

Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States

Stan Dorn
Matthew Buettgens
Caitlin Carroll

The Urban Institute
Health Policy Center
2100 M St. NW
Washington, DC 20037

September 2011

Prepared for:



Executive Summary

Using the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM), we estimate both national and state-specific effects of one approach to implementing the Basic Health Program (BHP) option created by the Patient Protection and Affordable Care Act (ACA). We find that implementing BHP to provide Medicaid-like coverage, modified to add cost-sharing typical of the Children’s Health Insurance Program (CHIP), would have the following effects:

- It would make coverage substantially more affordable for consumers, increasing the savings they would otherwise experience from ACA’s subsidies. Adults with incomes between 138 and 200 percent of the federal poverty level (FPL) would see their average annual premium payments drop from \$1,218 to \$100. Out-of-pocket costs would decline from \$434 to \$96 a year. BHP would thus reduce annual health care costs for low-income adults by an average of \$1,456. To place that result in context, single adults affected by these changes earn between \$1,252 and \$1,815 a month in pre-tax income.
- If every state implemented BHP along the lines we model—
 - An estimated 5.1 million people, or 1.9 percent of nonelderly residents, would enroll; and
 - The number of uninsured under the ACA would decline by 600,000 because of lower premium charges under BHP. Increases in coverage would be statistically significant in 34 out of 50 states.
- Mainly because provider payments are higher in private insurance than in Medicaid, federal BHP funding would exceed by an average of 23 percent the baseline cost of providing BHP adults with Medicaid-like coverage. Since all federal BHP funds must be spent on BHP consumers, this excess cannot be “pocketed” by states. However, it could be used to raise capitated payments or provider payment rates above baseline Medicaid amounts.

Despite such an increase, provider payments, hence the breadth of provider networks, would remain below private levels in most states. Policymakers focused on consumer interests thus face the following key question: For this particular low-income population, will access to coverage and care be affected more by higher costs in the exchange or smaller provider networks in BHP?

- Implementing BHP would reduce the size of health insurance exchanges. Nevertheless, exchanges would be large enough to remain stable and to recruit insurers on favorable terms. With BHP, exchange individual markets would cover 5.1 rather than 6.5 percent of nonelderly residents. Taking into account both individual and small group markets, BHP implementation would reduce the share of nonelderly residents covered through exchanges from 9.8 to 8.2 percent in the average state.
- States could save \$1.3 billion a year by shifting certain adults—namely, those with incomes above 138 percent FPL who now qualify for Medicaid under Social Security Act Sections 1115 and 1931—from Medicaid into BHP. Of course, states could achieve the same savings by moving these beneficiaries into the exchange rather than BHP, but that would greatly increase beneficiaries’ health care costs without yielding any additional state savings.

- BHP-eligible consumers enrolling in the exchange would incur health care costs that, on average, are 79 percent of the level for all individual market participants under the ACA. In most states, BHP implementation could thus increase the average cost of individual market coverage. However, such a result could be ameliorated by state policy choices and may not apply in states that eliminate Medicaid coverage of certain high-cost, near-poor adults. Further, because of the ACA’s insurance market reforms and premium subsidy structure, higher individual market premiums would neither trigger a “death spiral” nor significantly raise costs for low- and moderate-income consumers.

The precise results vary by state. Further, state policy choices could yield outcomes that differ from our estimates. For example, if an exchange includes plans with very low premiums—because the exchange is a tough negotiator or several exchange plans pay Medicaid rates to providers—federal tax credit amounts, hence federal BHP payments, would decline below the levels estimated here. Similarly, if a state lets insurers charge different premiums for smokers and non-smokers in the individual market, federal BHP payments would drop, since tax credits in such a state are based on the lower premiums charged to non-smokers.

Our modeling did not investigate several important topics, including the following:

- BHP’s potential reduction in the number of low-income adults who move between Medicaid and the exchange, which could lower state administrative costs and improve continuity of coverage and care;
- The additional increase in coverage that would result from BHP eliminating the risk that, by claiming subsidies, low-income adults could wind up owing money to the Internal Revenue Service; and
- Savings states could achieve by moving from Medicaid to BHP adults who now receive Medicaid in eligibility categories outside Social Security Act Sections 1115 and 1931.

Based on all of these factors, many states could seriously consider implementing BHP to build on current Medicaid and CHIP programs and substantially lower health care costs for low-income consumers while achieving state budget savings.

Contents

Introduction..... 1

ACA’s Provisions for the Basic Health Program 1

 Who qualifies for BHP?..... 1

 What do BHP consumers receive?..... 2

 Financing..... 2

The Approach to BHP That We Model 3

Results..... 4

 Costs for low-income consumers..... 4

 Coverage effects..... 6

 Federal BHP funding compared to state BHP costs 9

 State savings in shifting adults from Medicaid to BHP 11

 Effect of BHP implementation on exchange size 12

 Risk level of BHP enrollees 15

Discussion..... 17

 Comparing our findings to prior research..... 17

 State policy choices..... 17

Conclusion 22

Appendix 1: Methodology 23

Appendix 2: BHP implementation and exchange risk level 25

Appendix 3: Federal policy decisions..... 26

About the Authors and Acknowledgements 29

About the Urban Institute..... 29

About the Association for Community Affiliated Plans..... 29

Endnotes..... 30

Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States

Introduction

In increasing numbers, state officials throughout the country are considering the Basic Health Program (BHP) option created by Section 1331 of the Patient Protection and Affordable Care Act (ACA). This report provides national and state-level estimates of the cost and coverage effects of implementing BHP to build on existing state programs and provide low-income households with coverage more affordable than subsidized insurance in health benefits exchanges under the ACA.

We begin by summarizing the ACA's rules for BHP. We then explain the policy approach to BHP that we model; set out our estimates for state-specific and national effects of implementing BHP to provide low-income adults with coverage based on Medicaid and the Children's Health Insurance Program (CHIP); and analyze state policy implications of our findings. In appendices to this report, we describe our methodology for estimating cost and coverage effects, using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM); analyze issues related to exchange risk levels; and explore federal policy choices about BHP.

ACA's Provisions for the Basic Health Program

ACA Section 1331 gives states the option to create a BHP, as explained elsewhere in detail.¹ For purposes of this report, we limit ourselves to describing key features of the federal law.

Who qualifies for BHP?

To qualify for BHP, a consumer must have the following characteristics:

- Income at or below 200 percent of the federal poverty level (FPL);
- Ineligibility for Medicaid, Medicare, and CHIP;²
- Citizenship or lawful presence in the United States; and
- No access to employer-sponsored insurance (ESI) that meets the ACA's minimum standards for affordability and comprehensiveness.

Put simply, the ACA qualifies two groups of people for BHP in 2014:

- Low-income adults with incomes between 138³ and 200 percent FPL; and
- Lawfully present immigrants whose incomes are at or below 138 percent FPL but whose immigration status makes them ineligible for Medicaid. This group includes, for example, immigrants who have been lawfully present in the United States for less than five years; and

citizens of Micronesia, Palau, and the Marshall Islands, who are authorized to live and work in the United States under the Compact of Free Association.⁴

If Congress does not extend CHIP funding beyond 2015,⁵ a third group could receive BHP—children who now qualify for coverage under separate CHIP programs. Without BHP, those children would likely be subject to the same subsidy rules that apply in the exchange to adults at comparable income levels.⁶ Such a result would likely increase children’s premium and out-of-pocket costs well above CHIP levels.⁷

Numerous children could also qualify for BHP if Congress drops maintenance-of-effort requirements, as some have proposed. Such a change would let states end Medicaid and CHIP for children with incomes above 138 percent FPL in 2014, when federal subsidies become available, shifting children to either the exchange or BHP.⁸

To be clear, there are limits on BHP’s capacity to substitute for current Medicaid and CHIP coverage for children. BHP cannot serve children whose family income exceeds 200 percent FPL. In addition, BHP cannot cover children who have an ESI offer that is deemed affordable under the ACA.⁹ Without Medicaid or CHIP, children with access to such ESI will be barred from subsidized coverage, in both the exchange and BHP.

What do BHP consumers receive?

BHP consumers cannot join the exchange’s individual market. Instead, they enroll in health plans or with providers that contract with the state. Such BHP contracts must ensure that consumers pay no more in premiums than they would have been charged in the exchange; that out-of-pocket cost-sharing does not exceed specified levels; and that consumers receive all essential benefits required under the ACA.

These federal requirements define a floor, not a ceiling. Nothing prevents states from furnishing more generous coverage, such as that offered today by Medicaid and CHIP, to the extent it can be financed with federal BHP dollars.¹⁰

Because they do not receive health insurance tax credits, BHP consumers are not subject to end-of-year tax “reconciliation” procedures. Under such procedures, if health insurance tax credits advanced to insurers during the year turn out to be too high or too low, based on income reported on annual tax returns, consumers either receive additional refunds or owe money to the Internal Revenue Service (IRS). In the latter case, required payments to the IRS are capped at amounts that vary based on income. For example, taxpayers with year-end income at or below 200 percent FPL can be required to repay a maximum amount of \$300 for individual filers and \$600 for joint filers.

While reconciliation procedures do not apply to BHP consumers (unless a state chooses to recreate them in its BHP program), they affect federal funding levels. As explained in the next section, federal BHP payments are based on the subsidies that BHP consumers would have received in the exchange’s individual market—an amount that is affected by IRS reconciliation rules, among other factors.

Financing

To finance BHP contracts, states receive annual grants from the federal government. These grants equal 95 percent of what the federal government would have spent on health insurance tax credits for BHP consumers had they received coverage in the exchange, plus (depending on how

the U.S. Department of Health and Human Services [HHS] interprets the statute) either 100 percent or 95 percent of out-of-pocket cost-sharing subsidies that BHP consumers would have received in the exchange.

A state implementing BHP must place its federal BHP grant in a trust fund. These dollars must be used for BHP consumers' health coverage and may not be diverted to any other purpose.

Annual federal BHP grants are paid before the start of the year, based on estimates for the implementing state. After the year, federal officials determine whether the estimated payment was erroneous. Corrections are made by adjusting the next year's grant.

The Approach to BHP That We Model

BHP offers states enormous flexibility. Broadly speaking, BHP is nothing more than a funding mechanism for states that want to take their own approach to insuring low-income adults, so long as such approaches do not increase consumers' costs or reduce their benefits, compared to subsidized coverage in the exchange. Because BHP permits such an extensive range of state policies, it makes no sense to ask, "What would be the effect of implementing BHP in our state?" One can, however, estimate the effects of implementing BHP *in a particular way*.

In this paper, we use HIPSM to analyze the effects of implementing BHP through state policies along the following lines:

- As required by the ACA, Medicaid covers citizens and qualified immigrants with incomes at or below 138 percent FPL.¹¹
- For lawfully present immigrants who have incomes at or below 138 percent FPL but who are not "qualified aliens" for whom federal Medicaid funds are available, BHP pays for Medicaid-level benefits and cost-sharing protections.¹²
- For adults with incomes between 138 and 200 percent FPL, BHP pays for a scaled-back version of Medicaid benefits, reflecting such adults' slightly higher incomes, as follows:
 - Standard Medicaid health plans and adult benefits apply.¹³
 - Out-of-pocket cost-sharing amounts are comparable to those charged by a typical CHIP program—that is, coverage has a 98 percent actuarial value.¹⁴
 - Premium payments are like those charged in many separate CHIP programs—that is, \$50 a year for children and \$100 for adults.¹⁵
- States that now have separate individual and small group markets do not merge such markets.
- Insurance premiums in the exchange reflect estimated health care costs, plus a 15 percent administrative load. As a result, premiums are much like those charged in current insurance markets. We do not assume that either tough bargaining by the exchange, the participation of plans that pay Medicaid provider rates, or health care delivery reforms have a significant effect on lowering premiums in the exchange.
- Premiums in the individual market vary based on age, at a 3:1 ratio, and geography. They do not vary based on tobacco use.

- Federal BHP payments equal 95 percent of the premium tax credits plus 95 percent of the cost-sharing subsidies that enrollees would have received in the exchange if BHP had not been implemented.¹⁶

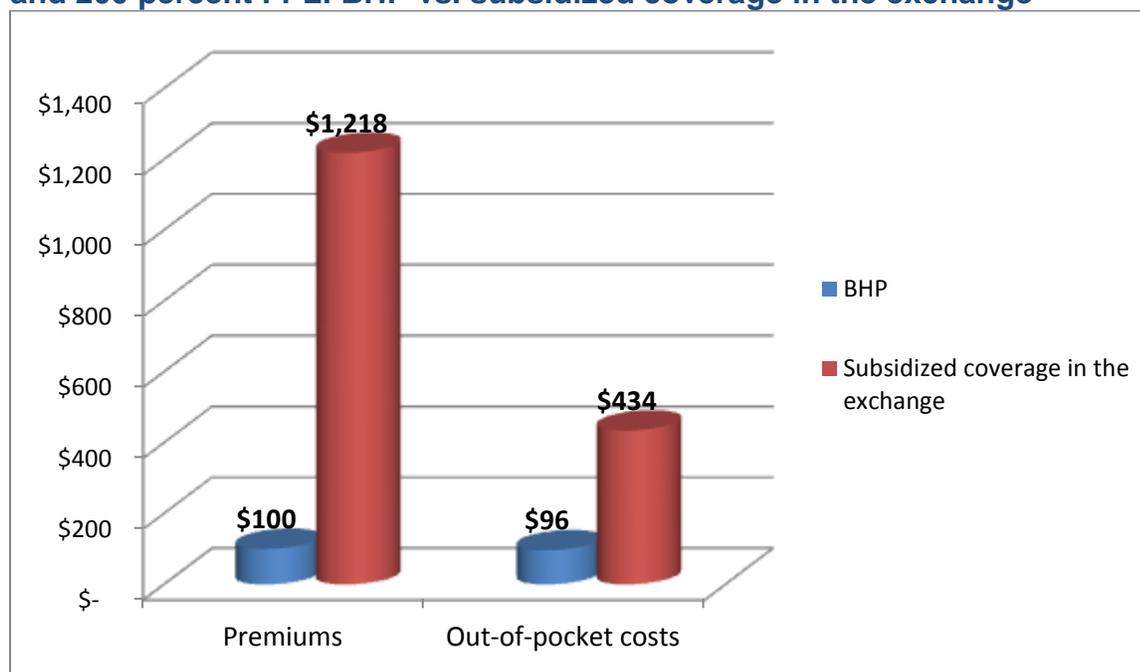
Results

Appendix 1 describes our modeling methodology. This section of the report explains our results.

