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The ACA's Basic Health Program Option: Federal Requirements and State Trade-Offs

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) gives states the option to implement a Basic Health Program (BHP) that covers low-income residents through state-contracting plans outside the health insurance marketplace, rather than qualified health plans (QHPs). In March 2014, the Centers for Medicare & Medicaid Services (CMS) issued final regulations on the requirements for a BHP and the methodology for calculating federal payments to states. States can choose to implement BHP beginning in 2015.

BHP REQUIREMENTS

In a state implementing this option, BHP is available to consumers with incomes up to 200% of the federal poverty level (FPL) who would otherwise qualify for subsidies in the marketplace.

Most are adults with incomes between 133 and 200% FPL, but some are lower-income consumers ineligible for federal Medicaid funding because of immigration status. In addition to meeting income requirements, BHP-eligible consumers must be state residents, age 64 or younger, U.S. citizens or lawfully present immigrants, and ineligible for other minimum essential coverage, including Medicaid, CHIP, and affordable insurance offered by an employer. Although any state can implement BHP, only those that also expand Medicaid are likely to do so.

BHP must be at least as comprehensive and affordable as subsidized coverage in the marketplace. BHP consumers are enrolled in “standard health plans” that cover the ten Essential Health Benefits required of QHPs in the marketplace. At state option, such plans may cover additional benefits as well. BHP premiums and out-of-pocket cost-sharing may not exceed what would have been charged by the benchmark plan (second-lowest cost silver plan) in the marketplace, taking into account premium tax credits (PTCs) and cost-sharing reductions (CSRs) for which consumers would have qualified. Standard health plans may be sponsored by state-contracting HMOs, insurers, Medicaid or CHIP managed care organizations, provider networks, or other qualified entities.

States can choose between Medicaid rules and rules that apply in the marketplace for most aspects of BHP. The flexibility to choose between these existing administrative structures applies to such BHP features as the rules for verifying and redetermining eligibility, effective dates of eligibility, criteria for plan network adequacy, grace periods for late payment of premiums, and enrollment opportunities—either continuous enrollment (as under Medicaid) or open and special enrollment periods (as in the marketplace). This flexibility simplifies state administration and facilitates continuity of coverage for consumers.

FEDERAL FUNDING OF STATE BHPS

The federal government pays 95% of what BHP enrollees would have received in marketplace subsidies. The federal payment for each enrollee includes two components: one reflecting the PTC and another reflecting the CSR the enrollee would have received in the marketplace. The same amount is paid for all enrollees within each federal payment cell, which is defined based on county of residence, age range, income range, household size, and type of BHP coverage (single, couple, etc.). These per capita amounts are set prospectively for each year. When BHP is first implemented, the state’s initial payments are based on projected enrollment into each payment cell. After the program starts, payments are adjusted to reflect actual enrollment

within each cell. The final payment methodology for 2015 was published in March 2014; in subsequent years, final payment methodologies will be published each February prior to the beginning of the BHP program year.

WHY STATES HAVE CONSIDERED BHP

States considering BHP seek to achieve multiple goals, including providing more affordable coverage and reducing “churning” between Medicaid and marketplace plans. Many of the states actively debating BHP envision providing coverage similar to that offered through existing Medicaid or Children’s Health Insurance Programs. If structured in this manner, BHP would give consumers more affordable coverage than what is offered in marketplaces, even with federal subsidies. The result would likely be higher levels of enrollment and greater access to care for the lowest-income group of subsidy-eligible consumers. Recent research suggests that the perceived unaffordability of coverage is a major obstacle to enrollment among the remaining uninsured. In addition, some states that had previously expanded coverage through a Medicaid waiver or through state-funded coverage would achieve savings by shifting those beneficiaries into a federally-funded BHP without reducing benefits or increasing costs for affected consumers. Finally, serving all residents with incomes up to 200% FPL through the same Medicaid-based health plans, with cost-sharing amounts changing but other coverage remaining constant as income rises and falls, would likely reduce the amount of “churning” (that is, involuntary movement between plans in response to income fluctuation). Churning would be further reduced under the final regulations’ option to provide BHP enrollees with 12-month, continuous eligibility.

BHP would also avoid the need for consumers to reconcile advance premium tax credits on federal income tax returns. Since BHP enrollees do not receive tax credits, they would not face the risk of losing tax refunds or owing tax debts if they turn out to receive excess subsidies during the year.

STATE COST ISSUES

States evaluating whether to implement BHP must compare expected federal funding to projected costs, factoring in potential offsetting savings, to determine BHP’s financial feasibility. States need to compare federal BHP funding, which will reflect marketplace benchmark premiums, to state BHP costs in assessing the amount (if any) that states need to contribute.

Enrollment patterns influenced by state policy choices will affect the relationship between federal funding levels and state costs. For example, states that encourage enrollment of the lowest-income BHP-eligible consumers by greatly lowering or eliminating their premium charges may see average federal funding per beneficiary increase, since the lowest-income consumers qualify for the highest QHP subsidies.

Potential state budget savings could also affect BHP’s fiscal impact. In addition to shifting enrollees in state-funded programs to federally-funded BHP, some states might achieve savings by using BHP’s negotiating leverage to lower plan and provider bids for both BHP and Medicaid and by structuring BHP benefits to substitute for state-funded services—for example, certain mental health and substance abuse treatment—that fall outside QHPs’ commercial coverage.

States must also decide how to finance BHP administrative costs, which cannot be directly paid with federal BHP funds. However, states can fund these expenses by surcharging BHP plans and using federal BHP funds to

cover the resulting premium escalation, just as many marketplaces fund administrative costs by surcharging QHPs and using PTCs to cover much of the consequent premium increase.

States concerned about BHP costs exceeding federal funding can lower BHP costs or “hedge” financial risks. A state can lower BHP costs by increasing consumer out-of-pocket cost-sharing, limiting benefits, or raising premiums (so long as BHP coverage remains at least as generous and affordable as QHP plans). States can also adjust plan payments and associated provider reimbursement levels to reduce BHP costs. BHP plan and provider payments are likely to be set at least somewhat below QHP levels, but cutting payments even further will reduce the state’s costs, albeit by potentially narrowing the provider networks available to beneficiaries.

States can also adopt strategies that hedge financial risks, rather than lower costs. They can share risks with health plans by holding back a small proportion of payments until the end of the year. Once uncertainties are resolved, those “hold-backs” can be disbursed. States can also retain a small percentage of federal payments as reserves, to help pay future years’ BHP costs if unforeseen contingencies materialize and federal BHP funds fall unexpectedly short of covering state BHP costs.

BHP AND THE MARKETPLACE SIZE

Although implementing BHP will reduce the size of a state’s marketplace, smaller marketplaces are likely to remain stable in most states. Implementing BHP will lead to a smaller marketplace as consumers with incomes under 200% FPL move out of the marketplace and into the BHP. However, the ACA’s insurance market reforms will promote stability in marketplaces with fewer enrollees. Those reforms base marketplace premiums on the risk level of the individual market as a whole, not solely on the risk level of enrollees within the marketplace or plan. This requirement, along with other premium stabilization mechanisms, should prevent spikes in premiums that might otherwise occur, as illustrated by a very small but stable marketplace in Massachusetts, operating under rules like the ACA’s. Massachusetts’ Commonwealth Choice exchange, which serves only unsubsidized residents above 300% FPL, has remained stable since its 2007 launch, even though fewer than one-half of 1% of non-elderly residents enrolled during Commonwealth Choice’s first three years.

However, a smaller marketplace could reduce competition and would need alternative sources of revenue. Fewer covered lives could make the marketplace less attractive to carriers. In response, carriers might reduce the number of plan options offered to consumers or avoid the marketplace. Moreover, many states are planning to fund marketplaces through assessments on participating plans. In those states, the administrative costs that are fixed—that is, those that are unchanged even if fewer people enroll—would be spread across a smaller base if fewer consumers receive marketplace coverage. However, BHP could help pay marketplace administrative costs that benefit BHP, such as for eligibility determination, compensating for lost QHP assessments.

BHP AND MARKETPLACE RISK LEVELS AND PREMIUMS

Implementing BHP could potentially alter the risk level of enrollees in the individual market; however, a state-based risk adjustment system that includes BHP plans could both prevent this change and lead to modest individual market premium reductions. If BHP enrollees have different

average costs than other marketplace enrollees, moving them into BHP would change the risk level of the individual market, hence the premiums charged by marketplace plans. At income levels low enough for subsidies, premium payments are determined primarily by household income, with tax credits absorbing overall changes to premium levels. If premiums rise or fall, the consumers most affected are those with incomes too high to qualify for subsidies.

A state can address those concerns by administering a risk-adjustment system that combines BHP plans with individual market carriers, thereby including BHP consumers in the individual market's risk pool. If such a state's BHP makes coverage more affordable, it will attract some healthier consumers than would have enrolled into the marketplace. The risk adjustment system will share those better risks with the individual market. The result would likely be modest reductions to individual market risk levels and marketplace premiums.

MINNESOTA'S 2014 EXPERIENCE WITH A BHP-LIKE OPTION

Minnesota did not provide marketplace coverage to residents with incomes at or below 200% FPL in 2014 because it was planning to implement BHP in 2015. Instead, these consumers were covered through a reconfigured version of the state's Medicaid waiver program, MinnesotaCare (MNCare). Removing all residents under 200% FPL from the state's marketplace did not appear to create any of the problems described above:

- **QHP enrollment was robust, albeit reduced because of MNCare.** By the end of open enrollment, 47,902 consumers joined QHPs, and 37,985 signed up for MNCare. As of July 2014, enrollment totals reached 52,233 in QHPs and 54,154 in MNCare.
- **Five participating carriers offered consumers numerous marketplace options, and benchmark premiums were the lowest in the country.** Thirty-three QHPs were offered in the median county in the state, including ten silver, ten bronze, eight gold, two platinum, and three catastrophic plans. In addition, benchmark QHP premiums in Minnesota were at least 17% lower than in any other state. For 2015, although the low-cost carrier that covered the most QHP members has withdrawn from the Minnesota marketplace, another carrier has taken its place. The total number of QHP options rose from 78 to 84, and state officials project urban benchmark premiums will remain the country's lowest.
- **The marketplace reports that it can cover its administrative costs, despite a smaller base of QHP enrollment on which to levy premium surcharges.** MNCare pays its proportionate share of marketplace costs related to eligibility and enrollment, replacing at least some of the lost premium surcharge revenue. The marketplace's capacity for self-support is also enhanced by the projected 69% decline in administrative costs in 2015 as work transitions from building infrastructure towards ongoing operations.

ALTERNATIVE APPROACHES TO IMPROVING AFFORDABILITY

States may consider alternatives to BHP, which include state-funded subsidies to supplement PTCs and CSRs in the marketplace and, in the future, more comprehensive approaches through state innovation waivers. Starting in 2017, broad state innovation waivers may allow states to develop methods bolder than BHP for making coverage affordable to low-income consumers. These waivers allow far-reaching (albeit budget-neutral to the federal government) restructuring of the ACA's fundamental architecture. In the meantime, the most plausible alternative to BHP for states interested in improving affordability involves supplementing PTCs and CSRs. That approach imposes state costs, even if the federal

government continues to provide Medicaid matching funds for state-furnished PTC supplements. Moreover, such supplementation will not shield consumers from income-tax reconciliation, and it may not let states achieve some of BHP's potential cost savings. On the other hand, a state that supplements PTCs and CSRs does not shrink its marketplace, is not at risk for costs other than those involving supplemental subsidies in the marketplace, and can help residents with incomes above 200% FPL. A state committed to improving affordability needs to carefully consider the many trade-offs inherent in these various alternative approaches.

