DELTA DENTAL

September 12, 2011

Introduction

This written statement has been prepared for submittal to the Legislative Study Committee ("Committee) by Delta Dental of Illinois. Pursuant to SB 1555, the Committee is to report *inter alia* its findings with respect to "the development of standards for the coverage of full-time and part-time employees and their dependents." These standards need to include the creation of tools for comparing health options to assist consumers. Our written statement addresses this issue.

Who We Are

Delta Dental of Illinois is one of 39 independently operated member companies of the Delta Dental Plans Association. Delta Dental member companies provide insured coverage and/or self-funded plan administrative services for nearly one-third of all Americans with dental insurance in all 50 states. Delta Dental is by far the largest dental benefits carrier in the country.

Delta Dental of Illinois (formerly known as Illinois Dental Service and later as Delta Dental Plan of Illinois) was granted a charter in 1967 under the Dental Service Plan Act as a not-for-profit dental service plan corporation. Under this Act, the company is authorized to establish dental care programs for entities headquartered in Illinois and for residents of Illinois, operating under the supervision of the Illinois Department of Insurance.

Involvement in Illinois

Delta Dental of Illinois, headquartered in Illinois, has approximately 150 employees, and a vested interest in Illinois. It provides insured dental benefit programs to Illinois individuals who do not have access to a group dental program, and insured and self insured dental benefit programs to 4,800 Illinois-headquartered groups of all sizes representing all business sectors (government entities, municipalities, labor groups, commercial employers, school districts, universities, hospitals, Fortune 1000 and other large national accounts), including more than 400 public sector clients in Illinois.

A cross-section of Delta Dental of Illinois clients includes:

- Archer Daniels Midland (ADM)
- Argonne National Laboratory
- Brunswick
- Chicago Public Schools
- Children's Memorial Hospital
- City of Naperville
- COUNTRY Financial
- Illinois Municipal Retirement Fund
- Integrys (formerly Peoples) Energy
- Kane County
- Loyola University
- McDonald's Licensees
- Nicor
- OfficeMax
- Resurrection Medical Center
- RR Donnelley
- Sara Lee
- Schneider Electric
- State of Illinois
- University of Chicago Student Plan
- University of Illinois Graduate Assistants and Graduate Students
- Walgreen
- Waste Management

Large Networks that Expand Access to Care for Enrollees

With more than 70 percent of dentist office locations in Illinois (nearly 9,000 locations) participating in a Delta Dental network and three out of four dentists nationwide participating, Delta Dental enrollees have access to a vast network of dentists. Participating dentists agree to accept our allowed fees as payment in full – and cannot

"balance bill" the enrollee for the difference between their charged fee and the Delta Dental allowed fee. This helps reduce out-of-pocket costs for enrollees and claims costs for groups. Dental networks help make dental care more affordable to consumers and to employers who choose to provide dental benefits.

Focus on Oral Health and its Importance to Overall Health

We are dental experts. Our claims administration, managed care networks, customer service, cost management and quality assurance expertise have always set the standards in the industry. Our dental benefit programs focus on prevention and we educate enrollees on the importance of good oral health and its connection to overall health.

Our Enhanced Benefits Program integrates medical and dental care – where oral health meets overall health. This program enhances coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions, and suppressed immune systems) that can be positively affected by additional oral health care. These enhancements are based on emerging scientific evidence that shows treating and preventing oral disease in these situations can improve overall health.

Benefits to the Communities

Part of the mission of Delta Dental of Illinois is to improve the oral health of the communities we serve. We further this mission by supporting programs that help provide oral health education and expand access to oral health care for the people of Illinois. To support this effort, Delta Dental of Illinois established a Foundation in 2008 to act as its oral health distribution arm. In the past eight years, the company – through the combined efforts of Delta Dental of Illinois and its Foundation – has donated nearly $2 million to programs and organizations in Illinois.

Some of our community benefit efforts include:

- Land of Smiles. Our free educational and entertaining children's theater program is geared to children in kindergarten through third grade. Featuring the Tooth Wizard and his nemesis, PlaqueMan, the show has visited more than 100,000 children in hundreds of elementary schools across Illinois, educating them on how to take care of their teeth and the importance of good oral health.

- Teeth on the Go. This "book bag" program based on curriculum requirements provides elementary school teachers and health professionals with a variety of learning tools to use during their study of oral health in the classroom. The program incorporates a variety of visual and audio learning tools, showing students how they can have healthy teeth and gums. It also includes instruction on the importance of teeth to a child's overall health, the impact of nutrition on teeth and proper oral hygiene and tooth brushing techniques.