Costs for low-income consumers

For adults with incomes between 138 and 200 percent FPL—\$1,252 and \$1,815 a month, respectively, for a single adult in 2011—using BHP to provide coverage modeled on Medicaid and CHIP would substantially reduce premiums and out-of-pocket costs. Nationally, such an approach would, on average, cut annual premiums from \$1,218 to \$100. Out-of-pocket costs would drop from \$434 a year to \$96 (Figure 1). BHP would thus lower annual health care costs by an average of \$1,456—approximately a month of pre-tax income for single adults in this income range. These effects do not vary substantially by state (Table 1).

Figure 1. Average annual costs for adults nationally with incomes between 138 and 200 percent FPL: BHP vs. subsidized coverage in the exchange



Source: HIPSM 2011. *Note:* Results show effects as if policies were fully implemented in 2011.

To be sure, costs will be much lower for low-income recipients of subsidized coverage in the exchange than for participants in today’s unsubsidized individual market. According to a Kaiser survey, for example, single-adult policies in the 2010 individual market averaged \$3,606 a year in premiums and \$924 in out-of-pocket costs.¹⁷ But implementing BHP to provide low-income adults with coverage like that furnished by Medicaid and CHIP would further reduce their health care costs substantially.

Table 1. Average annual costs for adults with incomes between 138 and 200 percent FPL: BHP vs. subsidized coverage in the exchange, by state

	Non-Group Exchange		BHP		Difference	
	Premium Costs	Out-of-Pocket Costs	Premium Costs	Out-of-Pocket Costs	Premium Costs	Out-of-Pocket Costs
New England:	1,123	552	100	95	1,023	458
Connecticut	1,078	477	100	88	978	389
Maine	1,030	598	100	88	930	510
Massachusetts	1,244	620	100	85	1,144	536
New Hampshire	1,042	337	100	99	942	238
Rhode Island	1,156	685	100	102	1,056	583
Vermont	997	519	100	90	897	429
Middle Atlantic:	1,148	419	100	96	1,048	323
Delaware	1,270	385	100	95	1,170	290
District of Columbia	1,299	433	100	91	1,199	342
Maryland	1,172	531	100	96	1,072	435
New Jersey	1,312	381	100	104	1,212	277
New York	1,060	385	100	88	960	297
Pennsylvania	1,183	456	100	106	1,083	350
East North Central:	1,258	483	100	94	1,158	389
Illinois	1,117	504	100	98	1,017	406
Indiana	1,100	590	100	99	1,000	491
Michigan	1,168	473	100	88	1,068	385
Ohio	1,385	442	100	87	1,285	355
Wisconsin	1,559	457	100	109	1,459	348
West North Central:	1,224	489	100	89	1,124	400
Iowa	1,203	485	100	82	1,103	403
Kansas	1,349	608	100	93	1,249	515
Minnesota	1,173	637	100	91	1,073	546
Missouri	1,115	555	100	91	1,015	270
Nebraska	1,340	512	100	93	1,240	419
North Dakota	1,339	368	100	86	1,239	282
South Dakota	1,534	353	100	89	1,434	264
South Atlantic:	1,231	456	100	97	1,131	359
Florida	1,247	423	100	98	1,147	325
Georgia	1,116	399	100	99	1,016	300
North Carolina	1,152	512	100	95	1,052	417
South Carolina	1,216	476	100	96	1,116	380
Virginia	1,480	519	100	91	1,380	428
West Virginia	1,010	633	100	107	910	526
East South Central:	1,403	396	100	91	1,303	305
Alabama	1,215	401	100	87	1,115	314
Kentucky	1,093	297	100	101	993	196
Mississippi	1,804	491	100	101	1,704	390
Tennessee	1,525	403	100	83	1,425	320
West South Central:	1,185	396	100	101	1,085	295
Arkansas	1,176	441	100	91	1,076	350
Louisiana	1,320	348	100	86	1,220	262
Oklahoma	1,048	498	100	100	948	398
Texas	1,185	384	100	104	1,085	280
Mountain:	1,284	392	100	92	1,184	300
Arizona	1,598	386	100	85	1,498	301
Colorado	1,064	363	100	91	964	272
Idaho	1,483	408	100	90	1,383	318
Montana	1,057	345	100	87	957	258
Nevada	1,056	350	100	92	956	258
New Mexico	1,063	461	100	103	963	358
Utah	1,351	454	100	107	1,251	347
Wyoming	1,340	413	100	102	1,240	311
Pacific:	1,178	411	100	98	1,078	313
Alaska	1,214	376	100	88	1,114	288
California	1,165	400	100	97	1,065	303
Hawaii	1,254	639	100	95	1,154	544
Oregon	1,181	548	100	112	1,081	436
Washington	1,261	381	100	103	1,161	278
Total	1,218	434	100	96	1,118	338

Source: HIPSM 2011. Note: Results show effects as if policies were fully implemented in 2011.

Coverage effects

BHP enrollment levels

Implemented nationwide, BHP would cover an estimated 5.1 million adults with incomes over 138 percent FPL, or 1.9 percent of all residents under age 65 (Table 2). Approximately 230,000 lawfully present immigrants with incomes below 138 percent FPL would also qualify for BHP (data not shown). Other such immigrants who now receive coverage entirely at state expense could be shifted from that coverage to BHP.

Table 2. Estimated BHP eligibility and enrollment of adults over 138 percent FPL, by state

	Residents under age 65		BHP-eligible adults		Estimated BHP enrollment	
	Number	% of all residents	Number	% of all residents	Number	% of all residents
New England:	12,185,912		231,581	1.9%	145,874	1.2%
Connecticut	3,033,750		56,702	1.9%	38,600	1.3%
Maine	1,111,738		30,929	2.8%	18,909	1.7%
Massachusetts	5,450,049		82,894	1.5%	47,054	0.9%
New Hampshire	1,145,024		23,036	2.0%	14,192	1.2%
Rhode Island	914,734		20,305	2.2%	15,024	1.6%
Vermont	530,618		17,715	3.3%	12,095	2.3%
Middle Atlantic:	41,485,371		976,193	2.4%	695,274	1.7%
Delaware	754,792		16,061	2.1%	11,682	1.5%
District of Columbia	544,820		12,573	2.3%	10,290	1.9%
Maryland	5,070,729		103,816	2.0%	77,069	1.5%
New Jersey	7,683,225		148,962	1.9%	105,742	1.4%
New York	17,080,604		421,954	2.5%	311,425	1.8%
Pennsylvania	10,351,201		272,827	2.6%	179,066	1.7%
East North Central:	40,298,232		1,075,532	2.7%	683,525	1.7%
Illinois	11,438,867		267,878	2.3%	169,723	1.5%
Indiana	5,456,345		137,524	2.5%	89,110	1.6%
Michigan	8,643,398		222,584	2.6%	139,392	1.6%
Ohio	9,936,977		334,454	3.4%	211,048	2.1%
Wisconsin	4,822,644		113,092	2.3%	74,252	1.5%
West North Central:	17,412,100		447,292	2.6%	297,504	1.7%
Iowa	2,612,185		62,176	2.4%	39,958	1.5%
Kansas	2,365,644		55,391	2.3%	40,350	1.7%
Minnesota	4,493,154		104,018	2.3%	73,631	1.6%
Missouri	5,138,696		145,817	2.8%	88,590	1.7%
Nebraska	1,563,748		47,490	3.0%	33,568	2.1%
North Dakota	546,695		14,430	2.6%	9,622	1.8%
South Dakota	691,979		17,970	2.6%	11,785	1.7%
South Atlantic:	44,615,687		1,306,934	2.9%	875,106	2.0%
Florida	15,317,609		480,643	3.1%	341,783	2.2%
Georgia	8,825,320		271,961	3.1%	168,464	1.9%
North Carolina	8,248,250		235,288	2.9%	158,426	1.9%
South Carolina	3,833,421		103,717	2.7%	70,005	1.8%
Virginia	6,908,634		179,842	2.6%	119,937	1.7%
West Virginia	1,482,453		35,483	2.4%	16,491	1.1%
East South Central:	15,653,508		464,133	3.0%	299,078	1.9%
Alabama	4,031,086		125,074	3.1%	67,847	1.7%
Kentucky	3,680,835		92,968	2.5%	68,237	1.9%
Mississippi	2,539,657		90,183	3.6%	51,146	2.0%
Tennessee	5,401,930		155,908	2.9%	111,848	2.1%
West South Central:	32,187,269		1,043,160	3.2%	708,386	2.2%
Arkansas	2,455,038		102,771	4.2%	62,426	2.5%
Louisiana	3,857,986		89,635	2.3%	58,074	1.5%
Oklahoma	3,117,052		96,377	3.1%	60,785	2.0%
Texas	22,757,193		754,377	3.3%	527,101	2.3%
Mountain:	19,789,639		586,519	3.0%	385,455	1.9%
Arizona	5,948,530		164,059	2.8%	107,480	1.8%
Colorado	4,504,678		118,181	2.6%	77,486	1.7%
Idaho	1,338,093		44,978	3.4%	28,931	2.2%
Montana	845,224		30,168	3.6%	18,464	2.2%
Nevada	2,353,754		81,339	3.5%	57,810	2.5%
New Mexico	1,832,765		65,235	3.6%	41,754	2.3%
Utah	2,494,182		63,487	2.5%	40,133	1.6%
Wyoming	472,413		19,072	4.0%	13,397	2.8%
Pacific:	45,135,131		1,376,268	3.0%	964,648	2.1%
Alaska	617,103		21,623	3.5%	13,760	2.2%
California	34,179,491		1,059,531	3.1%	764,063	2.2%
Hawaii	1,098,104		22,334	2.0%	10,182	0.9%
Oregon	3,353,455		109,875	3.3%	72,377	2.2%
Washington	5,886,978		162,905	2.8%	104,266	1.8%
Total	268,762,847		7,507,612	2.8%	5,054,850	1.9%

Source: HIPSIM 2011. Note: Results show effects as if policies were fully implemented in 2011

The number of uninsured

Under the ACA, subsidized coverage in the exchange will make health insurance much more affordable for low-income, uninsured adults than in the past, substantially increasing the number of such adults with coverage. That said, significant evidence suggests that, historically, even modest costs have prevented some low-income adults from enrolling.¹⁸

We thus find that, under the ACA, the number of uninsured would fall by an additional 600,000 if BHP were implemented nationally to provide coverage based on Medicaid and CHIP. In 34 of 50 states, such implementation of BHP would cause a statistically significant increase in the number of insured (Table 3).

These estimates are based on premium payments lower in BHP than the exchange. They do not include the additional increase in coverage that could result from BHP's elimination of year-end tax debts when consumers' annual income turns out to exceed projected amounts.