CONCLUSION

BHP offers the prospect of improved affordability for low-income residents, fiscal gains for some states, and reduced churning. However, it also poses financial risks for states and has implications for state marketplaces. In the coming years, some states may investigate a range of approaches to improving affordability of coverage for their low-income residents. Which approach is best—BHP, state supplementation of marketplace subsidies, or bolder alternatives permitted under state reform waivers that begin in 2017—will depend greatly on the unique circumstances facing each individual state.

Introduction

Beginning in 2015, states have the option to implement a Basic Health Program (BHP) providing low-income consumers with coverage outside health insurance marketplaces, which are sometimes called “exchanges.” The BHP option, provided by the Patient Protection and Affordable Care Act (ACA), permits a state to contract with “standard health plans” that serve consumers with incomes at or below 200% of the federal poverty level (FPL) (about \$39,500 for a family of three in 2014) who would otherwise qualify for subsidized marketplace coverage.¹ States opting for BHP receive federal funding equal to 95% of what the federal government would have paid in marketplace subsidies for BHP enrollees. BHP beneficiaries must receive coverage at least as affordable and comprehensive as what they would have obtained from a qualified health plan (QHP) participating in a marketplace.

Most states considering BHP have sought to provide low-income consumers with more affordable coverage than will be offered in marketplaces, using models provided by Medicaid or the Children’s Health Insurance Program (CHIP). These models lower the overall cost of coverage by reducing provider payments below levels in the private market and using state leverage to negotiate aggressively with health plans, thereby permitting nominal premiums and cost-sharing. Early microsimulation modeling estimated that such savings would let states use 95% of marketplace subsidies to provide consumers with substantially more affordable coverage than would be available from subsidized QHPs.²

In March 2014, the Centers for Medicare & Medicaid Services (CMS) published final BHP regulations³ and a final methodology for calculating state BHP payments in calendar year 2015,⁴ the first year when states will be allowed to operate BHP. This paper begins by summarizing these federal policies, including the requirements for BHP as well as the methodology for determining federal BHP payments. It then analyzes the key trade-offs facing states as they decide whether and, if so, how to implement BHP, with a particular focus on the impact of BHP on state budgets and the size, stability, and risk level of state marketplaces.

Requirements for a State BHP

ELIGIBILITY

As envisioned by states considering BHP, this option would provide more affordable coverage for low-income consumers than what they would obtain in the marketplaces. BHP is available to consumers with incomes at or below 200% FPL who would otherwise qualify for marketplace subsidies. Eligible consumers include those who:

- Are state residents;

Medicaid expansion and BHP eligibility

For citizens and qualified immigrants, BHP is not available below 133% FPL. If a state implements BHP without expanding Medicaid eligibility, such consumers between 100 and 133% FPL qualify for marketplace subsidies, those between 133 and 200% FPL can be eligible for the BHP but not marketplace subsidies, and those above 200% FPL can again qualify for marketplace subsidies. Such “stop-and-start” eligibility for marketplace subsidies makes it unlikely that states will implement BHP without a Medicaid expansion, even though they have the legal right to do so.

If a state expands Medicaid to 138% FPL, citizens and qualified immigrants are ineligible for BHP at or below 138% FPL, because they will be eligible for minimum essential coverage through Medicaid.

- Are age 64 or younger;
- Are U.S. citizens or legally residing immigrants;
- Either have income between 133 and 200% FPL or have income below 133% FPL but are not eligible for federally-matched Medicaid because of their immigration status;
- Are not eligible for other forms of minimum essential coverage, including CHIP and Medicaid (other than for pregnant women’s coverage or a form of Medicaid that offers less than full scope benefits, such as coverage limited to family planning services); and
- Are not offered affordable coverage from an employer.

A state must cover all eligible consumers, statewide. A BHP cannot cap enrollment, use a waiting period for those with prior coverage, set an upper income limit on eligibility below 200% FPL, or otherwise fail to enroll eligible applicants. However, to promote the smoother transition of individuals from marketplace coverage to BHP, a state can implement alternative initial enrollment strategies on a transitional basis during 2015 with CMS approval.⁵

COVERED SERVICES AND CONSUMER COSTS

A standard health plan provided through BHP must cover all ten Essential Health Benefits (EHBs) that are required for QHPs nationally. States adopting BHP have the flexibility to use a combination of more than one base benefit option. A BHP may cover additional services, but not fewer services, than those required for QHPs. Several specific benefit requirements for QHPs also govern BHP, including the following:

- Each plan must provide the state with its list of covered prescription drugs and meet prescription drug coverage requirements applicable to QHPs;
- Benefit design may not be discriminatory; and
- Federal funds may not be used for abortion services, except in the case of rape, incest, or danger to the woman’s life.⁶

BHP premiums⁷ and out-of-pocket cost-sharing levels⁸ may not exceed the amounts that would have been charged if BHP beneficiaries had enrolled in the so-called “reference” or “benchmark” plan—that is, the second-lowest cost silver-level QHP. These costs take into account the premium tax credits and cost-sharing reductions for which enrollees would have qualified. Accordingly, BHP premiums cannot exceed the percentages of household income shown in Table 1, which reflect the structure of premium tax credits. The cost-sharing reductions available in the marketplaces raise the actuarial value of plans to lower deductibles, co-payments, and out-of-pocket maximums. To meet these requirements, BHP actuarial values (AV) cannot fall below the levels shown in Table 2. In addition, American Indians and Alaska Natives (AI/AN) cannot be charged any cost-sharing—put differently, their standard health plans must have an actuarial value of 100%.⁹ While BHP consumers may not be charged more than they would have been charged in the marketplace, states can set lower premium payments and cost-sharing requirements.

As an additional protection, any BHP variations of premiums and out-of-pocket cost-sharing based on income cannot favor higher-income beneficiaries.¹⁰ Other QHP safeguards also apply, such as the prohibition against cost-sharing for preventive services.¹¹ As with QHPs, BHP plans must accept premium and cost-sharing payments made by Ryan White programs, AI/AN organizations, and state and federal government programs.¹²

Table 1. Maximum Permitted Premium Charges to BHP Consumers in 2015

Income (FPL)	Maximum permitted premium
<133%	2% of household income
133-149%	3% to 4% of household income (on a linear sliding scale)
150-200%	4% to 6.3% of household income (on a linear sliding scale)

Source: CMS 2014. Note: These income contribution amounts do not reflect the slight increases recently announced by the IRS, which are described below.¹³

Table 2. Minimum Required Actuarial Value for BHP Consumers

Consumer Characteristics	Actuarial Value
Up to 150% FPL	94%
151-200% FPL	87%
American Indian/Alaska Native (up to 200% FPL)	100% (no cost-sharing is permitted)

Source: CMS 2014

In one important respect, BHP consumers are exempt from a cost that can apply in marketplaces. QHP enrollees who claim advance payment of premium tax credits (APTCs) must reconcile those payments on their federal income tax returns. APTC claims, which are based on projected income for the year, are compared to PTCs based on the taxpayer’s final annual income. If the APTCs turn out to have been too high, consumers must repay some or all of the excess, through taxes owed or a reduced refund. If APTCs were too low, taxpayers can claim an additional credit on their return. Since BHP enrollees do not receive APTCs, they are not subject to tax reconciliation.

HEALTH PLANS

In states adopting BHP, BHP-eligible consumers cannot receive subsidized coverage through the marketplace, and are instead covered through a “standard health plan.”¹⁴ States may contract with the following types of entities to offer standard health plans:

- Licensed health maintenance organizations (HMO);
- Licensed health insurers, in which case the plan’s medical loss ratio must be at least 85%;¹⁵
- Non-licensed HMOs participating in Medicaid or CHIP; or
- Networks of health care providers demonstrating the capacity to meet the state’s minimum required negotiating criteria for its competitive contracting process. Such networks must be “capable of meeting the provision and administration of standard health plan coverage, including but not limited to, the provision of benefits, administration of premiums and applicable cost sharing and execution of innovative features, such as care coordination and care management” and “may include but [are] not limited to: Accountable Care Organizations, Independent Physician Associations, or a large health system [sic].”¹⁶ This provider network category could allow BHP plans to include innovative health care delivery systems with alternative financing methods that seek to improve population health and quality while slowing cost growth.

As a general rule, states must assure CMS that each BHP enrollee will have a choice of standard health plans from at least two offerors. However, a state may request an exception by demonstrating that it has reviewed (1) whether it is insisting on contractual requirements beyond those needed under federal law; (2) whether additional negotiating flexibility would be consistent with statutory requirements and available funding for the BHP; and (3) whether potential bidders have received enough information to participate in the BHP.¹⁷

BHP programs must meet competitive contracting requirements, except in 2015 for states that show they are unable to do so.¹⁸ Those requirements include standard state procurement procedures for federal grants.¹⁹ They also entail negotiation of premiums, cost-sharing, and benefits and include innovative features, such as:

- Care coordination and care management for enrollees (especially those with chronic conditions);
- Incentives for using preventive care; and
- Strategies to maximize patient involvement in health care decision-making, including through incentives for appropriate utilization and provider choices.

In clarifying the meaning of “negotiation,” CMS explained that “nothing precludes a state from establishing standards that will serve as the starting point for negotiations with standard health plans offerors.” That approach would leave room for negotiation around such elements as “price [paid by the state], the provision of benefits in addition to those specified in the state’s solicitation, lower premium and cost-sharing amounts than those specified in the state’s solicitation, or any other aspects of the state’s program...”

In its plan procurement process, the state must also consider additional criteria that ensure:

- Consideration of enrollees’ health care needs;
- Provider networks that meet applicable standards (discussed below);
- Managed care or similar processes to improve quality, accessibility, appropriate utilization, and efficiency of service provision;
- Performance measures and standards related to quality and improved outcomes;
- Coordination with other insurance affordability programs to ensure continuity of care; and
- Fraud prevention while ensuring consumer protection.