- Grants to Illinois Dental Schools and Dental Students. We've made contributions to two dental schools in Illinois — University of Illinois at Chicago (UIC) College of Dentistry's Department of Pediatric Dentistry and Southern Illinois University (SIU) School of Dental Medicine. The UIC Pediatric Clinic is the largest provider of dental services to children on Medicaid in Illinois; it has been expanded to include services for underserved children with special needs. The clinic has also launched a health promotion and disease prevention program, enrolling cavity-free infants and their mothers in an effort to help the children remain free of oral disease. Our contribution will help the UIC Department of Pediatric Dentistry create a state-of-the-art pre-doctoral pediatric dentistry clinic. Our contribution to SIU will help ensure the Main Clinic is fully equipped to meet the needs of its patients. A prominent feature of the addition is a pediatric dentistry bay, which includes four operatories dedicated to pediatric dentistry. We've also provided a grant to SIU that will

double the capacity of its Oral Surgery Clinic. We offer scholarship grants to University of Illinois at Chicago and Southern Illinois University dental students.

- Dental Clinic Support and Grants to Help Expand Access to Care for Illinois Children, Elderly, Disabled and Underserved. We support agencies across Illinois that help expand oral health access to the people of Illinois. We provide assistance to clinics delivering dental care to underserved populations throughout the state. We also provide goods-in-kind requests, such as toothbrushes, oral health brochures and dental floss.

- Mission of Mercy. In 2010, we helped fund the first ever Mission of Mercy event in Illinois. Originating in Virginia and spreading throughout the United States, more than 50 Mission of Mercy dental programs have been conducted since 2000 to provide free dental care to more than 100,000 adults and children who otherwise would be unable to receive treatment. Over 1,950 children and adults received dental care free of charge. In total, the Illinois Mission of Mercy delivered nearly $1,000,000 in basic dental care, including fillings, extractions and cleanings. During the event, Delta Dental of Illinois' own oral health superhero Tooth Wizard — and his arch nemesis PlaqueMan — performed the entertaining and educational "Land of Smiles" show.

Considerations in Establishing a Health Benefits Exchange in Illinois: ***Essential Pediatric Dental Benefits Should Be Separately Offered and Priced***

- One goal of exchanges is to facilitate a transparent shopping experience: If medical and dental benefits are offered and priced separately, consumers and small business will be able to make an apples-to-apples comparison of all coverage options. Transparency is achievable only if consumers and small businesses can compare the costs, services and provider networks among all dental options and can do so independently of the medical plan they might prefer.

- Consumers and small businesses should be afforded the opportunity to make a meaningful choice among the available options: By requiring Qualified Health Plans and dental plans to offer and price their medical and dental programs separately, consumers and small businesses would be able to assemble a complete benefit package to match their needs and preferences. This information will give them some of the same tools that brokers and agents provide today to help them choose the right medical and dental plan.

- Bundling dental benefits with medical benefits would not be prohibited: Separate offer and pricing of medical and dental options only requires that services, provider networks and cost be presented separately. Consumers and small businesses, NOT INSURERS, would be empowered to decide whether to purchase a separate medical and dental option or a combined i.e. bundled benefit program, if that is what they want.

- Illinois needs to preserve what already works well in the marketplace: 97% of people with dental coverage acquire these benefits separately from their medical coverage. When medical and dental products are issued under separate policies, purchasers have the opportunity to select the medical and dental coverage that best suits their needs.

- A requirement of separate offer and price will help create a level playing field: More medical insurers will be able to compete for exchange business in that stand-alone medical plans will be able to compete with full service health plans that offer a combined medical and dental program.

Health Alliance
Medical Plans

Governance and Sustainability of an Insurance Exchange in Illinois
Comments to the Health Benefits Exchange Study Commission
September 9, 2011

We applaud the State of Illinois for enacting Senate Bill 1555 establishing this Study Commission to grapple with the complex issues around establishing a state-based exchange in Illinois.

Establishing an exchange as a quasi-state entity makes the most sense for providing flexibility in meeting the unique needs of Illinois citizens and businesses. Residents and businesses of Illinois would be best served by a governing body for the exchange with representation from all stakeholders—consumers, agents and brokers, business, insurance, health care providers and regulators. The Department of Health and Human Services (HHS) proposed rules certainly allow for including insurance representation on the board, which, we believe will add the benefit of expertise in a very complex industry. Additionally, this governing body should not operate as a separate, duplicative insurance regulator but rather within the existing regulatory framework of the Illinois Department of Insurance.