Table 3. Under the ACA, without and with BHP, the number of uninsured by state, and the percentage they comprise of all residents under age 65

	Without BHP		With BHP		Difference
	N	%	N	%	N
New England:	585,796	4.8%	558,725	4.6%	27,070
Connecticut	197,430	6.5%	191,810	6.3%	5,621
Maine	*	*	*	*	*
Massachusetts	168,351	3.1%	154,607	2.8%	13,744
New Hampshire	62,902	5.5%	61,050	5.3%	1,852
Rhode Island	62,770	6.9%	59,524	6.5%	3,246
Vermont	33,842	6.4%	32,257	6.1%	1,585
Middle Atlantic:	3,544,478	8.5%	3,461,682	8.3%	82,796
Delaware	67,625	9.0%	64,939	8.6%	2,687
District of Columbia	*	*	*	*	*
Maryland	404,611	8.0%	390,387	7.7%	14,224
New Jersey	*	*	*	*	*
New York	1,701,756	10.0%	1,668,051	9.8%	33,705
Pennsylvania	573,742	5.5%	553,575	5.3%	20,167
East North Central:	2,666,041	6.6%	2,569,049	6.4%	96,992
Illinois	837,851	7.3%	806,526	7.1%	31,325
Indiana	*	*	*	*	*
Michigan	671,508	7.8%	652,176	7.5%	19,333
Ohio	588,674	5.9%	561,895	5.7%	26,779
Wisconsin	235,825	4.9%	224,343	4.7%	11,483
West North Central:	1,053,131	6.0%	1,022,689	5.9%	30,442
Iowa	183,578	7.0%	177,948	6.8%	5,630
Kansas	*	*	*	*	*
Minnesota	265,364	5.9%	255,456	5.7%	9,908
Missouri	244,626	4.8%	236,229	4.6%	8,397
Nebraska	100,937	6.5%	97,099	6.2%	3,837
North Dakota	*	*	*	*	*
South Dakota	*	*	*	*	*
South Atlantic:	4,298,425	9.6%	4,217,388	9.5%	81,037
Florida	1,812,259	11.8%	1,777,169	11.6%	35,090
Georgia	912,008	10.3%	889,351	10.1%	22,657
North Carolina	*	*	*	*	*
South Carolina	295,385	7.7%	284,096	7.4%	11,289
Virginia	*	*	*	*	*
West Virginia	*	*	*	*	*
East South Central:	1,132,978	7.2%	1,099,743	7.0%	33,234
Alabama	254,468	6.3%	240,986	6.0%	13,482
Kentucky	*	*	*	*	*
Mississippi	*	*	*	*	*
Tennessee	*	*	*	*	*
West South Central:	3,827,266	11.9%	3,725,847	11.6%	101,419
Arkansas	208,736	8.5%	200,612	8.2%	8,124
Louisiana	306,519	7.9%	286,832	7.4%	19,687
Oklahoma	222,243	7.1%	215,594	6.9%	6,649
Texas	3,089,767	13.6%	3,022,809	13.3%	66,958
Mountain:	2,161,229	10.9%	2,116,774	10.7%	44,456
Arizona	851,822	14.3%	844,489	14.2%	7,332
Colorado	411,593	9.1%	404,976	9.0%	6,617
Idaho	103,901	7.8%	98,829	7.4%	5,072
Montana	75,528	8.9%	73,510	8.7%	2,019
Nevada	271,440	11.5%	263,437	11.2%	8,003
New Mexico	230,856	12.6%	223,429	12.2%	7,427
Utah	180,074	7.2%	173,073	6.9%	7,001
Wyoming	36,015	7.6%	35,031	7.4%	984
Pacific:	5,283,733	11.7%	5,187,899	11.5%	95,834
Alaska	*	*	*	*	*
California	4,332,715	12.7%	4,242,195	12.4%	90,520
Hawaii	*	*	*	*	*
Oregon	*	*	*	*	*
Washington	*	*	*	*	*
Total	24,553,077	9.1%	23,959,797	8.9%	593,281

Source: HIPSM 2011. *Note:* Results show effects as if policies were fully implemented in 2011. Asterisks indicate states where differences in the number of uninsured are not statistically significant at the 5 percent level. Results do not include increased enrollment that might result from no risk of owing tax debts due to BHP participation.

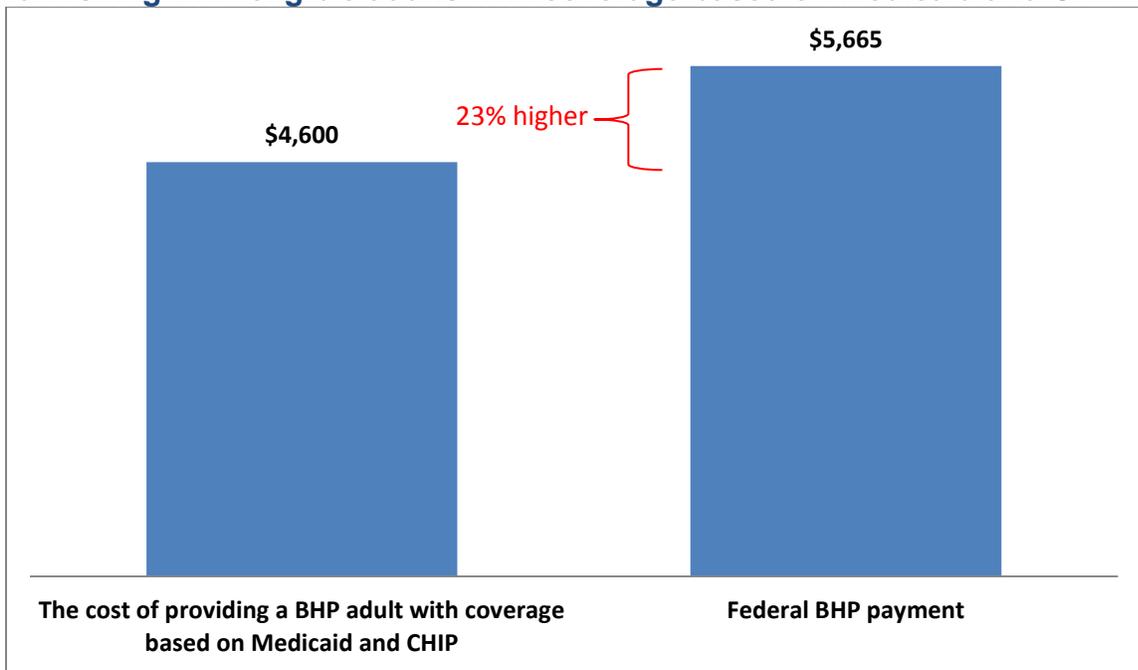
How to read this table: In Connecticut, for example, without BHP, 197,430 people, or 6.5 percent of all residents younger than 65, will be uninsured under the ACA. With BHP, 191,810, or 6.3 percent of all residents under age 65 will lack coverage. Accordingly, BHP would reduce the number of uninsured in Connecticut by 5,621.

Federal BHP funding compared to state BHP costs

Primarily (though not exclusively) because private provider payments exceed Medicaid levels, 95 percent of federal subsidies in the exchange will exceed the cost of providing BHP adults with Medicaid-like coverage (modified as described earlier to include CHIP-level premium payments and out-of-pocket cost-sharing). Nationally, federal BHP payments will average \$5,665, or 23 percent more than the \$4,600 average cost of providing BHP adults with Medicaid/CHIP-type coverage (Figure 2). As explained earlier, we estimate insurance premiums in the exchange based on health care spending, plus a 15 percent administrative load. These numbers vary by state, but in each state where sample sizes permit meaningful results, we find that federal BHP payments will exceed baseline coverage costs (Table 4). As noted earlier, these federal dollars must be used for BHP consumers; states may not pocket them for other uses.

Our results have an important caveat. As explained earlier, our modeling assumes insurance premiums in the exchange much like those in current markets. If premiums are significantly lower because of aggressive bargaining by exchanges, health plans that pay Medicaid rates to providers, or other factors, average federal subsidies in the exchange, hence federal BHP payments, will decline below projected levels. By the same token, if exchange premiums exceed estimates, so will federal BHP funding levels.

Figure 2. National average federal BHP payments compared to the cost of furnishing BHP-eligible adults with coverage based on Medicaid and CHIP



Source: HPSM 2011. *Note:* Results show effects as if policies were fully implemented in 2011. Coverage based on Medicaid and CHIP has a 98 percent actuarial value and \$100 annual adult premiums. Results assume premiums in the exchange much like those in current markets.

Table 4. Average federal BHP payments compared to baseline costs of furnishing BHP-eligible adults with coverage based on Medicaid and CHIP, by state

	Baseline state cost	Federal BHP payment	Difference
New England:	4,531	5,803	28.1%
Connecticut	4,197	5,163	23.0%
Maine	4,199	5,110	21.7%
<i>Massachusetts</i>	4,812	5,766	19.8%
New Hampshire	4,747	5,681	19.7%
<i>Rhode Island</i>	4,889	6,100	24.8%
Vermont	4,334	5,433	25.4%
Middle Atlantic:	4,599	5,535	20.3%
<i>Delaware</i>	*	*	*
<i>District of Columbia</i>	*	*	*
Maryland	4,603	5,765	25.2%
New Jersey	4,973	5,852	17.7%
New York	4,210	5,041	19.7%
Pennsylvania	5,106	6,164	20.7%
East North Central:	4,503	5,726	27.2%
Illinois	4,722	6,126	29.7%
<i>Indiana</i>	*	*	*
Michigan	4,221	5,293	25.4%
Ohio	4,185	5,376	28.5%
Wisconsin	5,233	6,251	19.4%
West North Central:	4,258	5,242	23.1%
Iowa	3,919	4,757	21.4%
<i>Kansas</i>	*	*	*
Minnesota	4,364	5,592	28.1%
<i>Missouri</i>	*	*	*
Nebraska	4,450	5,831	31.0%
<i>North Dakota</i>	*	*	*
<i>South Dakota</i>	*	*	*
South Atlantic:	4,638	5,825	25.6%
Florida	4,696	5,781	23.1%
Georgia	4,762	5,848	22.8%
North Carolina	4,559	5,928	30.0%
South Carolina	4,582	5,945	29.7%
Virginia	4,381	5,670	29.4%
<i>West Virginia</i>	*	*	*
East South Central:	4,335	5,405	24.7%
<i>Alabama</i>	*	*	*
<i>Kentucky</i>	4,869	5,796	19.0%
<i>Mississippi</i>	*	*	*
<i>Tennessee</i>	*	*	*
West South Central:	4,864	5,965	22.6%
Arkansas	4,362	5,453	25.0%
<i>Louisiana</i>	*	*	*
<i>Oklahoma</i>	*	*	*
Texas	5,019	6,163	22.8%
Mountain:	4,426	5,418	22.4%
<i>Arizona</i>	*	*	*
Colorado	4,377	5,259	20.2%
Idaho	4,326	5,277	22.0%
<i>Montana</i>	*	*	*
Nevada	4,400	4,863	10.5%
<i>New Mexico</i>	*	*	*
<i>Utah</i>	*	*	*
Wyoming	4,910	5,767	17.5%
Pacific:	4,720	5,643	19.6%
Alaska	4,196	4,984	18.8%
California	4,647	5,569	19.8%
<i>Hawaii</i>	*	*	*
Oregon	5,383	6,697	24.4%
Washington	4,960	5,525	11.4%
Total	4,600	5,665	23.2%

Source: HIPSM 2011. Note: Results show effects as if policies were fully implemented in 2011. Italicized states have small sample sizes for BHP-eligible adults. For Massachusetts, Rhode Island, and Kentucky, estimates were imputed using demographic and regional characteristics. Coverage based on Medicaid and CHIP has a 98 percent actuarial value and \$100 annual adult premiums. Results assume premiums in the exchange much like those in current markets.

State savings in shifting adults from Medicaid to BHP

A state that uses BHP to fund coverage like Medicaid or CHIP can substitute federal BHP dollars for current state Medicaid spending without significantly increasing costs for Medicaid beneficiaries. Beneficiaries for whom states now pay a portion of health care costs would move into BHP, where all subsidies are financed by the federal government.

We find that states could save \$1.3 billion a year by making this shift for adults who qualify under Social Security Act Sections 1115 and 1931 and have incomes above 138 percent FPL (Table 5). Additional savings could result from shifting other beneficiaries from Medicaid to BHP.¹⁹ Of course, states would save the same amount by moving Medicaid adults into the exchange. But that would raise health care costs for beneficiaries without garnering additional state savings.

Table 5. Annual state savings from eliminating Medicaid coverage under Social Security Act Sections 1115 and 1931 for adults over 138 percent FPL (thousands)

State	Savings
New England:	\$ 291,017
Connecticut	\$ 19,913
Maine	\$ 4,366
Massachusetts	\$ 233,957
New Hampshire	\$ 74
Rhode Island	\$ 8,164
Vermont	\$ 24,542
Middle Atlantic:	\$ 184,973
Delaware	\$ 169
District of Columbia	\$ 9,178
Maryland	\$ 17,809
New Jersey	\$ 138,510
New York	\$ 18,715
Pennsylvania	\$ 593
East North Central:	\$ 196,071
Illinois	\$ 104,026
Wisconsin	\$ 92,045
West North Central:	\$ 133,627
Iowa	\$ 44,598
Minnesota	\$ 89,029
South Atlantic:	\$ 249
North Carolina	\$ 249
East South Central:	\$ -
West South Central:	\$ -
Mountain:	\$ 40,967
Arizona	\$ 27,693
Nevada	\$ 10,164
New Mexico	\$ 2,728
Utah	\$ 382
Pacific:	\$ 462,908
California	\$ 285,926
Hawaii	\$ 3,767
Washington	\$ 173,215
Total	\$ 1,309,812

Source: HIPSM 2011. Note: Results show effects as if policies were fully implemented in 2011. Table shows only: (a) states with projected savings; and (b) state share of Medicaid costs.