Much like marketplace contracts with qualified health plans, state contracts with standard health plan offerors must address “network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, [and] provisions protecting the privacy and security of personally identifiable information.” Such contracts also need to address other requirements specified by HHS, including those involving “service delivery model[s that] further... the objectives of the program.”²⁰

States have the option to enter into multi-state compacts to jointly contract with standard health plan offerors that serve BHP beneficiaries in more than one state. Such contracts may cover either statewide areas or specific areas within states.²¹

STATE INTERACTIONS WITH CONSUMERS

In promulgating BHP rules, CMS gave states the option to use existing administrative structures whenever possible, to promote continuity of coverage for consumers and to simplify program administration. Accordingly, for most aspects of BHP, a state can choose between its Medicaid rules and the rules that apply in the marketplace. This flexibility applies to:

- Criteria for health plan network adequacy, mentioned above;
- Rules and procedures for verifying eligibility;²²
- Rules and procedures for redetermining eligibility (except as described below);²³
- Standards for authorized representatives (if the state permits their use for BHP);²⁴
- Standards and procedures for certified application counselors (if the state permits their use for BHP);²⁵
- Effective dates of eligibility;²⁶
- Appeals rules and procedures;²⁷
- Enrollment opportunities (that is, either continuous enrollment, as under Medicaid, or open and special enrollment periods no more restrictive than those used in the marketplace);²⁸ and
- Grace periods for late payment of premiums and coverage lock-out periods for non-payment of premiums that either (1) meet marketplace requirements, if the state uses marketplace enrollment procedures for BHP, or (2) provide grace periods lasting at least 30 days and meet CHIP lock-out requirements, if the state uses Medicaid enrollment procedures for BHP.²⁹

Other specific consumer provisions apply to all BHPs. For example:

- Eligibility must be redetermined every 12 months, unless it is redetermined earlier based on information received from beneficiaries or third-party data sources. Although enrollees must report changes in circumstances as if they were receiving marketplace subsidies, states have the option to provide BHP eligibility continuously based on circumstances at the time of initial application. Such continuous eligibility remains in effect regardless of changed household conditions, so long as the beneficiary remains under age 65, a state resident, and not enrolled in another form of minimum essential coverage.³⁰ As explained below, federal BHP allotments are based on the assumption that all BHPs provide continuous eligibility.
- States must inform potential applicants and enrollees about the BHP, including benefits, any coverage tiers used by the state, and eligibility criteria. States must require health plans to provide clear information about premiums, cost-sharing, covered services (including amount, duration, and scope limits); to make available and update at least quarterly information about currently participating providers; and to meet other consumer information requirements that apply to QHPs.³¹
- States may not “discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.”³²
- BHPs must use the same streamlined application form and meet the same eligibility coordination requirements that apply to other insurance affordability programs.³³
- Consumers must receive the same opportunity to apply and to receive assistance with their application that extends to Medicaid applicants.³⁴ As with Medicaid, BHP eligibility must be determined by the state or

another governmental entity to which the state delegates the authority to determine eligibility,³⁵ and takes place within the single eligibility service that is used for all insurance affordability programs.

- American Indian and Alaska Native consumers must receive the benefit of specified safeguards that apply to marketplaces.³⁶

STATE INTERACTIONS WITH THE FEDERAL GOVERNMENT

BHP BLUEPRINT

States interested in establishing BHP must furnish CMS with a comprehensive Blueprint describing the structure and administration of the program. The BHP Blueprint provides the roadmap for how the program will operate and documents compliance with federal legal requirements. In addition to specifying the BHP's components, the Blueprint must also include a description of how the state will ensure program integrity, an operational assessment documenting agency readiness, a transition plan if the state is proposing an alternative enrollment strategy for 2015, and a description of the qualifications and responsibilities of the BHP Trust Fund trustees and the method of their appointment. In concert with the Blueprint, states must submit a funding plan that includes enrollment and cost projections for the first year, along with any sources of funding beyond the BHP Trust Fund.³⁷

States must seek public comment on the initial Blueprint and any significant revisions to the Blueprint prior to submission to CMS. Public comment is required for revisions that alter core program functions or make changes to the benefit package or enrollment/disenrollment policies. States are required to provide federally recognized tribes with an opportunity to provide input.³⁸ To further promote transparency and allow public input, HHS will post the submitted Blueprint online.³⁹

States have the option, as an initial step before submitting a complete Blueprint, to provide a more limited Blueprint that describes the BHP's basic elements. CMS can grant interim certification of this more limited document to provide states with some certainty as they continue program development and procurement.⁴⁰

States may not begin enrolling consumers into the BHP or receive federal payment until CMS provides full certification. This requires the Blueprint to provide a complete description of the program and its operations, document compliance with federal requirements, and demonstrate the integration of BHP with other insurance affordability programs to ensure seamless and coordinated coverage.⁴¹

FEDERAL REVIEW

States operating BHPs must submit annual reports to HHS that discuss any evidence of fraud and demonstrate compliance with requirements related to:

- Eligibility verification;
- Limitations on the use of federal funds; and
- Collection of quality and performance measures from all standard health plans.

The report must also address requirements specified by the Secretary and list any recommendations identified through an HHS audit or evaluation that the state has not yet implemented.⁴²

HHS may conduct annual reviews or audits of state BHPs to identify if states have violated any BHP requirements, including those that may lead to withdrawal of the Blueprint certification. Such oversight will also assess whether any BHP trust fund monies were improperly spent.⁴³

BHP TRUST FUND

A BHP state must establish a BHP trust fund as an independent entity or as a segregated account within the state's General Fund. All federal BHP payments must be deposited into the BHP trust fund, along with non-federal funds. The trust fund must be overseen by a Board of Trustees and only allowable expenditures—payments to standard health plans that reduce premiums or cost-sharing or provide essential or additional benefits for BHP enrollees—are permitted.⁴⁴

Sound fiscal policies must ensure accountability in the receipt and expenditures of trust fund monies, including:

- Maintaining accounting records, including retaining records for at least three years;
- Obtaining annual certification that BHP trust funds are being used in accordance with federal requirements;
- Conducting an independent audit of expenditures; and
- Publishing annual reports of BHP trust fund expenditures.⁴⁵

The BHP trustees and the state must also develop policies and procedures to ensure restitution, within two years, of any BHP trust funds that may not have been properly spent. If no provision is made to restore improperly spent funds, states may be required to return those funds to HHS.⁴⁶

WITHDRAWAL AND TERMINATION OF BHP

A BHP may be terminated by a state or HHS. A state deciding to end BHP must submit written notice to HHS no later than 120 days before termination and include a proposed plan for transitioning consumers to other insurance affordability programs. Once a state receives approval, it is required to inform consumers and standard health plan offerors of its intention at least 90 days before the termination date. To ensure continuity of coverage, the state must transfer eligibility and verification information electronically to the marketplace or the Medicaid agency and inform consumers of their assessed eligibility for other insurance affordability programs.⁴⁷

HHS may withdraw certification of a BHP Blueprint if it determines the Blueprint no longer meets applicable requirements. A state must develop a transition plan for consumers within 30 days of the withdrawal of certification by HHS.⁴⁸

Federal Funding of State BHPs

As noted earlier, the federal government pays 95% of what BHP enrollees would have received in marketplace subsidies, had the state not implemented BHP. To calculate that amount, the federal government puts each BHP enrollee into a federal payment cell, which is defined based on county of residence, income, and other consumer characteristics. Before the year begins, the federal government announces the per enrollee amount it will pay for BHP enrollees in each payment cell.

When a state is about to start its BHP, the state projects quarterly enrollment levels in each cell. If those projections are deemed reasonable, CMS makes corresponding deposits into the state's BHP Trust Fund. Once actual enrollment data become available, CMS adjusts payment amounts so that, over time, the funding received by a state reflects actual rather than projected enrollment within each federal payment cell.

This section begins by explaining how federal payment cells are defined. It then touches on the timing for setting federal payment amounts. Finally, it uses one example to illustrate how CMS determines payment rates for each cell.

FEDERAL PAYMENT CELLS

Each BHP enrollee falls within a “federal payment cell” that is defined by the following characteristics of its members:

- County of residence;
- Age range (0-20, 21-34, 35-44, 45-54, 45-54, or 55-64);
- Income range (0-50, 51-100, 101-138, 139-150, 151-175, or 176-200% FPL);
- Household size; and
- Coverage status (single BHP coverage, two-adult BHP coverage, etc.).

THE TIMING FOR DEFINING FEDERAL PAYMENTS

As a general rule, the federal payment amounts for each cell—that is, the amount the federal government will pay for each BHP enrollee who fits within the cell—will be set prospectively, before the start of a BHP program year. The only uncertainty facing a state is thus the number of enrollees in each cell. This policy seeks to offer states fiscal predictability. If CMS changes its methodology for determining federal payment, those changes will be implemented only prospectively, for years after the change is made; they will not put into question funds already claimed by a state.

The precise methodology for calculating payments per cell may vary from year to year as CMS gathers experience with the operation of marketplaces and can better predict the subsidies that consumers would have received there. Proposed annual methodologies will be published in October, 15 months before the January start of the applicable BHP program year. The following February, 11 months before the BHP program year begins, annual methodologies will be finalized and federal payment amounts will be published, providing some lead time for state budget planning.

For 2015, the first year of potential BHP operation, the final payment methodology was published in early March, slightly later than is expected for future years. The timing of CMS publication of 2015 payment amounts will depend on various state choices, as explained in below. In the meantime, CMS will provide states with technical assistance to help project federal payment levels.

There are two exceptions to the general rule that federal payment amounts for each cell are not adjusted retrospectively. First, if a federal payment amount reflects an arithmetic error, the error will be corrected. Second, for 2015, a state can request a retrospective adjustment that, after the end of 2015, will change

marketplace premiums to compensate for the impact of BHP on the risk level within the individual market. This option reflects unique circumstances. Marketplaces and BHPs have not operated before, which makes it impossible for CMS to prospectively adjust for this factor. Such retrospective, population-wide risk adjustments are only provided for in the 2015 payment methodology, and CMS has not announced whether or not they will be allowed in future years.

DETERMINING THE PAYMENT AMOUNT FOR EACH CELL

The federal government pays the same amount for each BHP enrollee within a federal payment cell. That amount includes a premium tax credit (PTC) component plus a cost-sharing reduction (CSR) component. Those components equal 95% of what the average BHP beneficiary in the cell would have received in PTCs and CSRs, respectively, if the state had not implemented BHP and the beneficiary had enrolled in the second-lowest cost silver QHP rather than BHP.

Throughout the rest of this section, we will use an example payment cell to illustrate CMS' calculations. The illustrative payment cell includes all BHP enrollees with the following characteristics:

- Residence in Peoria County, IL;
- Age 45-54;
- Income between 139 and 150% FPL, inclusive;
- One-person household size; and
- Enrollment in single BHP coverage.

We explain below how the federal payment for each BHP enrollee within this payment cell is calculated to equal \$432 a month, combining a \$290 PTC component and a \$142 CSR component. At the conclusion of the section, we review all calculations in a text box, so readers can see how they all fit together.

THE REFERENCE PREMIUM

The starting point for defining the federal payment is the reference premium—that is, the average premium that would have been charged by the second-lowest-cost silver plan in 2015 to non-smokers in the BHP beneficiary's county and age range if the state had not established a BHP program. The average is calculated assuming that enrollees are evenly distributed by age within the payment cell. Premiums for non-smokers are used because PTCs are based on such premiums.

A BHP state makes two choices in deciding how CMS will determine its reference premiums in 2015:

1. As its first choice, a state could either:
 - Begin its calculations with actual marketplace premiums for the 2015 program year; or
 - Begin its calculations with 2014 marketplace premiums, trended forward to 2015 based on expected national changes to marketplace premiums from 2014 to 2015. CMS projects that national marketplace premiums will rise 8.15%, reflecting increased private insurance costs and changes in the ACA's transitional reinsurance program. To elect this second option, however, a state was required to inform CMS by May 15, 2014—a date that has now passed.

2. For its second choice, a state can either:

- Submit a protocol proposing a method for adjusting marketplace premiums retrospectively, after the end of 2015, to compensate for the impact of BHP implementation on average risk levels in the 2015 individual market; or
- Not adjust marketplace premiums to reflect the impact of BHP implementation on average risk levels in the individual market.