With respect to financial sustainability of the Illinois exchange, we believe it is too soon to establish legislation. The studies commissioned by the Department of Insurance will assist you in establishing the specific needs of the marketplace. Only then, can the costs to operate the exchange be truly assessed, which drive the decisions on establishing funding mechanisms. Additionally, your initial report is due to the Governor and the Illinois General Assembly on September 30, 2011, and the deadline for comments on the HHS proposed rule on the establishment of exchanges is September 28, 2011. Throughout its proposed rulemaking, HHS has solicited comments on very important components of exchange operations that lie within the realm of state flexibility. It would be premature to enact legislation before rules are established that define the federal framework within which states must operate.

Maintaining dual markets inside and outside the exchange will also be critical to financial sustainability of the exchange. Offering an open marketplace reduces the operational costs of the exchange and attains the goals of the Affordable Care Act with respect to accessibility, affordability and choice. The exchange will bring more standardization of benefits and greater transparency in price, but a strong external market is the place where innovation will be fostered. Building the capacity to administer plans for over 1.5 million uninsured individuals and small employers forced to shift from the external market would be a huge financial and operational challenge for an exchange-only marketplace.

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There are many issues and questions that must be addressed in developing a plan for an Illinois insurance exchange that supports a healthy insurance marketplace, fosters innovation, encourages competition, ensures quality and affordability, provides transparency and consumer choice within a context of fiscal responsibility. Given the importance of each of these factors, we appreciate the Commission inviting input from all stakeholders before decisions are made. We look forward to being a part of this open and transparent process.

Jeffrey C. Ingrum
President & Chief Executive Officer

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Presented to:

Illinois Health Benefits Exchange
Legislative Study Committee

MERIDIAN HEALTH PLAN

Michael Murphy
Michael Stines

September 15, 2011

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Representative JoAnn Osmond
Co-Chair
Illinois Health Benefits Exchange Legislative Study Committee
976 Hillside Avenue
Antioch, IL 60002

Re: The Basic Health Program is Right for Illinois

Dear Representative Osmond:

The Basic Health Program (BHP) is an option that is given to states to include as a part of their implementation of the Federal Patient Protection and Affordable Care Act. The BHP offers a significant opportunity for the State of Illinois to obtain billions of dollars in federal funding for the provision of health care to its citizens. This block grant funding can be deposited directly into state coffers annually and will exceed the medical costs of individuals covered under the program. We believe this program has many advantages for a specific segment of Illinois' population and its positive budget ramifications simply cannot be ignored.

To help in explaining the BHP state option and its advantages we have enclosed the following herewith:

1. A Meridian Health Plan analysis outlining the key aspects of the Basic Health Program concept and its advantages for Illinois;
2. An independent report by the Urban Institute and the Robert Wood Johnson Foundation.

We have discussed the Basic Health Program option with Michael Koetting with the Department of Health Care and Family Services and Kate Gross with the Department of Insurance. They have expressed a strong interest and have stated that they are anxiously awaiting additional guidance from the federal government on this issue.

In sum, we believe that Illinois cannot ignore this opportunity to obtain federal health care dollars. A failure to put in place the Basic Health Program as a part of the state's current efforts to implement the ACA in Illinois will result in forgoing available federal funding exceeding $1 billion annually and will increase out of pocket health care costs to a certain segment of Illinois citizens who otherwise would be forced inappropriately into the Health Benefits Exchange.

Please do not hesitate to contact me if you would like to discuss the Basic Health Program in more detail.

Sincerely,

Michael D. Cotton
Chief Operating Officer
Meridian Health Plan

The Federally-Funded Basic Health Program: An Option Illinois Should Not Ignore

Background

Last year, the Patient Protection and Affordable Care Act ("ACA"), was signed into law. The goal of the ACA is to make health care coverage affordable for all Americans. In order to achieve this goal, the ACA calls for the states to establish Health Benefit Exchanges ("Exchange") intended to facilitate the purchase of coverage by individuals, employers and other groups. The ACA provides wide discretion to states by allowing them to decide who may participate in the Exchange and to implement health reform in a way that maximizes cost savings by utilizing existing resources and infrastructure.