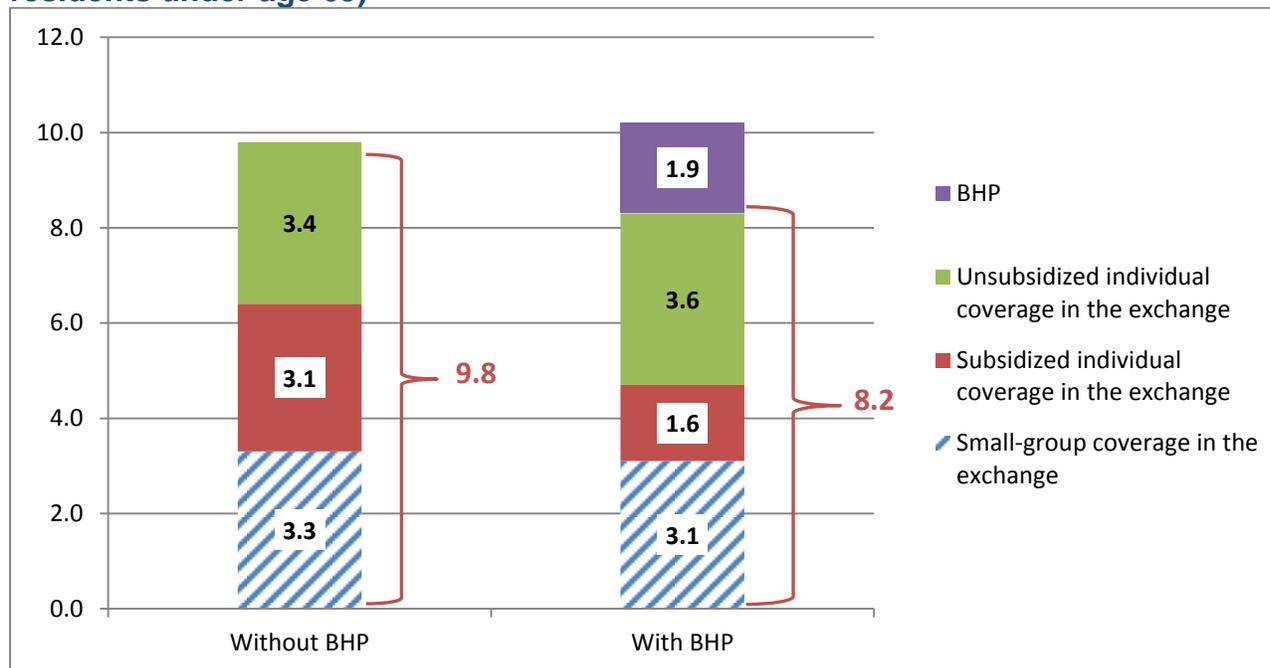
Effect of BHP implementation on exchange size

Many exchange functions will incorporate BHP. For example, all exchanges will process applications that result in BHP enrollment, and exchanges can take on other BHP tasks, such as those involving plan certification and consumer choice. That said, implementing BHP would withdraw subsidy-eligible adults with incomes between 138 and 200 percent FPL from the exchange's individual market.

On average, the proportion of nonelderly residents receiving individual coverage in the exchange would fall from 6.5 to 5.1 percent (Figure 3). Exchange individual markets would thus remain large, even though BHP implementation would significantly reduce the number of tax credit recipients in those markets. Our modeling shows that most unsubsidized participants in the nongroup market, other than those enrolled in so-called “grandfathered” plans that are exempt from some ACA requirements, will obtain coverage through the exchange. The main causes of this high participation level are slightly lower premium costs and greater convenience of enrollment in the exchange. A number of other researchers have reached similar conclusions.²⁰

In terms of the exchange as a whole, including small group as well as individual markets, the proportion of residents covered through the exchange would decline from 9.8 to 8.2 percent (Figure 3), which represents a 16 percent relative decrease. Similar results apply in all states (Tables 6 and 7). Even without BHP consumers, exchanges would clearly be large enough to remain stable and to attract insurers on favorable terms.²¹

Figure 3. BHP implementation and exchange size under the ACA (percentage of residents under age 65)



Source: HIPSM 2011. Note: Results show effects as if policies were fully implemented in 2011. Some totals do not add because of rounding.

Table 6. Percentage of nonelderly residents in exchange small group and individual markets, without and with BHP, by state

	Exchange Membership without BHP			Exchange Membership with BHP		
	Small Group Market	Individual Market	Total	Small Group Market	Individual Market	Total
New England:	3.5%	5.1%	8.5%	3.1%	4.4%	7.5%
Connecticut	3.7%	5.9%	9.6%	3.1%	5.3%	8.4%
Maine	3.3%	6.7%	10.0%	3.1%	5.8%	9.0%
Massachusetts	3.2%	3.6%	6.9%	2.9%	3.2%	6.0%
New Hampshire	4.4%	6.0%	10.5%	4.1%	5.2%	9.3%
Rhode Island	3.1%	6.8%	9.8%	3.0%	5.5%	8.5%
Vermont	3.6%	6.8%	10.3%	3.7%	5.3%	9.0%
Middle Atlantic:	3.6%	5.8%	9.4%	3.2%	4.7%	7.8%
Delaware	3.1%	5.4%	8.5%	3.1%	4.4%	7.4%
District of Columbia	3.3%	6.9%	10.2%	2.7%	5.6%	8.3%
Maryland	4.0%	5.9%	10.0%	3.2%	5.2%	8.4%
New Jersey	3.4%	5.2%	8.7%	3.4%	4.5%	7.9%
New York	3.4%	5.6%	8.9%	2.7%	4.2%	6.9%
Pennsylvania	4.1%	6.5%	10.5%	3.7%	5.4%	9.1%
East North Central:	3.8%	5.6%	9.4%	3.7%	4.3%	8.0%
Illinois	4.1%	5.1%	9.2%	4.0%	4.1%	8.1%
Indiana	3.5%	4.6%	8.1%	3.1%	3.3%	6.3%
Michigan	3.9%	6.0%	9.9%	3.8%	4.7%	8.5%
Ohio	3.6%	6.1%	9.7%	3.4%	4.4%	7.9%
Wisconsin	4.1%	5.9%	10.0%	3.7%	5.0%	8.7%
West North Central:	3.9%	6.6%	10.5%	3.7%	5.3%	9.0%
Iowa	3.7%	6.5%	10.2%	3.4%	5.2%	8.7%
Kansas	3.9%	6.5%	10.4%	3.4%	5.1%	8.5%
Minnesota	4.0%	5.8%	9.8%	3.8%	4.7%	8.5%
Missouri	4.0%	6.4%	10.4%	3.9%	5.0%	8.9%
Nebraska	3.5%	8.3%	11.7%	3.1%	7.0%	10.1%
North Dakota	4.3%	9.2%	13.6%	4.7%	8.1%	12.8%
South Dakota	3.8%	8.0%	11.7%	3.1%	6.8%	9.9%
South Atlantic:	3.0%	6.7%	9.6%	2.8%	5.2%	8.0%
Florida	2.5%	8.3%	10.8%	2.4%	6.8%	9.2%
Georgia	3.4%	5.4%	8.9%	2.9%	4.0%	7.0%
North Carolina	2.8%	6.1%	8.9%	2.5%	4.5%	7.0%
South Carolina	3.0%	6.1%	9.1%	3.1%	4.7%	7.8%
Virginia	3.5%	6.1%	9.5%	3.6%	4.9%	8.5%
West Virginia	2.9%	4.6%	7.5%	2.8%	4.1%	6.8%
East South Central:	3.2%	5.9%	9.1%	3.0%	4.6%	7.6%
Alabama	3.1%	4.7%	7.8%	2.5%	3.6%	6.1%
Kentucky	3.3%	6.5%	9.8%	3.2%	5.1%	8.3%
Mississippi	2.8%	6.3%	9.1%	3.0%	4.8%	7.9%
Tennessee	3.4%	6.3%	9.7%	3.1%	5.0%	8.1%
West South Central:	2.8%	7.0%	9.7%	2.6%	5.3%	7.9%
Arkansas	2.5%	6.4%	9.0%	2.7%	4.4%	7.1%
Louisiana	3.0%	5.8%	8.8%	2.5%	5.1%	7.6%
Oklahoma	3.0%	6.7%	9.7%	3.1%	5.4%	8.5%
Texas	2.7%	7.3%	10.0%	2.5%	5.5%	8.0%
Mountain:	2.8%	7.5%	10.3%	2.7%	6.0%	8.7%
Arizona	2.2%	6.4%	8.7%	2.2%	4.9%	7.2%
Colorado	2.8%	8.3%	11.1%	2.6%	7.1%	9.7%
Idaho	3.0%	9.9%	12.9%	2.7%	8.0%	10.7%
Montana	3.6%	8.0%	11.7%	3.6%	6.4%	10.0%
Nevada	2.4%	6.6%	8.9%	2.2%	4.7%	6.9%
New Mexico	2.7%	7.6%	10.3%	2.4%	6.1%	8.6%
Utah	3.9%	7.9%	11.8%	4.3%	6.7%	11.0%
Wyoming	2.8%	9.4%	12.2%	3.1%	6.8%	9.9%
Pacific:	3.1%	7.4%	10.5%	3.2%	5.9%	9.0%
Alaska	2.8%	7.7%	10.5%	2.8%	6.2%	9.0%
California	3.0%	7.6%	10.6%	3.0%	6.0%	9.0%
Hawaii	3.8%	3.9%	7.7%	3.8%	3.5%	7.3%
Oregon	4.0%	7.6%	11.6%	4.3%	5.6%	9.8%
Washington	3.0%	7.1%	10.1%	3.6%	5.6%	9.2%
						0.0%
Total	3.3%	6.5%	9.8%	3.1%	5.1%	8.2%

Source: HIPSM 2011. Note: Results show effects as if policies were fully implemented in 2011.

Table 7. Number of nonelderly residents in exchange small group and individual markets, without and with BHP, by state (thousands)

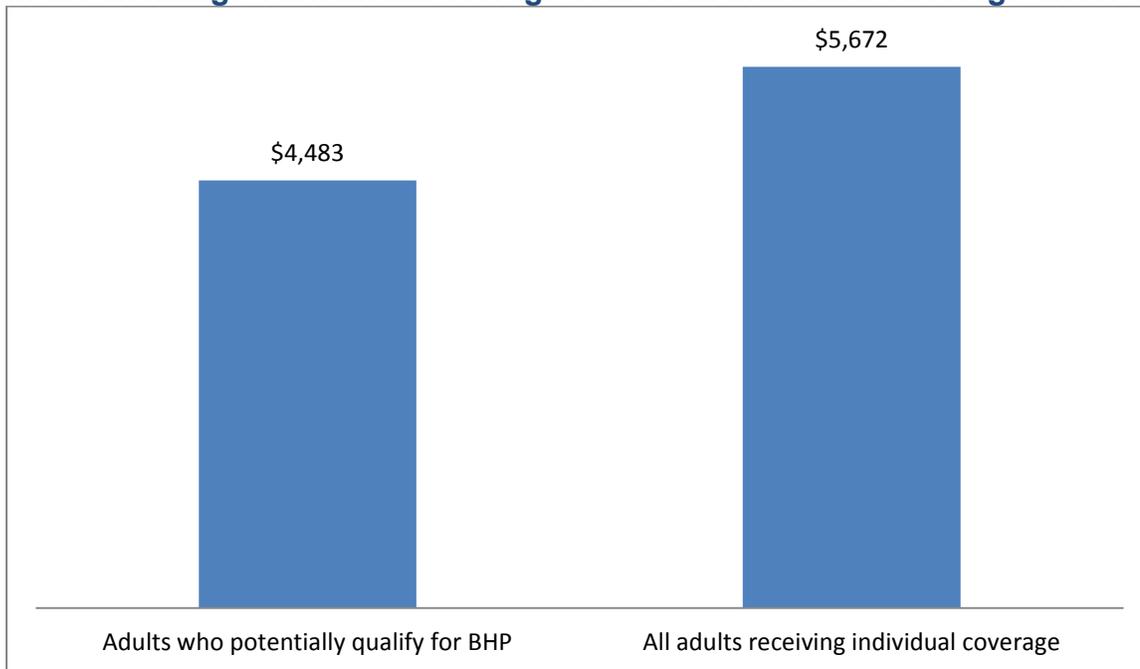
	Exchange Membership without BHP			Exchange Membership with BHP		
	Small Group Market	Individual Market	Total	Small Group Market	Individual Market	Total
New England:	422	618	1,041	378	538	916
Connecticut	111	179	290	94	161	254
Maine	37	74	111	35	65	100
Massachusetts	177	199	375	156	174	329
New Hampshire	51	69	120	47	60	107
Rhode Island	28	62	90	27	50	78
Vermont	19	36	55	20	28	48
Middle Atlantic:	1,504	2,398	3,901	1,308	1,947	3,254
Delaware	23	41	64	23	33	56
District of Columbia	18	38	56	14	31	45
Maryland	204	301	505	162	263	425
New Jersey	264	401	665	262	344	605
New York	574	950	1,524	468	715	1,183
Pennsylvania	420	668	1,088	378	561	939
East North Central:	1,550	2,252	3,802	1,477	1,740	3,218
Illinois	468	584	1,052	460	472	932
Indiana	191	253	444	167	178	346
Michigan	335	521	856	329	405	734
Ohio	361	607	968	342	442	784
Wisconsin	195	286	482	179	243	422
West North Central:	678	1,151	1,828	637	928	1,565
Iowa	95	171	266	90	136	226
Kansas	92	155	247	80	122	201
Minnesota	180	261	441	171	213	384
Missouri	206	329	535	201	256	457
Nebraska	55	129	184	48	110	158
North Dakota	24	51	74	26	44	70
South Dakota	26	55	81	21	47	68
South Atlantic:	1,316	2,979	4,295	1,238	2,341	3,579
Florida	381	1,277	1,658	366	1,037	1,403
Georgia	303	480	783	260	355	615
North Carolina	235	501	735	205	369	574
South Carolina	115	234	349	118	181	299
Virginia	240	418	658	249	338	587
West Virginia	43	69	111	41	61	101
East South Central:	498	931	1,429	463	727	1,190
Alabama	126	189	315	99	147	246
Kentucky	120	239	359	119	188	307
Mississippi	71	160	231	77	123	200
Tennessee	181	343	524	169	269	437
West South Central:	890	2,245	3,135	835	1,719	2,554
Arkansas	62	158	220	66	108	174
Louisiana	115	225	339	98	197	295
Oklahoma	92	209	301	96	168	264
Texas	621	1,654	2,275	576	1,247	1,823
Mountain:	546	1,492	2,038	535	1,197	1,731
Arizona	133	383	516	133	294	427
Colorado	127	372	498	116	319	435
Idaho	40	133	173	36	107	143
Montana	31	68	99	30	54	85
Nevada	55	154	210	52	110	162
New Mexico	50	140	189	45	113	157
Utah	97	198	295	107	168	275
Wyoming	13	44	58	15	32	47
Pacific:	1,413	3,345	4,758	1,426	2,644	4,070
Alaska	17	48	65	18	38	56
California	1,042	2,583	3,625	1,013	2,051	3,065
Hawaii	41	43	85	42	38	80
Oregon	134	254	388	143	187	330
Washington	179	417	595	210	330	540
Total	8,817	17,409	26,226	8,296	13,781	22,077

Source: HIPSM 2011. Note: Results show effects as if policies were fully implemented in 2011.