In our example, we assume that Illinois chooses to use 2014 marketplace premiums trended forward to 2015 and not to adjust marketplace premiums to reflect the effect of BHP on insurance risk levels. Calculation of the reference premium thus begins with 2014 QHP premiums. In 2014, the second-lowest-cost silver QHP in Peoria County, Illinois, charges non-smoking adults age 45-54 an average of \$345 a month for single coverage (Table 3). Increasing the \$345 premium for 2014 by 8.15% yields a 2015 reference premium of \$373.⁴⁹

Table 3. Monthly Premiums for Benchmark QHP in Peoria County, IL, for non-smoking, single adults ages 45-54, 2014

Age	Premium
45	\$282
46	\$293
47	\$306
48	\$320
49	\$334
50	\$349
51	\$365
52	\$382
53	\$399
54	\$417
Average 45-54	\$345

Source: Premium quotes from Healthcare.gov as of March 30, 2014. Averages are calculated assuming an even age distribution, as described in March 2014 BHP federal payment notice.

DETERMINING THE PTC COMPONENT

The next step is determining the percentage of household income QHP enrollees would spend on premiums for the “reference” or “benchmark” plan (that is, the second-lowest-cost silver QHP). For example, those percentages will be 3.0% at 133% FPL and 4.0% at 150% FPL in 2015, varying on a sliding scale between those “anchor points.” The average payment amount is then calculated for people in the federal payment cell, assuming an even distribution of households by FPL level. Subtracting that payment from the average reference premium yields an average PTC amount, approximating what consumers would have received in the marketplace.⁵⁰ Note: the Internal Revenue Service recently released updated percentages for 2015, which are slightly higher than those used for 2014—for example, consumers at 133% FPL must pay 3.02% of income,

rather than 3.0%, for benchmark coverage, and the contribution for those at 150% FPL has gone from 4.0% to 4.02% of income.⁵¹ For clarity's sake, the body of this paper will continue to use the simpler percentages that applied in 2014.

Here is how that calculation works in our example. For one-person adult households between 139-150% FPL, the average enrollee share of the premium payment for a benchmark plan is \$52, assuming the adults are evenly distributed by FPL level (Table 4). The resulting advance PTC for our group of middle-aged adults in Peoria County is \$321. That is the difference between the reference premium of \$373, which reflects the average cost of coverage based on the group's age and geography, and the average payment amount for benchmark coverage of \$52, which reflects their FPL and household size.

Table 4. Monthly premium payments required for the benchmark plan from single adults who have various incomes as a percentage of FPL: 2015

FPL	Monthly Income	Monthly Payment	
		Share of Income	Dollars
139%	\$1,352	3.4%	\$45
140%	\$1,362	3.4%	\$46
141%	\$1,371	3.5%	\$48
142%	\$1,381	3.5%	\$49
143%	\$1,391	3.6%	\$50
144%	\$1,400	3.6%	\$51
145%	\$1,410	3.7%	\$52
146%	\$1,420	3.8%	\$53
147%	\$1,430	3.8%	\$55
148%	\$1,439	3.9%	\$56
149%	\$1,449	3.9%	\$57
150%	\$1,459	4.0%	\$58
Average, 139–150% FPL			\$52

Notes: Assumes 2014 FPL levels, which will apply during the start of open enrollment for 2015. Premium payment levels for benchmark coverage are calculated as described in March 2014 BHP federal payment notice (3% of household income at 133% FPL, 4% of household income at 150% FPL, with premium payments increased on an even linear scale between those income levels). Averages assume an even distribution of income among households within each payment cell, by FPL level, as described in CMS payment notice.

The PTC is then adjusted to reflect the average impact of income tax reconciliation, had BHP consumers claimed advance payment of tax credits in the marketplace. CMS estimates that, for the average BHP enrollee nationally, such reconciliation would reduce PTCs by 5.08%. (This finding reflects CMS' assumption that BHP eligibility will not change at all during the year, regardless of actual income fluctuations.)

Finally, the resulting PTC amount is multiplied by 95% to determine the PTC component of the federal payment for each BHP enrollee in this cell.

In our example, making that 5.08% reduction to the \$321 PTC amount yields \$305. This is the estimated average amount that, after adjustment for tax reconciliation effects, individuals within this payment cell would have received in premium tax credits per month, if they had enrolled in QHPs rather than BHP in 2015. Illinois's federal payment amount for this cell thus includes a PTC component equal to 95% of \$305, or \$290.⁵²

DETERMINING THE CSR COMPONENT

The value of the CSR in the marketplace equals the portion of the total EHB health care claims for BHP enrollees that is paid by the increase in actuarial value resulting from the CSR. The CSR component of the federal BHP payment is then set to equal 95% of the value of the CRS in the marketplace. We describe each of these steps below.

The calculation of CSR value begins with an estimation of the average EHB health care claims covered by a silver-level plan charging the reference premium. To exclude administrative and other non-claim costs, CMS estimates that 80% of the reference premium is used to pay BHP claims, so 20% is subtracted from the reference premium.

Consumers also share in paying EHB claims through deductibles, copayments, and other cost sharing. Silver-level plans have an actuarial value of 70%, which means that, for an average population, the plans pay 70% of all covered claims. To add the amount of claims paid by the plan and consumers, the adjusted reference premium (less the 20% reduction for non-claims costs) is then divided by 70%.

As noted earlier, the reference premium amount in the payment cell used in our example is \$373 per month. Excluding the 20% of the premium related to administrative and other non-claim costs results in an average EHB claims amount of \$298.40. To determine the total amount of all covered claims, including payments from both the plan and the consumer, we divide \$298.40 by 70%, resulting in a total EHB claims amount of \$426.29.

These claims estimates are based on the reference premium that is charged for non-smokers. However, CSRs, unlike PTCs, pay the costs of tobacco-related care. CMS therefore increases the claims amount to reflect both the percentage of BHP enrollees who use tobacco (as shown by data from the Centers for Disease Control and Prevention, taking into account age and state)⁵³ and the estimated impact of tobacco use on health care costs (as shown by the difference between weighted average QHP benchmark premiums charged to tobacco users and non-users).⁵⁴

For purposes of our example, let us assume that, for Illinois residents age 45-54, CMS sets this tobacco adjustment to require a 30% average increase in EHB claims above the amount for non-tobacco users. Adding 30% to \$426.29 (that is, multiplying it by 1.3) results in a total average EHB claims amount of \$554.17.

One final adjustment is made to reflect the increased utilization resulting from the reduced cost-sharing faced by BHP enrollees. The calculations above reflect utilization of silver-level coverage, with 70% actuarial value. However, the federal payment cell in our example consists of consumers with incomes between 139 and 150% FPL, who will receive CSRs that raise the actuarial value of their coverage to 94%. This will reduce their cost-sharing, which in turn will increase their utilization. CMS estimates that such increased utilization will increase total claims by an average of 12%. Accordingly, the claims cost estimate for silver coverage must be increased by 12%, to reflect induced utilization.

Increasing the total claims amount in our example by 12%, to account for induced utilization resulting from lower cost-sharing, raises the average EHB claims per consumer to \$620.67.

As stated earlier, the value of the CSR component equals the increased share of health care claims paid by the federal government as a result of the CSR. The CSR increases the actuarial value of the reference plan by 24% for BHP enrollees with incomes at 133-150% FPL (AV = 94%) and by 17% for BHP enrollees with incomes at 150-200% FPL (AV = 87%). For those two groups the EHB claims costs estimates developed as described above are thus multiplied by 24% and 17%, respectively, to determine the CSR's value, had BHP enrollees received QHP coverage in the marketplace.

Finally, the resulting estimate of CSR value is multiplied by 95% to determine the CSR component of the federal payment for each BHP enrollee in this cell.

Our example involves BHP enrollees at or below 150% FPL. Accordingly, CSRs in the marketplace would have increased actuarial value from 70% to 94%, paying 24% of total claims. The average EHB claims amount in the marketplace for consumers in this payment cell is \$620.67 per month. The CSR's value in the marketplace would thus be 24% of such claims, or \$148.96 per month. The CSR component of the BHP payment is 95% of that CSR value, or \$141.51 a month—\$142, rounded off to the nearest dollar.

The total monthly federal BHP payment for each enrollee in this example payment cell equals the \$290 PTC component plus the \$142 CSR component, or \$432.

Calculating the Federal BHP Payment: A Recap

Reference premium for 2015

1. The average 2014 premium for non-smoking adults age 45-54 in Peoria County's second-lowest cost silver QHP (\$345) increased by the projected national average QHP premium increase for 2015 (8.15%) = \$373

Premium Tax Credit Component

2. Reference premium for 2015 (\$373) minus the average payment for benchmark plan in one-person households in this FPL range (\$52) = expected advance PTC amount (\$321)
3. Reduce expected advance PTC amount (\$321) by average tax reconciliation percentage assuming no mid-year eligibility adjustments (5.08%) = average PTC, post-tax reconciliation (\$305)
4. Multiply average PTC, post-tax reconciliation (\$305) by 95% for PTC component of BHP payment (\$290)

Cost Sharing Reduction Component

5. To determine EHB claims paid by silver-level QHP charging reference premium, exclude administrative costs (20%) from reference premium (\$373) = \$298.40
6. To add EHB claims paid by consumer, divide plan-paid claims (\$298.40) by silver level AV (70%) = \$426.29 in total EHB claims, including plan-paid claims plus consumer cost-sharing
7. Increase to add average claims costs for BHP smokers, as estimated by CMS. Assume CMS publishes 30% tobacco factor for BHP enrollees in this age group, raises EHB claims to \$554.17.
8. Increase claims (12%) to reflect greater utilization because of lower cost-sharing due to CSR. EHB claims = \$620.67.
9. In this FPL range, CSR in the marketplace would raise AV from 70 to 94%, so value of CSR is 24% of EHB claims (\$620.67) = \$148.96.
10. Multiply CSR value in the marketplace (\$148.96) by 95% to obtain CSR component of BHP payment (\$141.51, or \$142, rounded off to the nearest dollar)

Total Monthly Federal BHP Payment for Enrollees in Payment Cell

11. Add PTC component (\$290) and CSR component (\$142) = \$432

Key State Policy Questions

In this section of the paper, we begin by discussing the reasons some states have considered implementing BHP. We then explore the two main areas of concern that have been raised as arguments for not moving forward: namely, BHP's fiscal risks for states and BHP's potential adverse effects on marketplaces.

RATIONALE FOR BHP

Several states have seriously considered BHP. Depending on the state, the objectives prompting consideration have included the following:

Increasing the affordability of coverage for low-income adults. One analysis attempting to quantify the potential gains in this area found that providing BHP coverage like that offered by many state CHIP programs would lower monthly premiums for the average eligible adult under 200% FPL from \$100 a month, in subsidized marketplace plans, to \$8 a month.⁵⁵ It also found that average annual out-of-pocket costs would fall from \$434, in subsidized marketplace plans, to \$96. Making coverage more affordable could increase low-income consumers' willingness to enroll and, once enrolled, to obtain necessary non-emergency care.