Under the ACA, the two main ways to deliver coverage to adults with low incomes not eligible for Medicaid are: (1) through subsidized commercial insurance via an "Exchange" or (2) through a "Basic Health Program" ("BHP"). The BHP option offers a significant opportunity for Illinois to provide coverage for lower income individuals earning between 133% and 200% of the Federal Poverty Level ("FPL") by leveraging the well-established State Medicaid managed care program. The advantages of forming a BHP as opposed to placement of adults between 133% and 200% of the FPL in commercial insurance through the Exchange are numerous, making a BHP a very real option for insuring this population in Illinois.

The Current Uninsured Population in Illinois

There are approximately 1,600,000 uninsured individuals in the State of Illinois. Although there is currently no published data directly identifying the number of uninsured individuals by income level, the following constitutes a close approximation of what is true in Illinois today:

- Approximately 640,000 are below 133% FPL
- Approximately 400,000 are between 133% to 200% FPL
- Approximately 480,000 are between 200% and 400% FPL

Defining the Populations

In analyzing the benefits of a BHP, it is helpful to identify specific populations by income level.

The Working Poor

- Individuals that earn income between 133% to 200% of the FPL are considered the "working poor"
- The working poor are unable to sufficiently support themselves
- Many work in jobs such as child care workers or nursing assistants, but earn too little to support themselves and cannot build wealth
- The working poor are much more likely to have experience with Medicaid, as almost 25% of the population between 100% to 199% FPL are served by Medicaid

The Commercial Insurance Population

- The population between 200% and 400% of the FPL are more familiar with commercial insurance
- Only 7.3% to 11.9% of the population from 200% to 400% of the FPL are served by Medicaid
- More than 75% of the population from 200% to 400% of the FPL have insurance through their employer or have individual coverage

Structure of the BHP and Exchange

Illinois Medicaid, the BHP and the Exchange will operate by serving distinct populations, segregated by income level. As contemplated by the ACA, all individuals below 133% of the FPL will be insured through Illinois Medicaid, at least 50% of who will be insured by Medicaid managed care ("Care Coordination"). Illinois residents between 133% and 200% of the FPL will be placed into the BHP totaling approximately 400,000 Illinois citizens. Approximately 480,000 individuals will have the opportunity to participate in the Exchange.

Overview of the Basic Health Program

- Available on January 1, 2014 for eligible individuals between 133% and 200% of the FPL
- The State will establish a competitive bidding process
- Consumers will have the option to choose among participating health plans

What's in a name? The Basic Health Program is *not* Basic

- Offers enrollees a comprehensive benefits package
- Ensures value by requiring minimum loss ratios of 85%
- Essential benefits include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; and pediatric services including oral and vision care
- Includes additional benefits the cost of which are borne by the BHP plan or plans such as non-emergent transportation, translation services, and enhanced behavioral health and substance abuse assistance services
- Offers lower premiums, lower co-pays and lower cost sharing than the Exchange

Federal Funding

- The federal government will transfer to the state 95% of the premium tax credits that would have been provided as individual subsidies for Exchange participants
- BHP payments from the federal government are expected to cover the costs of all medical services provided to BHP participants
- The average Medicaid cost for a non-elderly, non-disabled adult will reach $3,756 in 2015, while 95% of the average exchange subsidy will total $4,940 according to Stan Dorn, a senior fellow at the Urban Institute
- Estimated BHP subsidies will exceed by 29% of what it would cost Medicaid to cover BHP eligible individuals
- If current trends continue, BHP subsidies could continue to exceed Medicaid costs for more than 25 years

Medicaid Managed Care is a Proven Model

- Illinois' Medicaid managed care program currently meets or exceeds the required essential benefits
- Managed care will use existing provider contracts, current case managed practices, provider networks, pharmacy benefits and claims processing systems

Administration

- The state already has key administrative staff in place to regulate the Basic Health Program
- Start up costs will be minimal, since it will be built on the existing platform of Medicaid managed care
- Increase in savings by moving formerly eligible Medicaid enrollees above 133% of the FPL into BHP by leveraging full subsidies of federal dollars instead of federal Medicaid match without reduction in benefits
- The BHP will seek approval to fund administrative costs through federal funding

Keeping Families Together

- Allows families to see the same provider
- Families have stability of coverage, rather than churning between public and private coverage

Recommendation

The Illinois Legislature should enact Exchange-enabling legislation that creates a Basic Health Program option designed as a Federally-funded Medicaid managed care expansion.