Risk level of BHP enrollees

Under the policy scenario we model, national health care costs per capita are lower for BHP-eligible adults than for other adults in the individual market, primarily because low-income working adults tend to be younger than other workers. To provide an “apples to apples” comparison, we contrast the cost of BHP adults covered through the exchange’s individual market with the average cost of all private, individual coverage under the ACA. To estimate health care costs, we combine insurers’ claim payments and consumers’ out-of-pocket costs. We find that, nationally, BHP-eligible adults, if covered through the exchange, would incur average health care costs of \$4,483, or 79 percent of the overall individual market average of \$5,672 (Figure 4). State-specific results vary greatly, depending on demographics and the characteristics of group and individual insurance markets (Table 8).

Figure 4. National average cost of potentially BHP-eligible adults receiving individual coverage in the exchange vs. national average cost of all individual coverage under the ACA



Source: HIPSM 2011. *Note:* Results show effects as if policies were fully implemented in 2011 and assume that states retain 2009 Medicaid eligibility for adults above 138 percent FPL except under Social Security Act Sections 1115 and 1931. This figure shows total average health care costs, including both claims covered by insurance and consumers’ out-of-pocket expenses.

This finding has an important caveat. As explained earlier, we model the effects of states shifting into BHP adults who have incomes above 138 percent FPL and who would qualify for current Medicaid coverage offered under Social Security Act Sections 1115 and 1931. We do not model the effects of states also shifting into BHP other Medicaid-eligible adults above 138 percent FPL. These other eligibility categories often comprise such relatively high-cost groups as pregnant women, women with breast or cervical cancer, people with tuberculosis, the medically needy, certain nonelderly people with disabilities, and so forth. If states save money by moving these affected adults out of Medicaid and into federally subsidized coverage, the average risk level of BHP-eligible enrollees would exceed what we show in our results.

Table 8. Average health care costs of potentially BHP-eligible adults receiving individual coverage in the exchange vs. average cost of all individual coverage under the ACA, by state

State	Average BHP costs	Average costs in the individual market	BHP costs as a percentage of average individual costs
New England:	5,776	7,649	75.5%
Connecticut	5,501	8,451	65.1%
Maine	6,610	10,352	63.9%
<i>Massachusetts¹</i>	5,830	6,294	92.6%
<i>New Hampshire</i>	*	*	*
<i>Rhode Island¹</i>	6,468	8,052	80.3%
Vermont	5,368	6,585	81.5%
Middle Atlantic:	3,935	6,831	57.6%
<i>Delaware</i>	*	*	*
<i>District of Columbia</i>	*	*	*
Maryland	6,152	7,381	83.3%
New Jersey	3,702	7,682	48.2%
New York	3,247	7,152	45.4%
Pennsylvania	4,291	5,643	76.0%
East North Central:	5,756	6,202	92.8%
Illinois	6,558	5,963	110.0%
<i>Indiana</i>	*	*	*
Michigan	4,776	4,905	97.4%
Ohio	4,828	7,685	62.8%
Wisconsin	6,611	6,085	108.6%
West North Central:	4,679	6,107	76.6%
Iowa	4,768	4,928	96.8%
<i>Kansas</i>	*	*	*
Minnesota	6,914	7,194	96.1%
<i>Missouri</i>	*	*	*
Nebraska	5,722	7,940	72.1%
<i>North Dakota</i>	*	*	*
<i>South Dakota</i>	*	*	*
South Atlantic:	4,430	5,148	86.1%
Florida	4,476	4,574	97.9%
Georgia	3,107	5,236	59.3%
North Carolina	5,332	6,004	88.8%
South Carolina	3,797	5,098	74.5%
Virginia	4,908	5,515	89.0%
<i>West Virginia</i>	*	*	*
East South Central:	4,963	4,882	101.7%
<i>Alabama</i>	*	*	*
<i>Kentucky¹</i>	5,186	5,606	92.5%
<i>Mississippi</i>	*	*	*
<i>Tennessee</i>	*	*	*
West South Central:	3,973	4,954	80.2%
Arkansas	4,487	4,716	95.1%
<i>Louisiana</i>	*	*	*
<i>Oklahoma</i>	*	*	*
Texas	3,435	4,875	70.5%
Mountain:	3,402	4,339	78.4%
<i>Arizona</i>	*	*	*
Colorado	3,394	4,235	80.1%
Idaho	3,338	3,891	85.8%
<i>Montana</i>	*	*	*
Nevada	2,549	4,035	63.2%
<i>New Mexico</i>	*	*	*
<i>Utah</i>	*	*	*
Wyoming	3,251	4,480	72.6%
Pacific:	4,410	5,600	78.8%
Alaska	4,127	6,467	63.8%
California	4,172	5,065	82.4%
<i>Hawaii</i>	*	*	*
Oregon	5,784	5,425	106.6%
Washington	5,140	8,218	62.5%
Total	4,483	5,672	79.0%

Source: HIPSM 2011. Note: States in italics have small sample sizes for BHP-eligible adults. Results show effects as if policies were fully implemented in 2011 and assume that states retain 2009 Medicaid eligibility for adults above 138 percent FPL except under Social Security Act Sections 1115 and 1931. Health care costs include both claims covered by insurance and consumers' out-of-pocket expenses.

1. Due to small sample size, state estimates are imputed using demographic and regional characteristics.

Discussion

Comparing our findings to prior research

Our estimates address some topics that have not previously been explored. However, when they involve questions for which others have produced quantified answers, our results are largely consistent with theirs. This outcome is particularly striking for actuarial firms, which use very different methods than ours but often reach similar conclusions. Mercer’s analysis of BHP implementation in California, for example, found that federal BHP dollars would exceed baseline Medicaid/CHIP costs by 28 percent, and that BHP implementation would have only a modest effect on exchange size.²² Milliman’s national analysis likewise found that federal BHP payments will exceed by 24 percent the cost of furnishing BHP adults with coverage like Massachusetts’ Commonwealth Care, which involves premiums and out-of-pocket cost-sharing roughly comparable to average CHIP programs.²³ Along similar lines, an analysis by the Community Service Society of New York, Gorman Actuarial, and Manatt Health Solutions found that, if New York were to provide Medicaid-like coverage with a 98 percent actuarial value, federal BHP funds would exceed baseline state costs, the state could achieve significant savings by moving Medicaid beneficiaries into BHP, and the number of uninsured would decline because of lower premium charges.²⁴

In terms of results from other microsimulation models, Jonathan Gruber of MIT estimated the effects of implementing BHP in Connecticut to provide low-income adults with Medicaid-level coverage. With results broadly similar to ours, Gruber found that federal BHP payments would exceed baseline Medicaid costs by at least 7 to 13 percent; that moving adults from Medicaid to BHP could save the state approximately \$50 million a year; and that BHP implementation would reduce the size of the exchange by only 30,000 people.²⁵

To be sure, not all previous studies reach conclusions like ours. Several suggest a larger impact of BHP implementation on exchange size than we find here.²⁶ However, such analyses do not appear to take into account the “ESI firewall,” which disqualifies, from both BHP and subsidies in the exchange, low-income adults who are offered ESI that meets the ACA’s standards of affordability and comprehensiveness. This is not a trivial issue. A surprisingly large proportion of low-income adults have access to ESI. Among workers with incomes between 100 and 199 percent FPL, for example, 65 percent were offered ESI by their employer or a spouse’s employer in 2005, the most recent year for which such results have been published.²⁷

Some of these analyses suggest that BHP adults may have higher costs than other exchange participants, since lower income is associated with greater health care needs, all else equal. However, not all else is equal. In particular, we find that BHP-eligible adults are younger, on average, than other participants in the individual market under the ACA, which lowers BHP adults’ average health care costs. Our results use census data to take into account age, health status, and other factors and estimate health care costs for both BHP adults and others who obtain individual coverage under the ACA.

State policy choices

Our numbers tell the following story:²⁸

1. **Consumer effects.** Low-income consumers would obtain more affordable, secure, and potentially continuous coverage if BHP were implemented to provide coverage like Medicaid

and CHIP. Such a policy would significantly lower premium and out-of-pocket costs for low-income adults. Lowering cost barriers to enrollment would modestly reduce the number of uninsured. A further reduction, which we do not estimate, would result from eliminating the risk of owing money to the IRS at the end of the year if household income turns out to exceed anticipated levels.

Based on other research, implementing BHP to reduce out-of-pocket cost-sharing among low-income households would increase their receipt of necessary care. As has been noted elsewhere,²⁹ continuity of coverage and care could be enhanced if BHP implementation lifted the threshold for moving between Medicaid-like coverage and the exchange from 138 to 200 percent FPL, since both income fluctuations and subsidy eligibility are more common at lower income levels.³⁰ And if safety-net plans do not participate in the exchange, BHP implementation would continue low-income households' access to such plans, even when income rises above 138 percent FPL.

On the other hand, provider networks in most states will likely be more limited with BHP built on Medicaid and CHIP rather than with private insurance offered in the exchange, even if federal BHP funding lets provider payments rise above Medicaid levels.³¹ *From a consumer perspective, perhaps the central question facing policymakers is whether, for this particular population, access is impeded more by higher costs in private insurance or limited provider networks in BHP.*

2. **Costs to Medicaid beneficiaries and to states.** In many states, BHP implementation as discussed here would shield Medicaid adults from significant cost increases that would result from movement into the exchange's individual market. A number of states could prevent such increases while still saving money by shifting adults from Medicaid into BHP.

To be clear, our modeling was limited to one source of state savings—using BHP to cover adults with incomes over 138 percent FPL who now qualify for Medicaid under Section 1115 waivers or Section 1931(b) of the Social Security Act. Depending on the state, other savings may also be possible.³²

3. **Federal funding.** If premiums charged in the exchange resemble those in current private markets, federal BHP payments will exceed the cost of providing BHP adults with Medicaid/CHIP-like coverage. This would let provider payments or capitated payments for BHP consumers exceed standard Medicaid levels. For example, a state could pay a year-end “bonus” to providers and plans for each BHP consumer they serve, basing the exact amount on the final BHP federal funding level for the year. Such a boost might raise provider participation above usual Medicaid levels, but in most states, BHP payments would remain below private-sector amounts for most providers.³³

Year-end reconciliation will further increase federal BHP payments, since each state aggregates the effects of the reconciliation that BHP consumers would have experienced if they had joined the exchange's individual market. If a BHP member experiences an income drop during the year that would have qualified the member for a tax refund in the exchange, the state receives 95 percent of the full refund. But if income rises and the BHP member would have owed money to the IRS, the member's repayment amount would have been strictly capped, based on income. The corresponding reduction in federal BHP payments would thus be 95 percent of the capped amount. If gains and losses are equal within the BHP

population, the state comes out ahead, even as reconciliation does not affect individual BHP members.³⁴

To be clear, state policy choices about the operation of the exchange could have a significant impact on federal BHP payments. Premium subsidies are based on the second-lowest-cost silver-level plan in the exchange. As noted above, if a state's exchange reduces premiums for such a plan far below current private insurance levels, federal BHP allotments would drop. For example, if several plans paying providers at Medicaid or near-Medicaid rates were to enter the exchange, subsidies could be based on a plan with costs similar to the BHP package, and federal BHP payments may not cover costs.³⁵

Moreover, the ACA gives states the option to vary premiums by tobacco use, permitting increases up to 50 percent for smokers. Implementing this option could reduce federal BHP payments below BHP costs. That is because, in a state that allows tobacco rating, federal subsidies in the exchange do not cover tobacco-related premium increases. Instead, such subsidies are based on the non-tobacco-use premium, and the tobacco user must pay the full additional cost. Accordingly, in a state with tobacco-rated premiums, federal BHP payments would be based on a calculation of health care costs that excludes tobacco-related care, but BHP would still need to pay those costs.

By carefully addressing these two policy questions, states can limit the risk of federal BHP payments falling below anticipated levels. But BHP, like any new federal program, involves inherent uncertainties, which state policymakers need to take into account as they decide how to proceed.