Experience with 2014 QHP enrollment reinforced the importance of these goals. An inability to afford coverage was the most commonly reported reason consumers remained uninsured as of June 2014, according to the Health Reform Monitoring Survey, a quarterly survey of the nonelderly that monitors ACA implementation. Among the uninsured with incomes between 139 and 400% FPL—the main target group for marketplace subsidies—52% cited financial reasons for not enrolling.⁵⁶ However, within that group, 40 percent had heard “little or nothing” about subsidies; and even among the remainder, who reported hearing “some” or “a lot” about subsidies, the perceived unaffordability of QHP coverage may not reflect accurate and complete information about available assistance.

Reducing “churn” between health plans. If Medicaid, CHIP, and BHP were combined so that the same health plans served all residents with incomes at or below 200% FPL, the total amount of “churning” between Medicaid plans and marketplace plans would decline by 16%, according to the only published analysis that took into account unaccepted offers of employer-sponsored insurance.⁵⁷ Moreover, final BHP regulations permit states to provide BHP enrollees with continuous, 12-month eligibility, based on household circumstances at the time of application, regardless of later, mid-year changes. In fact, federal BHP funding is premised on such continuous BHP eligibility, as noted earlier.⁵⁸ Implementing such continuous eligibility could greatly reduce mid-year transitions between insurance affordability programs.

Protecting consumers from the risk of tax reconciliation. As noted earlier, BHP consumers do not receive APTCs and so are not subjected to tax reconciliation. Shielding uninsured consumers from this risk could increase their willingness to enroll into subsidized coverage. Once the APTC reconciliation requirements become widely understood, some consumers who qualify for APTCs could choose to remain uninsured rather than risk losing tax refunds or owing money to the federal government due to tax reconciliation.

Achieving significant state budget savings while preserving existing access to care for beneficiaries of pre-ACA state programs. Before the ACA, some states covered low-income adults

through Medicaid waiver programs or using state-only funding. This coverage was typically much more affordable for consumers and, in some cases, offered more generous benefits than subsidized marketplace insurance. BHP lets states continue pre-ACA coverage for these groups, while substituting federal for state funding. Otherwise, such states face the dilemma of either: (1) moving their residents into the marketplace—thus saving state money but increasing residents' health care costs and potentially reducing their access to care—or (2) continuing to provide low-income residents with state-funded help—thereby preserving their pre-ACA access to care but persisting with state expenditures not paid by other states for similar populations.

Providing coverage that reflects state rather than federal policy preferences. Some state officials expressed interest in using BHP to provide low-income consumers with coverage like that furnished to children at similar income levels under state CHIP programs. They sought to use approaches preferred by state policymakers, rather than providing subsidies defined in federal laws governing marketplace coverage. In other states, officials felt that objectives related to delivery system reform might be better achieved with direct state control through BHP rather than through marketplace QHPs, particularly in federally facilitated marketplaces.

STATE FISCAL ISSUES

While BHP offers states federal funding that can be used to provide low-income consumers with more affordable coverage, its financing structure creates fiscal issues for states. Federal BHP funding equals 95% of what the federal government would have paid in premium and cost-sharing subsidies for BHP enrollees. If that funding proves insufficient to cover program costs, states will be responsible for covering any shortfalls. States must thus carefully compare BHP costs to available federal funding, taking into account any state savings created by BHP. This section explores these fiscal issues and discusses strategies for mitigating state risks.

ESTIMATING TOTAL FEDERAL FUNDING AND STATE BHP COSTS

A critical step in assessing the financial feasibility of BHP and estimating available federal funding is to identify the characteristics of BHP-eligible consumers. Previous sections of this report explain how CMS will set federal funding amounts for particular BHP consumers, but to project total federal funding levels, states will need to estimate the distribution of BHP-eligible consumers, by geography, age, and income. Among surveys conducted by the U.S. Census Bureau, the American Community Survey (ACS) has the largest state-specific samples and so is likely to provide the most reliable estimates. However, a limitation of this data set is that ACS data do not include information about offers of employer-sponsored insurance (ESI), which almost always preclude subsidy eligibility.⁵⁹ States that fail to take such offers into account will overestimate the prevalence of relatively high-income BHP-eligible consumers, since ESI offers grow increasingly common as income rises.⁶⁰ As a result, such states will underestimate federal BHP funding per BHP enrollee, since QHP subsidies, hence BHP funding levels, decline as income rises.

State BHP rules will affect federal funding. A state could structure its BHP program to boost the enrollment of consumers who qualify for particularly high federal funding levels. A state might encourage the enrollment of low-income BHP consumers, for example, by entirely or almost entirely eliminating premium charges for enrollees below a specified FPL level. Such consumers receive particularly large QHP subsidies and so would draw down particularly high federal BHP payments. Increased enrollment of low-FPL consumers, relatively to those with somewhat higher FPL levels, would likely increase the overall ratio of federal funding to state BHP costs, perhaps by non-trivial amounts.

States must carefully estimate BHP costs, exploring mechanisms to reduce those costs, if needed. Medicaid expenditures per member per month for healthy adults, increased to furnish provider reimbursement and associated plan payments to somewhere between Medicaid and QHP levels, can represent a useful starting point for estimating the cost of BHP adult coverage.⁶¹ A state can lower those costs by increasing out-of-pocket cost-sharing above Medicaid levels, which lowers utilization. Along similar lines, varying the scope of covered benefits can affect BHP coverage costs.⁶² The state could also impose or raise consumer premium charges.⁶³

Provider reimbursement and associated plan payment levels also influence BHP coverage costs. A state that further raises these amounts above Medicaid levels will increase BHP costs. If that increase would cause state costs to exceed federal funding levels or state policymakers' fiscal targets, offsetting program changes may be needed, such as benefit reductions or increases in consumer cost-sharing (so long as they do not violate the baseline federal requirement that BHP consumers must receive at least the covered benefits and cost-sharing protections that would have been available in the marketplace).⁶⁴ On the other hand, a state could reduce BHP costs by lowering provider and plan payments towards Medicaid levels, but that would limit provider networks, with potentially adverse effects on access to care, depending on the state.

States can finance BHP administrative costs through assessments on BHP participating plans.

As explained earlier, federal BHP dollars cannot directly pay for BHP administration. However, states can leverage BHP's new infrastructure to obtain administrative funding. As CMS explained, "states have the option to establish sources of non-federal funding to help offset administrative costs associated with BHP. Non-federal resources can include assessments imposed on BHP participating plans."⁶⁵

A BHP can thus fund administrative costs by surcharging BHP-participating plans. The resulting revenues are non-federal resources, which can pay BHP administrative expenses. Those assessments are part of standard health plans' costs, funded through premiums. The premiums, in turn, are paid using federal BHP funds. Many marketplaces use a similar strategy by raising administrative funds through QHP assessments. QHPs incorporate those assessments into higher premiums, which federal PTCs help pay.

POTENTIAL STATE BUDGET SAVINGS

States assessing their potential financial exposure could also consider potential sources of state budget savings that might result from BHP implementation.

State-funded populations could be shifted into BHP. Depending on state circumstances, the resulting state savings may involve the following groups:

- Lawfully present pregnant non-citizen women whose incomes are at or below 138% FPL receive, in many states, optional Medicaid coverage under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 or CHIP coverage. No maintenance-of-effort requirement applies to such women over age 18. A state implementing BHP could move them into federally-funded BHP without reducing their benefits or increasing their costs.
- Other lawfully present non-citizens whose incomes are at or below 138% FPL and who are ineligible for federal Medicaid funds because of immigration status receive state-financed health coverage in some states. Without BHP, such immigrants could receive subsidized QHP coverage, which may be significantly less

affordable than what the state previously furnished. BHP would let the state continue providing those immigrants with coverage along pre-ACA lines while shifting the cost of their care to the federal government.

- Pregnant women with incomes between 138 and 200% FPL receive optional Medicaid coverage in most states. A state implementing BHP could move such women who are over age 18 (to whom maintenance-of-effort requirements do not apply) into federally-funded BHP while preserving all the benefits and cost-sharing protections formerly provided by Medicaid. In some states, when women in this income range become pregnant, they must move from QHPs to Medicaid plans if they want to access Medicaid's additional services and cost reductions. If BHP is provided through the same plans that serve Medicaid beneficiaries, women could stay with the same plan and provider when they get pregnant without surrendering Medicaid's services and cost-sharing protections. Preserving continuity of care during pregnancy would ameliorate this potentially important form of churning, affecting low-income pregnant women, not discussed above.

BHP “covered lives” may give states additional negotiating leverage to obtain lower bids from plans or providers seeking to serve both Medicaid and BHP consumers. Even a small percentage reduction in Medicaid's per member per month costs could yield significant savings, given the total size of Medicaid managed care contracts in most states. Savings might also result from lower per unit costs if BHP is added to administrative services contracts that benefit multiple, state-administered health programs.

BHP benefits could be structured to substitute for state-funded services. For example, BHP could provide coverage for services such as mental health and substance abuse treatment of an amount, duration, and scope that exceeds the commercial benefits covered by QHPs. BHP provider networks could also be structured to assure or increase state fiscal gains in these areas.

LIMITING STATE FINANCIAL RISKS

As noted earlier, a state that implements BHP assumes the risk of a larger-than-anticipated gap between state BHP costs and federal BHP funds. Policymakers may be concerned that more than an expected amount of state general funds could ultimately be required to cover any resulting shortfall. Despite the efforts by federal officials to ensure a predictable level of federal funding, states face some inevitable uncertainties. The most important such uncertainties may involve fluctuating QHP benchmark premiums during the early years of marketplace operations, which directly influence federal BHP funding amounts. Such uncertainties are mitigated by CMS's publication of BHP payment amounts for each year in February of the previous calendar year and state options to base a year's BHP payments on the previous year's QHP benchmark premiums, trended forward based on CMS national projections. These two policies give states time to respond when QHP benchmark premiums change in surprising ways.

To limit fiscal uncertainties associated with the BHP, states can explicitly share risks with health plans through contractual contingencies. For example, a small proportion of payments to health plans could be held back until after the end of the year. Along similar lines, health plan contracts could reserve the right for states to reduce payment amounts if unforeseen shortfalls emerge. Similar contract language is already standard in many states for Medicaid and other programs.

States can maintain modest funding reserves to cover future shortfalls. CMS has made clear that a state is not required to spend all of its federal BHP funding during the year in which such funding is provided.

One year's funds can be retained and used for future BHP consumers.⁶⁶ A state BHP could thus carry over modest reserves to guard against future contingencies.

States must carefully consider the trade-offs of any strategies to mitigate financial risks. If a state uses its leverage with health plans to ask them to share risks, the state will have less leverage to obtain other desired concessions. And if for a given year a state holds some federal BHP funds in reserve, such a decision could translate into fewer covered services, higher costs for beneficiaries, or lower reimbursement levels for plans (and hence providers) during that particular year.

IMPACT OF BHP ON A STATE'S MARKETPLACE

Implementing BHP will reduce the size of the state's marketplace and potentially change its risk pool. This section explores those effects.