Basic Health Program vs. Commercial Exchange Coverage
(For adults earning between 133% and 200% of FPL)

Coverage/ Issue	Commercial Coverage (through Exchange)	Medicaid Managed Care Expansion in 2014 (Basic Health Program)
Cost to State	More: Fewer insured adults means an increase in uncompensated care and emergency department utilization, as well as higher costs when people re-enroll in Managed Care.	None. State can use federal funds to design a Medicaid Managed Care expansion that ensures access to high quality, affordable coverage in a proven model that helps our families. • Potentially saves money by reducing uncompensated care.
Number of Newly Insured	Fewer Insured: Many people will choose to remain uninsured if their commercial coverage options do not meet their needs and costs too much. Confusion: Many people who are not familiar with commercial insurance may find it difficult to enroll.	• More people are likely to gain coverage if they can enroll in Medicaid Managed Care, a proven model that meets their needs and is affordable. • Familiar and simple path to enrollment will increase number who become insured.
Cost Sharing for Consumers	Consumers will be required to pay higher premiums, co-pays and deductibles.	• Lower levels of cost-sharing will result in more people accessing their coverage and improving health outcomes.
Continuity of Care (Churn/ Turnover)	Confusion: Parents will churn through different types of coverage more often, increasing difficulty of understanding benefits and care options. Loss of choice: People may often have to switch doctors to remain in networks of new coverage, thus reducing continuity of care with their choice of family physician, pediatrician and other primary and specialty care professionals.	• Expanding eligibility in Medicaid Managed Care means fewer adults will move between commercial and Medicaid coverage, creating more predictable costs for families. • Continuity of care is increased as enrollees will keep same primary care and medical providers.

Coverage/ Issue	Commercial Coverage (through Exchange)	Medicaid Managed Care Expansion in 2014 (Basic Health Program)
Family Unity	Fragmentation: Family members will find themselves in different coverage products (children in Medicaid managed care and parents in commercial plans), making accessing care more confusing.	•Families will remain intact in same coverage, increasing simplicity of accessing care. • Parents of children enrolled in Medicaid managed care will remain in the same coverage as their children, improving quality of access for both.
Health Service Benefits	Underinsured: Services essential to low-income families are likely to be missing from commercial plans, including benefits such as transportation, interpretation, and social care coordination that improve access to care. Loss of ancillary benefits : Underinsurance means lower quality and worse health outcomes.	• Comprehensive Medicaid Managed Care benefits that are proven to work for low-income families will be preserved. • Current Medicaid Managed Care adults will not lose benefits that make accessing care possible.
Consumer Experience	Less Support: Commercial plans not experienced with needs of low-income community and may not have networks that include primary care, behavioral health and substance abuse providers experienced in meeting the needs of the population.	• Health plans currently working with Medicaid population are attuned to the delivery system needs of people with low-income. • Continuity of health plan for current Medicaid Managed Care adults will result in better care management.

Source: www.nhpri.org

COVERING MORE NEW YORKERS WHILE EASING THE STATE'S BUDGET BURDEN.

POLICY BRIEF

BRIDGING THE GAP: EXPLORING THE BASIC HEALTH INSURANCE OPTION FOR NEW YORK

June 2011

Community Service Society | Fighting Poverty Strengthening New York

NYS HEALTH FOUNDATION
Improving the state of New York's health

POLICY BRIEF

BRIDGING THE GAP: EXPLORING THE BASIC HEALTH INSURANCE OPTION FOR NEW YORK

By Elisabeth R. Benjamin and Arianne Slagle

The Affordable Care Act (ACA) constitutes a historic opportunity for New York State to offer health coverage to nearly 2.6 million uninsured New Yorkers. The establishment of a Health Insurance Exchange, the creation of federal subsidies to help individuals purchase insurance, and expansions in Medicaid eligibility will make it much easier for New Yorkers to select plans and enroll in coverage.

But many low-income residents will still face steep fiscal cliffs between the Medicaid program, which is effectively free for beneficiaries, and the relatively expensive private plans offered through the state-based Exchange. This problem is especially acute in high cost-of-living states, such as New York, where low-income people have little disposable income.

One provision of the ACA offers states an important opportunity to ameliorate this affordability gap for low-income residents by providing significant federal funding to establish a Basic Health Plan (BHP). Under a BHP, states can provide affordable, comprehensive coverage for people below 200 percent of the federal poverty level (FPL), which is roughly $37,000 for a family of three.

This report details the implications of offering a BHP in New York. Specifically, it describes: the amount of federal funding that would be available; the take-up rate by various eligible population groups; the cost of offering a comprehensive public look-alike product; the types of plan options the State could potentially offer; and the impact the establishment of a BHP would have on New York's Exchange and the rates of the uninsured upon the full implementation of the ACA in 2014.