4. **Exchange size.** Implementing BHP would reduce exchange size, but exchanges would remain quite large. They would not be destabilized, as the ACA requires plans to share risk across the entire individual market within each state, within and outside the exchange. They would also retain the leverage needed to secure plan participation on favorable terms (although some leverage could potentially shift to states in their role as direct purchasers of coverage).³⁶ However, fixed administrative costs would need to be spread across a smaller group of enrollees, potentially raising per capita charges in a state that funds administrative costs by surcharging users.³⁷
5. **Exchange risk level.** In most states, implementing BHP could raise average health care costs of the remaining individual market participants. Appendix 2 explains why, if such an increase occurs, it would not be destabilizing or raise premiums for low- and moderate-income consumers. As a preliminary matter, however, our finding has important limitations:
 - A state that eliminated Medicaid coverage above 138 percent FPL for high-cost groups, such as pregnant women, would raise the average cost of BHP-eligible adults above the amount we estimate.
 - Any increase in average costs would be less than many might anticipate. BHP implementation will affect the risk level of the entire individual market, not just coverage in the exchange. That is because the ACA combines risk for the entire individual market. Insurers offering nongroup coverage both within and outside exchanges must pool all their individual enrollees. Further, plans with above- or below-average risk levels participate in risk-adjustment and reinsurance systems that smooth out these differences.

- State policy decisions could limit the impact of BHP on risk levels. For example, a state might include BHP within risk-pooling arrangements that serve the individual market. That would convert BHP implementation into a *de facto* shift of consumers from one set of individual market plans to another.³⁸

Table 9 shows the major trade-offs that states face as they consider using BHP to provide their low-income residents with coverage that is more affordable than subsidized individual insurance in the exchange.

Table 9. Some state-level trade-offs of using BHP to provide low-income residents with coverage more affordable than subsidized insurance in the exchange

Group or interest at stake	Potential BHP advantages	Potential BHP disadvantages
<p>BHP consumers—that is:</p> <ul style="list-style-type: none"> • Adults with incomes between 138 and 200 percent FPL, including citizens and lawfully present immigrants; and • Lawfully present immigrants with incomes below 138 percent FPL who are ineligible for federally matched Medicaid 	<ul style="list-style-type: none"> • Lower premium costs, so more enroll. • Lower out-of-pocket costs improve access to care. • No risk of owing money to the IRS, so more enroll. • Low-income consumers retain access to safety-net plans. • Potentially less movement between Medicaid and the exchange, so more continuity of coverage.³⁹ 	<ul style="list-style-type: none"> • In most states, more limited provider networks impede access to care. • In most states, consumers have fewer commercial insurance options.
<p>State costs</p>	<ul style="list-style-type: none"> • Federal funds likely to exceed baseline costs. • States can save money, without greatly increasing consumer costs, by shifting adults from Medicaid to BHP. • Potentially fewer administrative costs from consumer movement between Medicaid and the exchange. • Slight increase in potential leverage with direct purchasing of state coverage. 	<ul style="list-style-type: none"> • Inherent uncertainties of any new federal program.
<p>Exchanges and private insurance markets</p>	<ul style="list-style-type: none"> • Potentially fewer administrative costs from consumer movement between Medicaid and the exchange.⁴⁰ 	<ul style="list-style-type: none"> • A smaller (though still large) exchange may have: <ul style="list-style-type: none"> ○ higher per capita charges to cover fixed administrative costs; and ○ reduced exchange leverage with insurers. • Potential change in average risk level of individual market, which might be ameliorated through state policy choices.

Conclusion

The ACA will make health coverage much more affordable to low-income Americans, thereby increasing access to necessary care. The ACA's Basic Health Program option could help states achieve this core goal more effectively by further lowering low-income adults' costs, building on current Medicaid and CHIP programs. The precise benefits and risks of such an approach, however, will depend on state characteristics and policy choices.

Appendix 1: Methodology

To estimate the ACA's effects, we use the Urban Institute's Health Insurance Policy Simulation Model.⁴¹ HIPSIM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, insurance market reforms, and the requirement to obtain coverage. The model estimates changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms.⁴²

We simulate the main coverage provisions of the ACA as if they were fully implemented in 2011 and compare results to the HIPSIM baseline results for 2011—that is, cost and coverage without ACA implementation. The time frame for our results thus differs from those of the Congressional Budget Office and the Centers for Medicare and Medicaid Services (CMS) actuaries, who typically provide multiyear estimates. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief.⁴³ Note that employee choice vouchers were repealed in spring 2011 and are not modeled here. We adjust raw Current Population Survey (CPS) results for the so-called “Medicaid undercount,” but in the results presented in this report do not attempt to fully reconcile baseline coverage estimates with any particular state's administrative data.

To simulate state-level effects, we made the following enhancements to the model not reflected in earlier documentation:

- Two years of CPS data (survey years 2009 and 2010) were pooled together to increase state sample size. Results for large states are based on a larger number of surveyed households than results for small states and thus have greater accuracy. Note that the CPS oversamples small states, so the number of observations is not necessarily proportional to state size. In states with samples that included fewer than 50 individuals with relevant characteristics, we did not list state results, with the exception of a few states noted in the tables. For those states, we computed special estimates by dividing observations into cells based on demographic and economic characteristics, calculating averages for each cell over the entire region, and then computing our estimate using the state-specific population in each cell and the regional average. Thus, we captured the effect of differences in demographic and economic characteristics between the state and its region.
- Medical expenditures were adjusted to reflect state-level differences in health care pricing and utilization as measured in the National Health Expenditure Accounts.⁴⁴
- Private health insurance premiums reflect both the state-level differences in expenditures from the previous item and state-specific differences in the risk pools of enrollees for a given type of insurance.
- The ACA was inspired in its general form by the comprehensive health reforms enacted in Massachusetts. The HIPSIM results for Massachusetts without the ACA take into account some important provisions of that state's health reform law, though we did not comprehensively model it.

We project individual and employer decisions based on an expected utility model, calibrating it to be consistent with empirical observations. As a result, our model shows pre-ACA, Medicaid, and CHIP take-up rates consistent with the empirical literature.⁴⁵ These baseline take-up rates

(that is, take-up rates under current law) for the uninsured are between 60 and 70 percent, depending on person type and income group. The ACA contains important provisions that would increase take-up. For example, states must establish a web site capable of determining eligibility for Medicaid and automatically enrolling eligibles; hospitals can grant presumptive eligibility; and other new requirements simplify enrollment and renewal of Medicaid and CHIP. Take-up rates vary based on individual characteristics, but the model yields an average Medicaid take-up rate under ACA of about 73 percent for newly eligible uninsured. This participation level is higher than the baseline rate under current law due to outreach and enrollment simplification provisions in the ACA⁴⁶ as well as a modest indirect effect of the individual mandate as observed in health reform in Massachusetts; low-income consumers unaffected by that state's mandate nevertheless were prompted to enroll when they paid careful attention to communications from state agencies regarding health coverage, as consumers were often unaware of the limits of the individual requirement to obtain coverage.⁴⁷ Our Medicaid take-up analysis is consistent with the enhanced outreach scenario in Holahan and Headen.⁴⁸ When BHP is introduced as an insurance option, the resulting overall take-up rate (67 percent) is somewhat lower than for Medicaid because, under the version of BHP we model, enrollees pay some premiums and cost-sharing. In all cases, our enrollment estimates result, not from simple, across-the-board assumptions about take-up rates, but from our expected utility model, after being calibrated to Medicaid and private insurance price-responsiveness observations.

We simulate two implementations of the ACA, one with BHP and one without. We compute federal BHP payments based on the premium and cost-sharing subsidies that BHP-enrolling consumers would have been received if BHP had not been implemented. Had we instead based federal BHP payments on the premiums charged in the exchange as it would operate under BHP implementation, our estimated federal BHP payment levels would have been higher, since we find that costs are lower for BHP-eligible adults than for other individual market participants. As discussed in Appendix 3, there are important open questions regarding how the federal government will compute BHP payments.

To estimate what premiums in the exchange would have been for BHP-eligible consumers, we calculate their health care costs based on a combination of CPS data, Medical Expenditure Panel Survey health care cost data statistically matched to CPS files, and state estimates in the National Health Expenditure Accounts. We then add a 15 percent administrative load in the exchange, reflecting likely efficiencies.

Finally, we emphasize that the estimates in this paper assume a uniform implementation of the ACA, including a single approach to BHP. We compare the effects of a consistent policy across states. There are many important implementation decisions within a state's authority. If a state chose to implement BHP and the ACA differently than under the policies we model, the effects would differ from our findings.

Appendix 2: BHP implementation and exchange risk level

As explained in the text, we find that average health care costs could be lower for BHP-eligible adults than for other participants in the individual market. However, increased risk levels are unlikely to trigger the vicious cycle sometimes seen in the past. Traditionally, increased risk levels for a set of health plans meant higher premiums for those plans. The healthiest enrollees left for coverage sold elsewhere that offered similar benefits at a much lower price. This raised the plans' risk level, further increasing their premiums, triggering the departure of the remaining healthiest enrollees, etc. Such a "death spiral" seems highly unlikely under the ACA, for several reasons:

- Plan premiums are based on risk levels in the market as a whole, not a plan's specific enrollees. The ACA's risk-pooling rules, along with risk adjustment and reinsurance mechanisms, aim to break the link between the premiums a plan charges and the risk level of enrollees in that plan. If these policies achieve their goals, a plan's enrollment of high-cost members will not trigger a "death spiral," since it will not increase premiums and so will not cause a departure of the lowest-cost members.
- Similar coverage will not be available elsewhere at a much cheaper price. Even if the ACA's risk-pooling and risk-adjustment policies work imperfectly, price differences will likely be far below current levels.
- Even if average risk levels rise in the individual market, premium costs for low- and moderate-income consumers will be largely unaffected. Premium payments from tax credit recipients are based on two factors: (a) household income; and (b) the difference between the second-lowest-cost silver premium (the so-called "reference premium") and the premium of the plan in which the consumer enrolls. A uniform increase in all plans' risk levels, hence all premiums, will not affect consumers' income, and will have only limited impact on the difference between reference premiums and other premiums.
- It is true that consumers with incomes above 400 percent FPL, who will be ineligible for tax credits, could choose to be uninsured rather than purchase individual coverage. But such consumers will be subject to the full force of the individual mandate. It seems unlikely that any marginal increase in premiums resulting from BHP implementation will be sufficiently large to change many of these consumers' decisions about whether to obtain coverage. Some of these consumers may choose less comprehensive coverage, but that seems unlikely to trigger a "meltdown" of the individual market.

Appendix 3: Federal policy decisions

Federal policymakers may be interested in supporting state flexibility to implement BHP along the lines discussed here. Such state policies would increase coverage and receipt of necessary care among low-income adults, advancing interests that federal officials have articulated as high priorities for ACA implementation.

BHP would probably not have a dramatic effect on federal costs. With fewer uninsured, more consumers would receive subsidies. But BHP would lower federal per capita costs, since federal BHP payments are less than subsidy amounts in the exchange.

Following are some of the key issues facing federal officials as they decide how to apply the ACA's BHP provisions:

- **States need guidance.** While many states have expressed interest in BHP, none has yet moved forward. One important reason is that states do not know how HHS will interpret the law. To be sure, CMS faces an overwhelming regulatory docket. However, if CMS could provide early non-regulatory guidance addressing key questions, states could make better-informed decisions about whether to implement BHP. Some outstanding questions include the following:⁴⁹
 - How (if at all) are federal BHP payments adjusted to reflect BHP risk levels?⁵⁰
 - Do states have the flexibility to keep BHP consumers within the same risk-sharing mechanisms that would have applied if such consumers had remained in the exchange's individual market? That is, may states:
 - ❖ Require licensed insurers that serve BHP and the individual market to pool both sets of enrollees together; and
 - ❖ Include BHP plans, whether or not they are state-licensed, within the risk-adjustment and reinsurance mechanisms that apply to the individual market?
 - Can federal BHP funds pay state administrative costs of BHP implementation?⁵¹
 - Is federal BHP funding based on premiums actually charged in the exchange? Or is it based on the potentially different premiums that would have been charged if BHP adults had been included in the exchange? If the latter, how are such premiums estimated?
 - What standards and procedures determine whether a state's federal BHP payment was in "error" and therefore requires a compensating adjustment in a later year? In answering that question, how are the following factors balanced? And will the balance be struck differently over time?⁵²
 - ❖ State interests in fiscal predictability;
 - ❖ The undesirability of penalizing states for factors outside their control; and
 - ❖ The federal interest in BHP payments that accurately reflect the subsidy amounts BHP consumers would have received in the exchange.
 - In determining federal BHP payments to states, which percentage of cost-sharing subsidies applies—95 percent or 100 percent?

- The statute appears to envision a two-step process for defining the amount a state receives in federal BHP funding:
 - ❖ Establishing the federal BHP payment for an individual BHP enrollee by—
 - Determining what the federal government would have provided in subsidies if the enrollee had been served through the exchange’s individual market;⁵³ and
 - Based on that determination, calculating the amount of the federal BHP payment.
 - ❖ Establishing the state’s total federal payment by combining these amounts for all BHP enrollees.

Section 1331(d)(3)(A)(ii) thus begins by stating. “The Secretary shall make the determination [of federal BHP payments] *on a per enrollee basis....*” (Emphasis added) This provision concludes by explaining, “This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty.” Does the latter sentence reference the determination of “per enrollee” BHP payments mentioned in the provision’s opening words? Or does it require HHS to base a state’s BHP payments on what HHS thinks enrollment would have been like—who would have gone into the exchange, who would have enrolled in Medicaid, and who would have been uninsured—if the state had not implemented BHP? If the latter, how will such a counterfactual enrollment scenario be determined? For example, in a state that uses BHP to lower premiums and reduce the number of uninsured, will HHS cap the state’s BHP payments based on exchange enrollment levels observed in other states where higher premiums are charged?