A SMALLER MARKETPLACE

BHP will reduce marketplace size. Microsimulation estimates of the impact of BHP on the marketplace conducted before the start of open enrollment in October 2013 suggested that, in the average state under full ACA implementation, BHP would reduce the number of APTC-recipient marketplace enrollees by about half, from 3.1% to 1.6% of residents under age 65. Adding unsubsidized enrollees, the average marketplace was projected to shrink by 20% under BHP, from 6.5% to 5.2% of non-elderly residents.⁶⁷ Now that the open enrollment period has ended, policymakers should be able to determine the percentage of marketplace enrollees whose incomes are at or below 200% FPL and who would leave the marketplace if their state implemented BHP. New York is the only state to publish income tabulations describing QHP enrollment. There, 39% of QHP beneficiaries are under 200% FPL and would leave the marketplace following BHP implementation; 35% qualify for subsidies with incomes between 200 and 400% FPL; and 26% of QHP enrollees are unsubsidized, with incomes above 400% FPL.⁶⁸

A smaller marketplace is highly unlikely to become unstable, in most states. Before the ACA, purchasing pools could become dangerously unstable and experience so-called "death spirals" when small size made them vulnerable to adverse selection. Prior to the ACA's insurance market reforms, a pool's premiums were based on risk levels within the pool. As a result, a few costly enrollees in a small pool could raise premiums significantly. Healthy consumers could then buy the identical coverage for a much lower cost outside the pool. Many healthy consumers would leave the pool, further raising the average risk level within the pool, further raising premiums, causing an exodus of the healthiest remaining consumers, etc.

This is highly unlikely to happen with the ACA's insurance reforms and market stabilization mechanisms, which share risk across the entire individual market. Insurance rating rules, risk-adjustment mechanisms, pooling requirements, and reinsurance seek to make the cost of coverage reflect the risk level of the individual market as a whole, rather than the risk level of enrollees within a particular plan or within the marketplace. Consequently, even if a relatively small marketplace attracts members who are comparatively unhealthy, marketplace premiums are unlikely to rise above the level charged outside the marketplace by more than a small amount. Moreover, the healthiest marketplace enrollees cannot purchase the identical coverage elsewhere for a substantially lower cost. At the same time, a coverage mandate brings healthy enrollees into the individual market, lowering the overall risk level. Illustrating the stability yielded by ACA-like insurance reforms, Massachusetts's Commonwealth Choice marketplace, which was limited to unsubsidized consumers

above 300% FPL, remained perfectly stable even though, during its first three years, it served less than one-half of one percent of non-elderly residents (see text box).⁶⁹

A smaller marketplace may need to charge higher amounts to cover administrative costs. Some administrative costs vary with size and will decline if a marketplace shrinks. Other costs are fixed, however. The latter will need to be spread across a smaller base if a state implements BHP. Accordingly, if a marketplace relies on QHP assessments to fund administrative costs, the amount charged per plan will rise. If the result is higher QHP premiums, consumers who qualify for tax credits will be largely unaffected, but unsubsidized consumers would face a somewhat higher cost for coverage inside the marketplace than outside.⁷⁰ To address this problem, BHP could help pay marketplace administrative costs, in proportion to benefits received, as is taking place in Minnesota (described below); or the marketplace could apply surcharges to BHP standard health plans.

A smaller marketplace may have less appeal to carriers. With fewer covered lives in the marketplace, carriers may be less interested in offering coverage. As a result, marketplace consumers could have fewer plan options. While this would simplify consumer choice, some consumers may have valued the options that are lost. Moreover, it is not clear whether carriers would have the same incentives to lower premiums and maximize market share if fewer covered lives are at stake.

A Tiny but Stable Health Insurance Marketplace: The Massachusetts Experience

The much greater stability of purchasing pools under reform has already been observed in Massachusetts, which implemented policies like those the ACA has put in place nationwide. That state's Commonwealth Choice program began in July 2007, functioning as a health insurance marketplace serving individuals with incomes above 300% FPL and some small firms. By the end of 2007, slightly fewer than 15,000 people received individual coverage.⁷¹ Enrollment was still under 20,000 by the end of 2008.⁷² By July 2010, several programs for small employers were added, and total enrollment reached approximately 35,000, of whom nearly 27,000 received individual coverage.⁷³ At no point did the small number of people receiving individual coverage through the exchange cause its destabilization.

If anything, greater challenges faced Commonwealth Choice than marketplaces in states that implement BHP. The Massachusetts program was limited to consumers over 300% FPL. More importantly, Commonwealth Choice offered no subsidies. By contrast, even in a state that implements BHP, marketplaces will be the only place where consumers with incomes between 200 and 400% FPL can obtain subsidized coverage, providing a force for stability and enrollment of healthy consumers that was not present with Commonwealth Choice.

EFFECT ON THE MARKETPLACE RISK POOL

BHP's impact on the risk pool will depend on state circumstances and should not be exaggerated. The health status of BHP-eligible consumers will affect the risk pool of the marketplace. While lower income is associated with poorer health status, BHP-eligible consumers are more likely to be young adults, who are typically healthier, compared to others in the individual market. Analysts using the Urban Institute's Health Insurance Policy Simulation Model found, for example, that because many Utah adults below

200% are relatively young, BHP implementation in that state would raise premiums in the individual market, hence in the marketplace, by approximately 2%; but in Washington State, where low-income adults tend to be older than in the country as a whole, BHP implementation would not change the individual market's risk level.⁷⁴

Regardless of the state, however, the magnitude of BHP's impact should not be exaggerated. As noted earlier, marketplace enrollees are pooled together with other participants in the individual market. Accordingly, if consumers under 200% FPL move from marketplace to BHP, the risk pool of the entire individual market will be affected, not just the smaller pool within the marketplace. The proportionate impact on risk levels, hence premiums, will thus be smaller than is sometimes envisioned.

The effect of the BHP on the marketplace risk level also depends on the extent to which a state's Medicaid program covers high risk individuals, including pregnant women and people with disabilities between 138 and 200% FPL.⁷⁵ A state with broad Medicaid eligibility in this income range has fewer high-risk individuals whom BHP would shift out of the marketplace. How low-income adult demographics and Medicaid coverage play out—and so how BHP implementation would affect the individual market's risk pool—vary greatly by state.

BHP can be structured to improve the individual market risk pool. If BHP is more affordable than subsidized marketplace coverage, BHP will likely attract some healthy consumers who would not enroll into the marketplace. CMS has made clear that federally-operated risk-adjustment systems cannot include BHP. However, a state-operated risk-adjustment system can combine BHP standard health plans with individual market carriers.⁷⁶ That would keep consumers below 200% FPL within the individual market's risk pool while adding to that pool the better risks attracted by BHP's more affordable cost structure. The result would likely be a modest reduction to individual premiums charged both within and outside marketplaces.

Notwithstanding its appeal, this approach has trade-offs. Establishing and operating a risk adjustment system could require significant effort from state officials, even if much of the information technology infrastructure and methodologies required for such a system will already be in place because of the federal system. Moreover, BHP standard health plans will either receive or make risk-adjustment payments, modestly increasing the uncertainties such plans face at initial BHP implementation.

THE IMPACT ON MINNESOTA'S MARKETPLACE OF BHP-LIKE COVERAGE IN 2014

Minnesota policymakers plan to implement BHP starting in 2015. As a transition policy for 2014, consumers with incomes at or below 200% FPL do not receive QHP subsidies in Minnesota's marketplace. Instead, they are covered through the state's preexisting (but reconfigured) Medicaid waiver program, MinnesotaCare (MNCare). Excluding consumers under 200% FPL from the state's marketplace has not yet appeared to create significant problems along the lines suggested above.

- **QHP enrollment is reduced but remains robust.** According to the first data available after the end of open enrollment, 47,902 consumers had enrolled in QHPs by April 13, 2014, and 37,985 had joined MNCare.⁷⁷ Since then, MNCare enrollment has remained unconstrained, but only those qualifying for special enrollment periods have been able to sign up for QHPs. Accordingly, as of July 10, 2014, 52,233 consumers were covered through QHPs and 54,154 had joined MNCare.⁷⁸ Approximately half of all consumers who

applied for QHP subsidies were found eligible. These results were achieved despite significant problems with the marketplace's early rollout.

- **Broad carrier participation provides consumers with numerous QHP options.** Five different carriers, contracting with ten different provider networks, sponsored Minnesota QHPs in 2014. In the median county, consumers could choose from among 33 QHPs, including ten silver, ten bronze, eight gold, two platinum, and three catastrophic plans.⁷⁹ While this range of choices was significant, it was somewhat narrower than in the average marketplace rating area nationally, where five carriers offered 47 QHPs.⁸⁰ For 2015, although the low-cost carrier that covered the most QHP members has withdrawn from the Minnesota marketplace, another carrier has taken its place, and the total number of QHP options rose from 78 to 84.⁸¹
- **QHP reference premiums are very low, and the marketplace appears stable.** Rather than experiencing adverse selection that raised QHP premiums and risked a potential death spiral, Minnesota had the country's lowest benchmark QHP premiums in 2014, at least 17% below those in the second least-expensive state;⁸² and Minnesota's marketplace showed no signs of instability.⁸³ Even though the lowest-cost carrier has left the marketplace for 2015, average premium increases are forecast at 4.5 to 12 percent.⁸⁴ State officials characterize 2015 benchmark premiums in Minnesota's urban areas as continuing to be the lowest in the country.⁸⁵
- **The marketplace reports that it can cover its administrative costs, despite a smaller base of QHP enrollment on which to levy premium surcharges.** The marketplace has proposed a balanced budget for 2015, without requiring additional resources from the state or federal governments. Officials anticipate receiving \$11 million from a 3.5% "withhold" of premium revenues from QHPs, along with \$22 million from the Medicaid program—including MNCare. Marketplace operations involving enrollment and eligibility determination help achieve the purposes of MNCare and the underlying Medicaid program. The latter programs contribute to those functions in proportion to the benefits they receive. In effect, MNCare's implementation shifted some of funding of marketplace administration from health plan assessments to Medicaid. Another factor facilitating financial feasibility is that the marketplace's annual administrative costs are projected to fall by 69% in 2015 as the bulk of its work transitions away from initial infrastructure development and towards ongoing operations.⁸⁶

While serving consumers under 200% FPL through a separate system of coverage has not yet created significant problems for Minnesota's marketplace, problems might develop in the future.

ALTERNATIVE STATE OPTIONS TO MAKING COVERAGE MORE AFFORDABLE FOR LOW-INCOME CONSUMERS

States may consider state innovation waivers beginning in 2017. Broad state innovation waivers, which can go into effect starting in 2017, may allow bold approaches that combine federal resources offered by the ACA and, in ways that are budget-neutral to the federal government, provide low-income consumers with more affordable coverage than they would obtain in marketplaces with standard ACA subsidies.⁸⁷ However, CMS has not yet promulgated substantive guidelines, although Vermont long ago announced its plan to use such a waiver to implement a state-based single-payer system.

Until states can adopt innovation waivers, the most plausible alternative state-level method of improving affordability involves supplementing subsidies offered in the marketplace. For example, Massachusetts and Vermont, which used pre-ACA Medicaid waivers to provide subsidized coverage

to adults with incomes above 138% FPL, are lowering the cost of marketplace coverage by supplementing PTCs and CSRs for residents with incomes up to 300% FPL. A Medicaid waiver provides federal matching funds for PTC supplements;⁸⁸ but federal matching funds are not available for CSR supplements, which these states are therefore funding with state-only dollars.⁸⁹

The ACA permits states to supplement marketplace subsidies.⁹⁰ However, it is not clear that states with pre-ACA coverage less generous than that offered by Massachusetts and Vermont can obtain Medicaid waivers to help pay the cost of PTC supplements, since such states cannot argue that waivers are needed to prevent their low- and moderate-income residents from suffering harm. With or without such waivers, a state supplementation strategy involves state budget costs that need to be compared against potential costs under BHP.

