach will require the following efforts.

- The Legislature will need to pass a new law.
- The Exchange will need to re-calculate the assessment it charges (likely to increase this assessment).
- Insurers will need to re-price the plans they offer through the Exchange.
- Both insurers and the Exchange will need to re-work their operations.
- The Exchange Board may need to re-rate the health plans offered by the Exchange.

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