- Suppose a state provides BHP consumers with “Medicaid look-alike coverage.” Suppose further that the state’s Medicaid program has received a federal waiver permitting a single health plan to be offered in a particular geographic area. Can BHP consumers in that area likewise all be enrolled in that same plan? More broadly, what flexibility do states have to resolve potential tensions between the following statutory requirements: (a) offering multiple plans “to the maximum extent possible;”⁵⁴ (b) using a “competitive process for entering into contracts;” and (c) “coordinat[ing] the administration of, and provision of [BHP] benefits with ... other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care”⁵⁵? Do states have the flexibility to meet the latter requirement by extending existing Medicaid contracts to cover BHP-eligible consumers, thereby lowering administrative costs and increasing continuity of coverage and care?
- To determine income for Medicaid purposes, 5 FPL percentage points are deducted from MAGI. Is a clear distinction maintained between Medicaid and BHP eligibility by applying that same deduction in determining income for purposes of BHP?
- In administering BHP, how much flexibility do states have in determining income? Must they project annual income levels; may they use Medicaid methodologies for calculating “point in time income;” or may they use other methods entirely?

- How are federal BHP payments calculated when, because of mid-year changes in circumstances, a consumer enrolls in BHP during part of the year and receives subsidies in the exchange’s individual market during other parts of the year?⁵⁶
- Suppose that a state combines BHP and Medicaid into a single program that serves all low-income residents with incomes at or below 200 percent FPL. Suppose further that, to streamline enrollment and lower administrative costs, the state does not ask adults with incomes below 138 percent FPL for documentation needed to distinguish between: (a) qualified immigrants, who are eligible for Medicaid; and (b) other lawfully present immigrants, who are eligible for BHP. Is such a state foreclosed from claiming federal BHP dollars for the latter immigrants? Or may the state use the methods that proposed CMS regulations allow for claiming enhanced Medicaid matching funds for newly eligible adults? Such methods include caseload sampling and other approaches that do not require identifying those adults during the enrollment process.⁵⁷
- **States would benefit from predictable funding.** It would be helpful for CMS to develop a method for giving states reliable, advance projections of BHP funding levels. This would be particularly important before initial implementation of BHP. Otherwise, fear of fiscal risk could deter some states from moving forward.
- **BHP’s tax treatment could influence the extent and nature of BHP implementation.** ACA Section 9010 imposes a fee on insurers based on their total volume of business. Under subsection (c)(2)(C)(iii), the fee does not apply to a nonprofit entity “more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act.”

Successful BHP implementation, along the lines discussed here, will be more likely if this tax exclusion encompasses programs that combine funds under BHP, Medicaid (Title XIX), and CHIP (Title XXI) to provide low-income populations with Medicaid/CHIP-type benefits and cost-sharing protections, paying plans amounts that do not exceed average levels under Medicare (Title XVIII). Non-profit health plans would be more likely to support and participate in such a program if it were not classified like private coverage in determining whether insurers are subject to taxation.

On the other hand, a state may implement BHP in a way that provides consumers with coverage like that available in the exchange’s individual market, without integrating BHP into the same program that serves Medicaid and CHIP beneficiaries. In that case, BHP consumers could make payments and plans would charge BHP premiums typical of private insurance. With such an approach, BHP could fall outside the public program exclusion without contravening the apparent statutory goal—namely, that fees under Section 9010 should not be charged to nonprofit entities that accept payments below private levels to furnish coverage through public programs that are tailored to meet the needs of low-income, elderly, or disabled consumers.

About the Authors and Acknowledgements

Stan Dorn is a senior fellow, Matthew Buettgens is a senior methodologist, and Caitlin Carroll is a research assistant at the Urban Institute Health Policy Center.

The authors are grateful to the Association for Community Affiliated Plans (ACAP) for funding this research. The authors thank ACAP's staff and members and John Holahan of the Urban Institute for reviewing prior versions of this paper and providing helpful comments. Neither ACAP, those individuals, the Urban Institute, nor its funders or trustees are responsible for the opinions expressed in this report, which are the authors'.

About the Urban Institute

The Urban Institute gathers data, conducts research, evaluates programs, offers technical assistance, and educates Americans on social and economic issues—to foster sound public policy and effective government.

About the Association for Community Affiliated Plans

The Association for Community Affiliated Plans is a national trade association representing 58 nonprofit safety net health plans in 28 states. ACAP's mission is to represent and strengthen not-for-profit, safety-net health plans as they work with providers and caregivers in their communities to improve the health and well-being of vulnerable populations in a cost-effective manner. Collectively, ACAP plans serve 8 million enrollees in Medicaid, Medicare, CHIP and other health programs, and represents around one-third of all people in Medicaid managed care.

Endnotes

¹ Stan Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States* (prepared by the Urban Institute for the State Coverage Initiatives Program of AcademyHealth, March 2011).

² It is not completely clear whether BHP can cover individuals who are eligible for a Medicaid eligibility category that does not include all “essential benefits” under the ACA. In ACA Section 1331, compare subparagraphs (e)(1)(A) and (e)(1)(C).

³ The ACA extends nominal Medicaid income eligibility to 133 percent FPL. However, in determining income, 5 FPL percentage points are subtracted from modified adjusted gross income. Accordingly, the functional income-eligibility limit for Medicaid is 138 percent FPL, the amount stated in the text.

⁴ The applicable regulatory definition, for ACA purposes, is 45 CFR 152.2, contained in regulations for the Pre-existing Condition Insurance Plan Program. For a detailed list of immigration categories included within lawful presence, see Social Security Administration, POMS Section: RS 00204.025, “Evidence Requirements for Establishing U.S. Lawful Presence,” <https://secure.ssa.gov/poms.nsf/lnx/0300204025>.

⁵ Although the ACA requires states to maintain 2009-level CHIP eligibility through 2019, the legislation provided CHIP allotments only through 2015. For such allotments to continue, federal policymakers must, in effect, reauthorize CHIP.

⁶ This is how the Congressional Budget Office (CBO) reads the statute. See CBO, *Cost Estimate: H.R. 1683, State Flexibility Act* (May 11, 2011). However, children’s coverage may be affected by Social Security Act Section 2105(d)(3)(B), added by ACA Section 2101(b), providing that when a state’s CHIP allotments have run out, “the State shall establish procedures to ensure that [CHIP-eligible] children are enrolled in a qualified health plan that has been certified by the Secretary” as offering benefits and cost-sharing comparable to CHIP.

⁷ First Focus, *Children in Health Reform: Comparing CHIP to the Exchange Plans*, December 2009, <http://www.firstfocus.net/sites/default/files/r.2009-12.8.ff.pdf>.

⁸ While states could cut eligibility before 2014 if the ACA’s maintenance of effort requirements were repealed, such reductions could become more likely after federal subsidies become available to replace CHIP for many children.

⁹ Under proposed regulations, a child will be ineligible for subsidies if he or she is offered dependent coverage by a parental employer that makes worker-only coverage affordable to the child’s parent. In such cases, dependent coverage will be deemed affordable, regardless of how much families must pay for dependent coverage.

¹⁰ Nothing in ACA prevents a state from supplementing federal BHP dollars with state funds.

¹¹ As required by the ACA’s maintenance-of-effort requirements, states that provided Medicaid to lawfully present but not qualified immigrant children must continue to do so, so long as federal CHIP allotments remain available.

¹² We do not assume any reductions in current Medicaid eligibility for such immigrants.

¹³ Our modeling assumes the provision of standard benefits for adults, not the “benchmark benefits” permitted, in some cases, by Social Security Act Section 1937.

¹⁴ Such an actuarial value typifies many separate CHIP programs today. Among 17 states surveyed by the actuarial firm Watson-Wyatt, the median CHIP program provided coverage with 100 percent actuarial value for children with incomes at 175 percent FPL and 98 percent actuarial value for children at 225 percent FPL. Watson-Wyatt Worldwide, *Implications of Health Care Reform for Children Currently Enrolled in CHIP Programs* (prepared for First Focus, September 25, 2009), <http://www.firstfocus.net/sites/default/files/r.2009-10.1.watson.pdf>.

¹⁵ In adjusting CHIP premiums to adults, we follow the actuarial rule of thumb that adult costs average approximately twice children’s costs. For a survey of premiums and out-of-pocket costs in separate CHIP programs, see Martha Heberlein, Tricia Brooks, Jocelyn Guyer, Samantha Artiga, and Jessica Stephens, *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and Chip, 2010–2011* (Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, January 2011).

¹⁶ We have not applied the alternative statutory interpretation that BHP payments equal 95 percent of tax credits plus 100 percent of cost-sharing subsidies. ACA Section 1331(d)(3)(A)(i) sets the federal BHP payment as “95 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided” if BHP-eligible adults had received coverage through the exchange. It is not clear whether the words “95 percent of” apply to the clause “the cost-sharing reductions under section 1402.”

¹⁷ Kaiser Family Foundation, *Survey of People Who Purchase Their Own Insurance* (June 2010), <http://www.kff.org/kaiserpolls/upload/8077-R.pdf>.

¹⁸ See, e.g., Katherine Swartz, *Cost-sharing: Effects on Spending and Outcomes*, Research Synthesis Report No. 20 (Robert Wood Johnson Foundation, December 2010); Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Kaiser Commission on Medicaid and the Uninsured, March 2003); Bill J. Wright, Matthew J. Carlson, Heidi Allen, Alyssa L. Holmgren, and D. Leif Rustvold, "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs* 29(12) (December 2010): 2311–16; Dana P. Goldman, Geoffrey F. Joyce, and Yuhui Zheng, "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health," *Journal of the American Medical Association* 298(1) (July 4, 2007): 61–69; Becky A. Briesacher, Jerry H. Gurwitz, and Stephen B. Soumerai, "Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature," *Journal of General Internal Medicine* 22(6) (June 2007): 864–71; Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences* (Kaiser Commission on Medicaid and the Uninsured, May 2005). Many of these studies also show that modest out-of-pocket costs charged to low-income consumers reduce the utilization of necessary care among those who do enroll.

¹⁹ See discussion in Dorn, op cit.

²⁰ See, e.g., for California, Peter Long and Jonathan Gruber, "Projecting The Impact Of The Affordable Care Act On California," *Health Affairs* 30(1) (2011): 63–70; David Auerbach et al., *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in California* (prepared by the Rand Corporation for the Council of State Governments, 2011). See also Deloitte Center for Health Care Solutions, *Health Insurance Exchanges: A Strategic Perspective* (2011).

²¹ See discussion in Dorn, op cit. Insurers' interest in the exchange will be affected by the nature of the exchange's participating members, not just their number. However, it is not clear how this would play out under the ACA. As explained below, BHP-eligible consumers may have average costs lower than other individual market enrollees. However, we do not know whether adverse selection will operate more severely with (a) the lowest-income tax credit recipients, who have higher subsidies and lower penalties for uninsurance but less disposable income; or (b) higher-income tax credit recipients, who will receive less generous subsidies but have higher disposable income and will be charged greater penalties for uninsurance. In addition, some private insurers may want to avoid low-income consumers who are particularly subject to income fluctuation (hence changing premium obligations) and who some insurers may view as more challenging or otherwise less desirable than middle-class customers. Such insurers may be more interested in participating in an exchange if it lacks the lowest-income members allowed by the ACA.

²² Mercer Health & Benefits LLC, *Exploring the Financial Feasibility of a Basic Health Program in California* (prepared for the California Healthcare Foundation, May 12, 2011). Mercer's analysis differs from ours in that Mercer expects BHP-eligible adults to have lower average health care costs than other participants in the exchange's individual market.

²³ Jeremy Palmer, *Healthcare Reform and the Basic Health Program Option: Modeling Financial Feasibility* (Milliman, Inc., April 2011).

²⁴ Elisabeth R. Benjamin and Arianne Slagle, *Bridging the Gap: Exploring the Basic Health Insurance Option for New York* (prepared by the Community Service Society for NYS Health Foundation, June 2011), <http://www.nyshealthfoundation.org/userfiles/BHP2011-final-WEB.pdf>.

²⁵ Stan Dorn, *SustiNet Policy Options: Cost and Coverage Estimates* (prepared by the Urban Institute for the Sustinet Partnership Board of Directors, November 18, 2010), <http://www.ct.gov/sustinet/lib/sustinet/dorn-gruber.modeling.results.111810.ppt>. According to HIPSM results, federal BHP payments in Connecticut would exceed baseline Medicaid costs by 23 percent; the state would save \$20 million annually; and BHP implementation would reduce the size of Connecticut's exchange by 66,000 residents.

²⁶ Alan Mills, Tim Barclay, and Ben Diederich, *Planning Washington's Health Benefit Exchange: The potential impact of three key decisions* (prepared by Milliman, Inc., for the Washington State Health Care Authority, June 13, 2011); Rosemarie Day, Bowen Garrett, and Ceci Connolly, *The Basic Health Plan—An Emerging Option for States* (McKinsey Center for U.S. Health System Reform, March 24, 2011).

²⁷ See Figure 6 in Lisa Clemans-Cope and Bowen Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005* (prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, December 2006). Writing several years before ACA enactment, Clemans-Cope and Garrett analyzed only the question of whether ESI was offered. They did not assess the extent to

which ESI offers were affordable or involved comprehensive benefits, factors that are relevant to eligibility for BHP and subsidies in the exchange.