A state supplementation approach has other important differences from BHP:

- It does not shield low-income residents from the tax reconciliation risks of losing tax refunds or incurring federal income tax debts if they inaccurately project annual income when they enroll.
- It would likely not provide the same reduction in “churning,” since most consumers would need to change plans when their income moves above or below 139% FPL, and since 12-month continuous eligibility will not be available.
- It may or may not provide the same opportunities for state budget savings, depending on state circumstances.
- It keeps consumers below 200% FPL in the marketplace, incorporating the healthier risks attracted by lower premiums into the individual market without requiring the state to administer risk adjustments.
- Consumers between 138 and 200% FPL will retain access to marketplace networks, rather than Medicaid provider networks, which may improve their access to care.
- It lets the state make coverage more affordable for residents with incomes above 200% FPL. For a BHP state to help such residents, it would need to combine BHP for consumers up to 200% FPL with marketplace supplements for consumers above that income level.

How Would a Rise in Risk Levels within a Marketplace Affect Consumers?

Increased risk levels within a marketplace are shared throughout a state's individual market. Each carrier pools all individual market enrollees, within and outside the marketplace. Moreover, risk-adjustments and reinsurance payments combine risks among all carriers' individual market plans. As a result, if marketplace risk levels rise, marketplace premiums will increase by less than would be the case without market-wide risk sharing, but premiums will also rise for individual plans outside marketplaces.

To illustrate the impact of higher risk on various consumers, suppose average risks inside a marketplace rise by 10%, risks outside the marketplace do not change, the marketplace includes half of all individual market enrollees within a state, and the ACA's risk-sharing mechanisms are fully effective. Individual market premiums will rise by 5%, both inside and outside the marketplace. Effects will vary among consumers, depending on whether they receive tax credits and which plan they choose, as follows.

- 1. Individual market enrollees, both within and outside the marketplace, who do not receive tax credits will see their premiums rise based on the average change in market-wide risk.** In this example, their premiums will increase 5%.
- 2. Tax credit beneficiaries who enroll in benchmark coverage will be unaffected.** If a tax credit beneficiary selects the second-lowest cost silver plan in the marketplace, his or her premium payment depends entirely on income. The plan's 5% premium increase will be paid entirely by higher tax credits.
- 3. Tax credit beneficiaries who enroll in coverage more expensive than the benchmark plan will pay slightly more in premiums.** They pay both their income-based amount and the difference between the benchmark premium and the higher premium charged by their chosen plan. If all marketplace premiums rise by 5%, that difference increases by 5%. For example, a single adult earning \$25,000 a year who chooses the benchmark plan pays 6.92% of income in premiums, or \$144 a month.⁹¹ If that adult instead enrolls in a plan that costs \$50 more than the benchmark plan, the consumer's monthly payments are \$194. If all premiums rise by 5%, the differential between the consumer's plan and the benchmark plan will be \$52.50, rather than \$50, so the consumer's monthly payment will be \$196.50—a 1.3% net increase.
- 4. Tax credit beneficiaries who enroll in coverage less expensive than the benchmark plan will pay slightly less in premiums.** They pay their income-based amount minus the difference between the benchmark premium and the lower premium charged by their chosen plan. If all marketplace premiums rise by 5%, that difference increases by 5%. To continue with the prior example, if a consumer earning \$25,000 a year picks a plan costing \$50 less than the benchmark, the consumer pays \$94 a month. If all premiums rise by 5%, the difference between the consumer's plan and the benchmark plan will be \$52.50, rather than \$50, so the consumer's monthly payment will be \$91.50—a 2.7% net decrease.

Conclusion

BHP offers prospects of improved affordability for low-income residents, fiscal gains for some states, and reduced churning. Structured carefully to attract good risks and share them with the rest of the individual market via state-administered risk-adjustment systems, BHP could improve the individual market's overall risk level, modestly lowering marketplace premiums. On the other hand, BHP would reduce marketplace size, potentially narrowing the range of QHP options and raising marketplace administrative charges.

In the coming years, some states may investigate a range of approaches to improving affordability of coverage for their low-income residents. Which approach is best—BHP, state supplementation of marketplace subsidies, or bolder alternatives permitted under state reform waivers that begin in 2017—will depend greatly on the unique circumstances facing each individual state.

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Notes

¹ Technically, a state contracts with a “standard health plan offeror” that sponsors a “standard health plan.”

² See, e.g., Stan Dorn, Matthew Buettgens, Caitlin Carroll. *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States*. Washington, DC: Urban Institute, Sept. 2011, <http://www.urban.org/UploadedPDF/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households.pdf>.

³ CMS. “Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity.” *Federal Register*. Vol. 79, No. 48 (March 12, 2014): 14112-14151, <http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05299.pdf>.

⁴ CMS: “Basic Health Program; Federal Funding Methodology for Program Year 2015.” *Federal Register*. Vol. 79, No. 48 (March 12, 2014): 13887-13906, <http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05257.pdf>.

⁵ 42 CFR 600.305.

⁶ 42 CFR 600.405.

⁷ 42 CFR 600.505.

⁸ 42 CFR 600.520(c).

⁹ 42 CFR 600.520(b).

¹⁰ 42 CFR 600.520(a).

¹¹ 42 CFR 600.510(b).

¹² 42 CFR 600.520(d). In addition, the state must provide consumers with access to information about premiums and cost-sharing at different income levels as well as the consequences if premiums are not paid. Such information must be made available upon request or through an Internet web site and at various key junctures, such as at enrollment and redetermination. 42 CFR 600.515.

¹³ IRS. *Revenue Procedure 2014-37*. <http://www.irs.gov/pub/irs-drop/rp-14-37.pdf>.

¹⁴ 42 CFR 600.415(a).

¹⁵ 42 CFR 600.415(b)(3).

¹⁶ 42 CFR 600.5

¹⁷ 42 CFR 600.420(a).

¹⁸ 42 CFR 600.410.

¹⁹ See 45 CFR 92.36 (b) through (i).

²⁰ 42 CFR 600.415(b)(1). These contracts must also include the provisions required for all state contracts that use federal grant funds, under 45 CFR 92.36(i).

²¹ 42 CFR 600.420(b).

²² 42 CFR 600.345.

²³ 42 CFR 600.340(c) and (d).

²⁴ 42 CFR 600.310(c).

²⁵ 42 CFR 600.315.

²⁶ 42 CFR 600.320(c).

²⁷ 42 CFR 600.335.

²⁸ 42 CFR 600.320(d).

²⁹ 42 CFR 600.525.

³⁰ 42 CFR 600.340.

³¹ 42 CFR 600.150.

³² 45 CFR 155.120(c)(2), cited in 42 CFR 600.165

³³ 42 CFR 600.310(a), 42 CFR 600.330.

³⁴ 42 CFR 600.310(b).

³⁵ 42 CFR 600.320(a).

³⁶ 42 CFR 600.160.

³⁷ 42 CFR 600.110.

³⁸ 42 CFR 600.115 (c).

³⁹ 42 CFR 600.110 (c).

⁴⁰ 42 CFR 600.110; 42 CFR 600.120 (a).

⁴¹ 42 CFR 600.120.

⁴² 42 CFR 600.170.

⁴³ 42 CFR 600.200.

⁴⁴ 42 CFR 600.705.

⁴⁵ 42 CFR 600.710.

⁴⁶ 42 CFR 600.715.

⁴⁷ 42 CFR 600.140.

⁴⁸ 42 CFR 600.142.

⁴⁹ These calculations assume that, in each case, premiums are rounded off to the nearest dollar. If instead calculations did not use rounding, the 2014 average premium would be \$344.70, and the 2015 reference premium would be \$372.79.

One other comment is appropriate. Illinois might seek to apply a retrospective adjustment to premiums based on the state's Medicaid coverage of pregnant women, outside the marketplace, to 200 percent FPL (and slightly higher). After the end of the 2015 BHP program year, actuaries could estimate the impact on Illinois's individual market risk pool if pregnant women covered through BHP in 2015 had instead received coverage in the individual market. The result could be a slight increase in reference premiums, hence federal BHP funding for 2015. We could not estimate the amount of that increase here, however, and assume that Illinois opts not to make this retroactive adjustment.

⁵⁰ FPL levels are based on the thresholds for calendar year 2014, since those will be in effect at the November 2014 start of 2015 open enrollment.

⁵¹ IRS. *Revenue Procedure 2014-37*. <http://www.irs.gov/pub/irs-drop/rp-14-37.pdf>.

⁵² As before, these numbers round off each product to the nearest dollar. Without such rounding, the PTC amount, before application of the IRF, would be \$321.06; the IRF would reduce that amount to \$304.75; and the final PTC component would 95 percent of the latter figure, or \$289.51.

⁵³ For an example of state-specific 2012 smoking rates by age, see Illinois's rates as reported by CDC: <http://apps.nccd.cdc.gov/brfss/age.asp?cat=TU&yr=2012&qkey=8161&state=IL>.

⁵⁴ To be more precise, the ratio between premiums charged to tobacco users and non-users shows the effect of tobacco use in raising claims costs above those that were covered by the premiums charged to non-tobacco users.

⁵⁵ Dorn, Buettgens, Carroll, op cit.

⁵⁶ Adele Shartzter, Genevieve M. Kenney, Sharon K. Long, Katherine Hempstead, and Douglas Wissoker. *Who Are the Remaining Uninsured as of June 2014?* July 29, 2014. Washington, DC: Urban Institute, <http://hrms.urban.org/briefs/who-are-the-remaining-uninsured-as-of-june-2014.pdf>.

⁵⁷ Matthew Buettgens, Austin Nichols, and Stan Dorn. *Churning Under the ACA and State Policy Options for Mitigation*. Washington, DC: Urban Institute (prepared for the Robert Wood Johnson Foundation), June 2012, <http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf>. Other studies, which did not consider the impact of unaccepted offers of employer coverage, reached mixed results. Graves, John, Rick Curtis, and Jonathan Gruber, "Balancing Coverage Affordability and Continuity under a Basic Health Program Option," *New England Journal of Medicine*. Vol. 365, no. 24 (2011): e44. Hwang, Ann, Sara Rosenbaum, and Benjamin D. Sommers, "Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning between Medicaid and Exchanges," *Health Affairs*. Vol. 31, no. 6 (2012): 1314-20.

This is a key methodological issue. In effect, BHP can raise the threshold of transition between Medicaid plans and marketplace plans from 138 percent FPL to 200 percent FPL. The impact of BHP on churning is thus greatly affected by the number of subsidy-eligible households near those two thresholds. Studies that fail to fully consider offers of employer coverage, which are more frequent at higher income levels, understate the potential impact of BHP in reducing churning.