If adopted, New York could build off of its existing Medicaid expansion program, Family Health Plus (FHP), to offer high-quality coverage with no co-premiums to an estimated 467,000 New Yorkers.

The Community Service Society of New York (CSS) is an informed, independant, and unwavering voice for positive action that serves the needs of low-income New Yorkers.

David R. Jones, Esq., President & CEO

Steven L. Krause, Executive Vice President & COO

Elisabeth R. Benjamin, MSPH, JD, is Vice President of Health Initiatives at CSS. Previously she directed the Reproductive Rights Project at the New York Civil Liberties Union and founded the Health Law Unit at the Legal Aid Society of New York. She attended Columbia Law School, Harvard School of Public Health, and Brown University.

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We would also like to acknowledge many of our colleagues who, unfortunately, are too numerous to list individually, but work at the following groups: Center on Budget and Policy Priorities, Community Catalyst, Empire Justice Center, Families USA, Health Care for All New York, Health Pass, the Legal Aid Society, the National Health Law Program, the PHP Coalition, and the Urban Institute.

CSS's Health Initiatives policy work is also generously supported by: The New York Community Trust, The Nathan Cummings Foundation, The Ira W. DeCamp Foundation, the Baisley Powell Elebash Fund, the United Hospital Fund, The Robert Wood Johnson Foundation, The Atlantic Philanthropies, and the Affordable Care Act Implementation Fund.

If adopted, New York could build off of its existing Medicaid expansion program, Family Health Plus (FHP), to offer high-quality coverage with no co-premiums to an estimated 467,000 New Yorkers. As summarized in Table 1, New York State would receive nearly $2.6 billion in federal financing for its BHP. These federal financing estimates are conservatively based on HMO small group premiums instead of New York's current expensive individual market premiums or other more generous small group products. Based on the medical claims costs in New York's existing FHP program, it would cost New York State approximately $2.5 billion to offer a comprehensive BHP plan with no monthly co-premiums, for a total net operating margin of $27 million.

TABLE 1
Summary of Financing, Cost, and Savings Estimates for New York's BHP Program

Estimated Number of BHP Enrollees	**467,000**
Estimated Federal Funding	$2,580,299,000
Estimated BHP Program Costs	$2,553,619,000
Sub-Total: Net Operating Margin	$26,680,000
State Cost Savings Offsets	$510,752,000
Provider Rate Increase	($255,362,000)
Plan Design at 94% Actuarial Value	$104,229,000
Net Financial Impact of BHP for New York State	$386,299,000

Establishing a BHP is a particularly attractive option for the State of New York in that it would alleviate the State's current costs of providing public coverage to several groups of residents, including: (1) parents of children who receive public coverage above the new federal Medicaid income threshold (through the FHP program); and (2) legal immigrants who receive State-only funded public insurance coverage. By moving these populations into a BHP, the state could generate an additional savings of $511 million.

A series of plan options, with varying levels of benefits, is also explored. Based on the plan design chosen, there is a greater potential for state savings which could be used to increase provider reimbursement rates. As described in Table 1, even if New York adopted a slight increase in enrollee-cost sharing and enhanced provider reimbursement rates, BHP still would generate a net financial gain to the State of around $386 million annually (see Table 1).

Not only would a BHP engender significant savings for the State, it would also reduce the potential number of uninsured New Yorkers come 2014. Without a BHP, low-income New Yorkers would either have to pay potentially cost-prohibitive premiums in the Exchange or a penalty and forgo coverage altogether. Our estimates indicate that if the State were to offer a free or very low-cost BHP, nearly 100,000 more New Yorkers are likely to gain coverage.

In summary, this Policy Brief urges New York to consider seriously adopting a BHP for the following reasons:

- A BHP would offer 467,000 low-income New Yorkers more affordable and comprehensive coverage than they would receive in the Exchange;
- Federal financing is adequate to cover the costs of offering a BHP in New York State;
- Adopting a BHP will potentially generate roughly $511 million in State savings;
- Due to having no or very low co-premiums, nearly 100,000 more New Yorkers are likely to gain coverage if New York adopts a BHP.

Introduction

The Affordable Care Act (ACA) of 2010 seeks to guarantee quality, affordable coverage to nearly everyone living in the United States. The ACA builds upon the two existing pillars of health coverage: employer-based coverage and public coverage (Medicaid, State Children's Health Insurance program, and Medicare). It augments the level of consumer protections in the private insurance market, placing stringent regulations to hold health plans accountable and setting new standards for the financial risk exposure of enrollees.