²⁸ One issue we do not address is the potential, under BHP, to increase the number of children who enroll in the same health plans that serve their parents. While research suggests that children benefit when their parents receive coverage, the authors are unaware of any evidence that children benefit when their parents are covered through the same plan that serves the children, rather than through a different plan. See Genevieve M. Kenney and Stan Dorn, *Health Care Reform for Children with Public Coverage: How Can Policymakers Maximize Gains and Prevent Harm?* (prepared by the Urban Institute for the Robert Wood Johnson Foundation, June 2009), http://www.urban.org/UploadedPDF/411899_children_healthcare_reform.pdf. Notwithstanding this evidentiary gap, parents may seek more necessary care, for themselves and their children, if they need to learn the procedural requirements of one plan and program, rather than two; staff-model health maintenance organizations and family practitioners within a single plan can serve both parents and children during a single visit if all family members enroll in a single plan; there may be some clinical benefits when a single provider knows all family members; and some people may find it hard to understand why the ACA forces children and parents into different programs, a perception that could reduce the program's long-term viability.

²⁹ Dorn, op cit.

³⁰ The impact of BHP implementation on continuity would vary with state policy decisions. For example, a state that combined Medicaid, CHIP, and BHP dollars to fund a single, integrated system of health coverage for all citizens and lawfully present immigrants up to 200 percent FPL would promote continuity of coverage far more effectively than if BHP involved health plans and a health coverage system that was entirely distinct from both Medicaid and coverage in the exchange.

³¹ In addition, we estimate that BHP implementation would increase by 5 percent the number of consumers who receive Medicaid-like coverage under the ACA, which will place additional pressure on the existing network of Medicaid providers. This additional stress could be ameliorated, to some degree, by raising BHP provider payment rates above baseline Medicaid levels, thus encouraging more providers to participate.

³² States could likewise shift Medicaid costs to BHP for pregnant women and other adults with incomes over 138 percent FPL or for lawfully present immigrants under 138 percent FPL who do not qualify for federal Medicaid funds.

In an important variant, states with medically needy eligibility could structure BHP to lower out-of-pocket costs for medically needy individuals, thereby delaying the point at which they meet applicable spend-down requirements and qualify for Medicaid. See Dorn, op cit.

Further, a state that mandates coverage of benefits that fall outside what the federal government classifies as "essential" would save money under BHP. The ACA requires that such a state pay the entire increase in exchange premiums that results from these mandates. BHP implementation would relieve the state of the need to pay such costs for adults with incomes between 138 and 200 percent FPL.

Finally, observers who believe that BHP enrollees can be used as leverage to lower premiums may conclude that, if a state adds such enrollees to the leverage it already applies in purchasing coverage and care, state savings could result.

³³ An important exception involves community health centers, which receive cost-based reimbursement under both Medicaid and coverage in the exchange.

³⁴ For example, suppose that (1) consumers A and B experience midyear, \$10,000 income increases and decreases, respectively; (2) such income changes would lower or raise their tax credits by \$1,000; but (3) the applicable cap limits their maximum repayment of excess tax credits to \$600. If these consumers are covered through the exchange, consumer A receives \$1,000 from the IRS at the end of the year, and consumer B owes the IRS \$600. If they are covered through BHP, neither receives a tax credit, so neither experiences any tax consequences of their unexpected income changes. However, their state's BHP amount is affected by the reconciliation that would have taken place in the exchange. The state's amount would be increased by \$950 for consumer A, which is 95 percent of the \$1,000 he or she would have received from the IRS. For consumer B, the state's BHP payment would fall by \$570, which is 95 percent of the \$600 he or she would have owed IRS. As a result, the state would come out ahead by \$380.

³⁵ This possibility would have other far-reaching effects on the insurance market. It would discourage enrollment in standard commercial coverage, since tax credit beneficiaries would need to pay the difference between commercial premiums and the second-lowest-cost silver plan.

³⁶ See Dorn, op cit.

³⁷ This effect would be reduced or eliminated if a state's BHP program reimbursed the exchange for administrative services the exchange provides to BHP consumers.

³⁸ These points are developed at some length in Dorn, op cit. One additional option would combine a state's small group and individual markets. The resulting combined market would be so large that BHP implementation would likely have a minimal impact on its average risk levels. However, in many states, the combined risk pool would have lower average risk levels than would a separate individual market. This would reduce federal subsidy amounts, hence BHP payment amounts. How these factors play out is likely to vary by state.

³⁹ At lower income levels, income fluctuations are more common, and more people qualify for subsidies. See Dorn, op cit. However, whether BHP implementation promotes continuity of coverage depends on the details of state implementation. A single program for all low-income residents that blends federal dollars under Titles XIX, XXI, and BHP would greatly promote continuity of coverage and care. The same cannot be said for an approach that would cover adults and children between 138 and 200 percent FPL through an expanded CHIP program that uses very different health plans from those that participate in Medicaid and the Exchange.

⁴⁰ As noted above, some insurers may view BHP-eligible adults as undesirable, because of unstable incomes or other factors. An exchange without such consumers could be viewed as more attractive by such insurers.

⁴¹ For more about HIPSM, see <http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf>. A more technical description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas, *The Coverage and Cost Impacts of Expanding Medicaid* (prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, 2009), <http://www.urban.org/url.cfm?ID=411905>.

⁴² HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey, the Statistics of Income Public Use Tax File, and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.

⁴³ Matthew Buettgens, Bowen Garrett, and John Holahan, *America under the Affordable Care Act* (prepared by the Urban Institute for the Robert Wood Johnson Foundation, 2010), http://www.urban.org/health_policy/url.cfm?ID=412267.

⁴⁴ National Health Expenditure Accounts, CMS Office of the Actuary. <https://www.cms.gov/NationalHealthExpendData/>.

⁴⁵ See, for example, Garrett et al., 2009, op. cit.

⁴⁶ See, for example, ACA Section 1413.

⁴⁷ Stan Dorn, Ian Hill, and Sara Hogan, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage* (prepared by the Urban Institute for the Robert Wood Johnson Foundation and the State Health Access Reform Evaluation, November 2009).

⁴⁸ John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* (prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, May 2010).

⁴⁹ Several questions of federal interpretation are not stated in the text but may be relevant to states or have been expressed by other observers. For example:

- May BHP coverage have lower actuarial value than what BHP consumers would have received through cost-sharing subsidies in the exchange? Compare Section 1331(a)(2)(A)(ii) with the final sentence of Section 1331(a)(2).
- If coverage in the exchange includes payments that are not part of a state's BHP program (such as cost-based reimbursement for federally qualified health centers), will federal BHP payments be reduced below levels specified in Section 1331(d)(3)(A)?
- Will HHS forbid states from using federal BHP payments to pay providers in "Medicaid look-alike" plans reimbursement amounts that exceed Medicaid levels?

⁵⁰ At one point, ACA Section 1331(d)(3)(A)(ii) requires federal BHP payments to take into account "the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange." This arguably implies a congressional intent to adjust BHP payments so that the same risk adjustment and reinsurance systems apply, whether these adults receive BHP or enroll in the exchange. A policy that carries out this intent, as indicated earlier, could greatly limit the impact of BHP implementation on the risk level of the individual market. On the other hand, this statutory provision begins by requiring a consideration of "all relevant factors necessary to determine the value

of the premium tax credits and cost-sharing reductions that would have been provided” in the absence of BHP; and health status (along with the accompanying risk adjustments and reinsurance payments) does not affect the amount of premium tax credits or cost-sharing reductions.

⁵¹ ACA Section 1331(d)(2) states that federal BHP payments may “only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals.” Of course, without payment for reasonable administrative costs, BHP programs will be unable to do any of these things or to meet other applicable requirements. For example, Section 1331(c)(4), which mandates coordination of BHP with other insurance affordability programs, would presumably permit federal BHP funds to be used to pay an exchange for the cost of determining eligibility for BHP consumers.

⁵² Over time, aggregate subsidy amounts that BHP-eligible consumers would have received in the exchange’s individual market will become more predictable. Policymakers could thus strike the balance in the text differently during the initial and later years of ACA implementation.

⁵³ In deciding whether a consumer goes to Medicaid, BHP, or the exchange, the state will need to determine the consumer’s income level and household size. In addition, BHP enrollees can be asked to file federal income tax returns and to share them with the state, as a condition of participating in BHP. Those facts will go a long way towards determining the subsidies the consumer would have received in the exchange, both initially and at reconciliation.

⁵⁴ Section 1331(c)(3)(A).

⁵⁵ Section 1331(c)(4).

⁵⁶ Two aspects of this question are easy to answer. First, for the period the individual received BHP, the cost-sharing subsidy amounts in the exchange could be established based on the exchange’s income determination that qualified the consumer for BHP. Second, the total amount of the tax credit that could have been claimed if the consumer had been enrolled in the exchange rather than BHP can be calculated based on the year-end tax return.

Less obvious is the appropriate method for allotting the final tax credit amount between (a) the consumer’s BHP enrollment and (b) the consumer’s part-year receipt of advance credits.

Approach #1 would simply subtract the consumer’s actual advance credits from the final year-end credit amount and give BHP 95 percent of the remainder. This approach has the advantage of simplicity. One disadvantage of this policy is that consumers who qualify for BHP part-year and overclaim advance credits for the remainder of the year would avoid tax liability, effectively shifting that cost to the state BHP program.

Approach #2 would avoid that disadvantage by adding (i) the consumer’s actual advance credits plus (ii) imputed advance tax credit amounts that would have been paid during the period of BHP enrollment, based on the income determination made by the exchange. If this sum differs from the final tax credit amount, based on the year-end return, the taxpayer would be responsible for any reconciliation adjustments.

To illustrate the implications of these approaches, the following examples use estimates from the Kaiser Family Foundation’s subsidy calculator, at <http://healthreform.kff.org/SubsidyCalculator.aspx>, rounded off to the nearest dollar.

Suppose 50-year-old taxpayer Tom, who lives in a medium-cost state, has monthly income of \$2,157, at 225 percent FPL, during January through June 2014. For that period, Tom receives advance tax credits equal to \$427 a month, totaling \$2,561. He also receives cost-sharing subsidies.

During July through December, Tom’s income drops to \$1,678 a month, or 175% FPL. For that period, he is covered by BHP. How is his state’s BHP payment calculated?

If Tom had been in the exchange during July through September and his income had been 175 percent FPL, his monthly cost-sharing subsidy for July through December would have been an amount sufficient to raise his AV from 70 percent to 87 percent, or an estimated \$141 a month, based on a monthly total premium amount of \$582 for a 70 percent AV plan. For the entire 6-month period, his cost sharing subsidy would have totaled \$847. If HHS interprets the ACA so that the state’s BHP payment includes 95 percent (rather than 100 percent) of the cost-sharing subsidy that would have been paid in the exchange, this part of the state’s BHP payment for Tom equals \$805.

Both of the above approaches to calculating the tax credit component of a state’s BHP payment begin by determining Tom’s year-end tax credit amount. His annual income of \$23,011, or 200 percent FPL, would allow a final annual tax credit of \$5,529.

Approach #1 would subtract from that amount Tom’s \$2,561 advance credits, yielding a \$2,969 estimate of advance tax credits amounts that would have been paid in the exchange for Tom, in the absence of BHP. The state’s

95 percent share would equal \$2,820. Added to the \$805 BHP cost-sharing amount, the total BHP payment for Tom is \$3,625.

Approach #2 reaches nearly the same result through a different path. It imputes an advance tax credit for July through December, based on the exchange's finding that Tom's income was 175% FPL during that period. Accordingly, his advance credit would have been \$2,971. The state's 95% BHP share is \$2,822, yielding a total BHP payment of \$3,627.

However, Approach #2 involves a reconciliation process. It compares the sum of actual advance credits (\$2,561) and the imputed advance credit (\$2,971) with the year-end, final tax credit amount (\$5,529). In this case, the former--\$5,531--exceeds the latter by \$2, which Tom must repay on his tax return. This small difference between approaches, based on the Kaiser subsidy calculator, could easily be a rounding error.

These two approaches would come to very different results, however, if Tom's advance tax credit amounts did not accurately reflect his income during January through June. Suppose Tom underestimates his income for January through June as \$2,013 a month, or 210 percent FPL. His advance tax credits are \$448 a month, or \$2,686 over the entire 6 month period—\$126 above the proper amount.

Approach #1 would subtract Tom's \$2,686 advance credits from the year-end tax credit amount of \$5,529, yielding a \$2,843 estimate of the remaining advance credits for July through December. The state's 95 percent share of the latter amount is \$2,701. Combined with the BHP amount for Tom's July through December cost-sharing subsidy, the state's total payment is BHP \$3,506. Tom's overclaiming of tax credits for January through June has reduced the state's BHP payment for July through December, and Tom experiences no adverse tax consequences of that overclaiming.

Under Approach #2, the state's BHP amount of \$3,627 is unaffected by Tom's overclaiming of advance credits, since the state's payment is based entirely on the income determination made by the exchange. However, Approach #2 compares Tom's year-end credit amount of \$5,529 with the sum of his \$2,686 advance credits and the imputed BHP credits of \$2,971. That sum is \$5,657, so Tom is liable for a \$128 excess payment.

Note that, even under Approach #2, any incorrect income determinations for BHP should ultimately affect state, not federal costs. As explained earlier, if a state errs in one year's BHP amount, the next year's BHP payment is adjusted accordingly.

⁵⁷ See proposed 42 CFR § 433.202, et seq., in CMS, "Proposed Rule: Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," *Federal Register*, Vol. 76, No. 159, August 17, 2011, page 51185.