⁵⁸ A state might adjust BHP eligibility mid-year, based on new information from enrollees or reliable third-party data sources. Such adjustments do not increase the PTC component of federal BHP payments on the theory that mid-year adjustments of APTC claims would reduce tax-reconciliation offsets, thus increasing the PTC amounts received by BHP consumers had they enrolled in QHPs in the marketplace. Instead, as noted earlier, the tax reconciliation reduction to the PTC component is calculated based on the assumption that BHP eligibility is continuous so, in effect, APTCs would not have been modified mid-year.

As a result, a state that chooses to implement 12-month continuous eligibility for BHP will not suffer any adverse effects in its receipt of federal funding. Costs would rise for a state that pays part of BHP expenses, however. Such a state would experience increased enrollment, hence increased expenditures, as a result of continuous eligibility. By the same token, increased enrollment would bring such a state a corresponding increase in federal BHP payments.

⁵⁹ Among consumers with incomes between 139 and 400 percent FPL who are offered ESI, between 97 percent and 99.8 percent of such offers meet the ACA's definition of affordability. Even among consumers in this income range who do not accept ESI offers, between 87 percent and 99 percent of the rejected offers are affordable. See the U.S. panel in table 1 in Matthew Buettgens, Stan Dorn, Habib Moody. *Access to Employer-Sponsored Insurance and Subsidy Eligibility in Health Benefits Exchanges: Two Data-Based Approaches*. Washington, DC: Urban Institute (prepared for the California HealthCare Foundation), Dec. 2012, <http://www.urban.org/UploadedPDF/412721-Access-to-Employer-Sponsored-Insurance.pdf>.

⁶⁰ See Buettgens, Dorn and Moody, 2012.

⁶¹ An alternative approach would begin with QHP costs. For example, a recent BHP analysis for the state of Oregon took that approach. In extrapolating to the cost of using a Medicaid-based infrastructure, this analysis discounted QHP costs based on the estimated average difference between QHP and Medicaid provider reimbursements. Tim Courtney, Julia Lerche, Patrick Holland, Karan Rustagi, Matthew Buettgens, Stan Dorn, Jay Dev, and Hannah Recht. *Oregon Basic Health Program Study*, prepared for the Oregon Health Authority, Oregon Health Policy Research. October 2014, Clearwater, FL: Wakely Consulting Group and the Urban Institute.

⁶² For an example of how varying the details of BHP coverage can affect likely costs, see Matthew Buettgens, Stan Dorn, Jeremy Roth, Caitlin Carroll. *The Basic Health Program in Utah*. Washington, DC: Urban Institute, Nov. 2012, <http://www.urban.org/UploadedPDF/412695-The-Basic-Health-Program-in-Utah.pdf>.

⁶³ Such premium increases could deter participation by healthier consumers, increasing average risk levels and the costs of those who do enroll. However, so long as BHP premiums remain significantly below those charged in the marketplace, this effect is likely to be much less significant than the fiscal contributions resulting from consumer premium payments.

⁶⁴ If states believe that they can likely increase plan payments (and ultimately the associated provider reimbursements) above Medicaid levels but there is some uncertainty as to the amount that federal funding will support, some of the increase could be held back and paid as a bonus after the end of the year. The total statewide payment amount would be based on how the relevant uncertainties were resolved, and the amount received by each plan (and ultimately provider) would be in proportion to the total amount of care furnished to BHP consumers.

⁶⁵ 79 Federal Register at 14133.

⁶⁶ 42 CFR 600.705(e).

⁶⁷ Dorn, Buettgens, Carroll, op cit.

⁶⁸ Authors' calculations, New York Department of Health. "2014 Open Enrollment Report," *NY State of Health: The Official Health Plan Marketplace*, June 2014, Albany, NY.

⁶⁹ For an estimate of the state's non-elderly population, see U.S. Census Bureau, "Massachusetts," *State & County Quick Facts*, Last Revised: Thursday, 27-Mar-2014 09:55:43 EDT, <http://quickfacts.census.gov/qfd/states/25000.html>.

⁷⁰ A smaller marketplace also has less leverage to change health care delivery and financing to improve population health and quality while slowing cost growth. However, those important goals need not be compromised if the state acting as purchaser uses BHP among other state programs to accomplish those same objectives. In fact, if the marketplace is federally facilitated, BHP could enhance a state's ability to implement delivery system and payment reforms, as noted in the text.

⁷¹ Massachusetts Commonwealth Connector (Connector). *Commonwealth Choice Progress Report*. December 13, 2007.

⁷² Connector. *Connector Summary Report*. December 11, 2008.

<https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2008/2008-12-11/Connector%2520Summary%2520Report%2520-%252012%252011%252008.xls>.

⁷³ By July 2010, enrollment was approximately 36,000-37,000, of which 75 percent was in the non-group portion of the program. Connector. *Report to the Massachusetts Legislature: Implementation of Health Care Reform, Fiscal Year 2010*. November 2010. Total enrollment, in both small group and non-group portions of the program combined, has now levelled off at slightly higher than 40,000. Connector. *Report to the Massachusetts Legislature: Implementation of Health Care Reform, Fiscal Year 2012*. December 2012.

⁷⁴ Matthew Buettgens, Stan Dorn, Jeremy Roth, Caitlin Carroll. "The Basic Health Program in Utah." Washington, DC: Urban Institute, November 2012, <http://www.urban.org/UploadedPDF/412695-The-Basic-Health-Program-in-Utah.pdf>; Matthew Buettgens, Caitlin Carroll. "The ACA Basic Health Program in Washington State." Washington, DC: Urban Institute, April 2012, updated August 2012, <http://www.urban.org/UploadedPDF/412572-The-ACA-Basic-Health-Program-in-Washington-State.pdf>.

⁷⁵ Depending on the details of Medicaid coverage, it can either preclude BHP eligibility or, as a practical matter, make BHP enrollment less likely. As noted earlier, one can simultaneously qualify for (1) pregnancy-related Medicaid or categories of Medicaid eligibility that provide less than minimum essential coverage and (2) BHP or marketplace subsidies. However, enrollment in BHP or marketplace coverage is much less likely to take place, as a practical matter, with someone who is receiving Medicaid than with someone who is uninsured or previously paid for individual insurance.

⁷⁶ States may also have the authority, in their role as regulators of insurance markets, to require carriers that serve the individual market and BHP to pool both sets of enrollees.

⁷⁷ MNSure. *MNSure Metrics Dashboard: Prepared for Board of Directors Meeting, April 16, 2014*, <https://www.mnsure.org/images/bd-2014-04-16-dashboard.pdf>.

⁷⁸ MNSure. *MNSure Metrics Dashboard: Prepared for Board of Directors Meeting, July 16, 2014*, <https://www.mnsure.org/images/bd-2014-04-16-dashboard.pdf>.

⁷⁹ Authors' calculations, MNSure. *Provider Networks*. (undated) <https://www.mnsure.org/images/Individual-ServiceAreas-ProviderLook-up.xls>.

⁸⁰ Amy Burke, Arpit Misra, and Steven Sheingold. "Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014." *ASPE Research Brief*, June 18, 2014, Washington, DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (ASPE/HHS).

⁸¹ MNSure. "Health Care Coverage and Plan Rates for 2015." October 1, 2015, <https://www.mnsure.org/images/2015-10-1-MNSure-healthcare-coverage-plan-rates.pdf>.

⁸² According to HHS estimates of weighted average premiums by state, Minnesota's premiums for the lowest-cost silver plan, second-lowest cost silver plan, and lowest-cost bronze plan were \$192, \$192, and \$144 a month, respectively, well below those in any other state among the 48 (including the District of Columbia) for which data were reported. The state with next lowest such premiums for silver plans was Tennessee, with \$235 and \$245 weighted average premiums for the lowest and second-lowest-cost silver plans, respectively, 18 percent and 22 percent above Minnesota's corresponding averages. The state with the second-least-expensive weighted-average lowest-cost bronze plan was Oklahoma, with \$174 monthly premiums that exceeded Minnesota's levels by 17 percent. Authors' calculations. ASPE Office of Health Policy. "Table 4: Weighted Average Premiums, 48 States," *Health Insurance Marketplace Premiums for 2014*. September 25, 2013, http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf.

⁸³ James Nord. "MNSure claims success in first year sign-ups." *Politics in Minnesota*. April 4, 2014. <http://politicsinminnesota.com/2014/04/mnsure-claims-success-in-first-year-sign-ups/>.

⁸⁴ Christopher Snowbeck. "MNSure: Twin Cities' rates still look cheaper, but gap is shrinking in Minnesota," *Star Tribune*, October 4, 2014, <http://www.startribune.com/business/278072961.html>.

⁸⁵ Minnesota State Department of Commerce. "Commerce Announces Minnesota Health Insurance Rates – Lowest Rates in Nation for Second Year," October 1, 2014, <http://mn.gov/commerce/insurance/media/newsdetail.jsp?id=209-143493>.

⁸⁶ The other major source of funding is \$5 million in unspent federal exchange grant funds from 2013. MNSure. "Preliminary MNSure Budget for Calendar Year 15," March 12, 2014, <http://www.lcc.leg.mn/mnsure/meetings/04092014/Bd-2014-03-12-Prelim2015Budget.pdf>; Christopher Snowbeck, "MNSure board OKs 3.5 percent premium withholding," *TwinCities Pioneer Press*. May 14, 2014, http://www.twincities.com/politics/ci_25762410/mnsure-board-oks-3-5-percent-premium-withholding; James Nord. "MNSure enrolls 170,000 Minnesotans as insurance deadline passes." *Politics in Minnesota*. April 1, 2014, <http://politicsinminnesota.com/2014/04/mnsure-enrolls-170000-minnesotans-as-insurance-deadline-passes/>.

⁸⁷ ACA Section 1332 permits state innovation waivers that allow major changes to ACA's architecture, including marketplaces, PTCs, and CSRs. Such changes must be cost-neutral and may not increase consumer costs or reduce benefits, compared to the ACA without a waiver. These waivers may not be into effect until 2017.

In this context, they might allow a state to use 100 percent, rather than 95 percent, of PTCs and CSRs to serve consumers through state-sponsored coverage that makes coverage more affordable for low-income consumers who include and potentially go beyond those who qualify for BHP. For the final regulation concerning the process for obtaining such waivers, see CMS, Department of the Treasury. "Application, Review, and Reporting Process for Waivers for State Innovation." *Federal Register*. Vol. 77, No. 38, 11700-11721, Monday, February 27, 2012, <http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf>, promulgating 31 CFR 33.100 et seq., 45 CFR 155.1300, et seq.

⁸⁸ Massachusetts Executive Office of Health and Human Services (EOHHS). *MassHealth: Roadmap to 2014*. Revised May 2013, <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/aca-transition-plan-draft.pdf>; Letter from CMS Administrator Marilyn Tavenner to EOHHS Secretary John Polanowicz, October 1, 2013, <http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/ma-1115-amendment-approval-oct-1-2013.pdf>. For Vermont's premium costs, see Vermont Health Connect Subsidy Calculator, http://info.healthconnect.vermont.gov/tax_credit_calculator.

⁸⁹ Brian Rosman, Health Care for All Massachusetts, personal communication, 2013.

⁹⁰ ACA §1412(e).

⁹¹ Results from Kaiser Family Foundation Subsidy Calculator, <http://kff.org/interactive/subsidy-calculator/>.

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