With notable exceptions, the ACA requires most people to have health coverage. Large employers must automatically

enroll their employees in coverage, thus maintaining the existing system for those who have job-based coverage. Small businesses are not required to offer coverage, but are eligible for tax credits if they do so, in order to stem the current decline in small group coverage.

To facilitate the purchase of affordable coverage by individuals and small businesses, states have the option to establish local, state or regional Exchanges—marketplaces which will offer insurance for individuals and small businesses. Exchanges provide important opportunities for collective, or bulk, purchasing and risk spreading across a large number of people.[1]

Exchanges also will ease the complex task of purchasing coverage by categorizing insurance products according to their actuarial values (AV), as described in the sidebar. To ensure a standard level of quality on the Exchange, only "qualified health plans" are allowed to participate—plans which offer at least the minimum "essential health benefits" and criteria prescribed by the federal government. Qualified health plans will fit into four different categories based on actuarial level: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%).

Importantly, the Exchanges will offer advanceable and refundable tax credits or "premium subsidies" of up to the cost of Silver-level coverage for people with incomes up to 400 percent of the federal poverty level (FPL), or $73,000 for a family of three. Additionally, to protect against medically-related personal bankruptcies, the ACA includes an annual cap on cost-sharing equal to $5,950 for an individual and $11,900 for a family, and annual deductible limits of $2,000 for individuals ($4,000 for families) small group coverage. As displayed in Table 2, people with incomes below 400 percent of FPL who enroll in a Silver-level plan will be eligible for a reduction in the annual cap on cost-sharing by as much as two-thirds, depending on income.

People earning between 100 and 250 percent of FPL who enroll in a Silver-level plan are also eligible for an additional cost-sharing subsidy. Cost-sharing subsidies are described in the ACA as increases in the actuarial value of a Silver-level plan: for the poorest people with incomes below 150 percent of FPL, the AV increases from 70 to 94 percent; for people with incomes between 150 and 200 percent of FPL, the AV increases from 70 to 87 percent; and for people with incomes between 200 and 250 of FPL, the AV increases from 70 to 73 percent.

For the lowest income residents of the United States, Medicaid coverage will be expanded to eligible people with incomes up to 139 percent of FPL, or around $25,760 a year for a family of three. Taken together, these measures are estimated to provide coverage to nearly 32 million people nationwide, with roughly equal numbers of newly insured through the expansion of Medicaid and coverage through the Exchange or through private employers.[2] In New York, nearly 1.2 million uninsured are expected to gain new coverage.[3]

Levels of Coverage on the State Health Benefit Exchange

Insurance Exchanges will be used to facilitate the purchase of qualified health plans offered at different actuarial values (AVs). An AV is the percentage of total medical costs that an insurance plan pays. The difference is the amount a consumer or employer pays. Plans with higher AVs have lower out-of-pocket costs for members:

PLATINUM LEVEL = 90% AV
GOLD LEVEL = 80% AV
SILVER LEVEL = 70% AV
BRONZE LEVEL = 60% AV

While consumers are free to choose any plan, under the ACA, people who enroll in a Silver level plan may receive additional cost-sharing subsidies, depending on income.

TABLE 2: SUBSIDIES AND OUT-OF-POCKET COST PROTECTION IN THE ACA

Annual Costs for a Family of Three (2 adults, 1 child) in the Exchange

FPL	Income	Family Annual Co-Premium	Reduced Annual Out-of-Pocket Cap
100%	$18,530	$366	n/a
200%	$37,060	$2,335	$3,967
300%	$55,590	$5,281	$5,950
400%	$ 74,120	$7,041	$7,933

Addressing Affordability Concerns: The Basic Health Plan Option in the ACA

The ACA significantly expands access to quality, affordable health coverage to low- and middle-income individuals and families. However, despite efforts to ensure affordability for low-income people come 2014, those earning over 138 percent of FPL will still face steep eligibility cliffs between the effectively free Medicaid program and the relatively expensive private plans offered through the state-based Exchanges. Even with federal subsidies, many of the roughly seven million uninsured working families in the Unites States with incomes between 139 and 200 percent of FPL may face significant financial hardships purchasing coverage through the Exchange—especially if they live in a high cost-of-living state.

Section 1331 of the ACA provides states with flexibility to help bridge the gap in affordability between the effectively free Medicaid program and private coverage in the Exchange by providing states with a significant federal funding opportunity to offer a Basic Health Plan (BHP) for people with incomes below 200 percent of the FPL.[4] Eligibility to enroll in a BHP program is limited to people who are under the age of 65, who are ineligible for Medicaid, and who have incomes below 200 percent of FPL. If a state elects to offer a BHP, individuals eligible for the BHP would be precluded from purchasing subsidized coverage through the Exchange.

States that opt to offer a BHP will be required to set up a trust fund for the program. The ACA authorizes the federal government to pay into the BHP trust fund 95 percent of what the federal government would have paid in premium tax credits, plus 100 percent of the cost-sharing subsidies that the state's BHP enrolled population would have received had they instead bought a plan on the Exchange.[5] To qualify for this funding, a BHP must offer the federally mandated "essential health benefits," a medical-loss ratio of at least 85 percent, and out-of-pocket premium costs no greater than what an enrollee would have received on the Exchange.[6] States which offer a BHP must also establish a competitive procurement process for selecting health plans.[7] Once these requirements have been met, states would have wide latitude to design their BHP benefits and cost-sharing structure.

New York's Public Insurance Programs

New York is a nationally recognized "leader state" in providing access to affordable, high quality health coverage for its low-income residents. Family Health Plus (FHP), a Medicaid expansion program created under the State's Section 1115 Waiver program, offers coverage above the Medicaid threshold of 78% of FPL for qualifying adults. FHP coverage is available to childless adults with incomes up to 100% of the FPL and parents up to 150% of FPL. Additionally, New York offers free coverage through its Child Health Plus (CHP) program to children in families with incomes below 160% of FPL and subsidized coverage to children in families up to 400% of FPL.

As of April 2011, there are approximately 2.9 million New Yorkers covered in Medicaid Managed Care, 403,000 enrollees in FHP, and 407,000 in CHP (New York State Department of Health, April 2011). New York receives a 50% federal match for both its Medicaid and FHP programs, and 65% federal matching funds for its CHP program. The state pays 100% of the cost for more than 110,000 legal immigrants in its public insurance programs who are ineligible for federal matching funds.

Why Should New York State Policymakers Consider the BHP Option?

For the State of New York, there are two significant benefits of opting into the BHP. First, BHP could offer financial security to low-income residents by ensuring their access to affordable and stable coverage. Second, a BHP would bring substantial cost savings to the State by enabling it to obtain increased federal funding while simultaneously maintaining comprehensive affordable coverage to low-income residents.

Ensuring Financial Security with Affordable Coverage

For New York's low-income consumers, BHP provides an affordable bridge between Medicaid and coverage on the Exchange. Premiums for a family of three on the Exchange will begin at around $730 a year for those at 139 percent of FPL, and escalate from there. Many New Yorkers with incomes below 200 percent of FPL have significant amounts

of debt, with little or no disposable income left to pay for health insurance premiums: 40 percent have credit card debt; 26 percent have medical debt; and 32 percent report having no savings at all.[8] A BHP could provide a lower-cost—or free—option for families struggling to break even.

BHP would bring substantial cost-savings to the State by enabling it to obtain increased federal funding while simultaneously maintaining comprehensive affordable coverage to low-income residents.

In addition to easing the financial burdens of low-income individuals, a BHP would also lead to greater coverage rates if built off of New York's existing FHP program. As described later in this Policy Brief, if a free or low cost BHP program were available, roughly 100,000 fewer families would opt to forgo coverage and pay penalties than would do so if their only option were the relatively expensive coverage available to them in the Exchange.

As displayed in Table 3, the State could choose to design a BHP which could be free or cost as much as $2,335 annually. But in the Exchange, the annual cost of co-premiums for coverage would reach the upper limits of the affordability schedule, ranging from $366 to $2,335, for people with incomes between 139 and 200 percent of FPL. Finally, a BHP without co-premiums, or even very low premiums, would make low-income New Yorkers less likely to experience significantly fewer coverage disruptions or gaps in coverage related to income fluctuations. This is a serious concern as experts estimate that nearly 50 percent of low-waged workers will fluctuate between Medicaid and Exchange eligibility within any given year.[9]

In short, by adopting a BHP, low-income New Yorkers could have better, more affordable, and potentially seamless coverage.

Generating State Savings

Next, for the State, a BHP presents two important opportunities to replace State funding for public coverage with federal financing while simultaneously maintaining comprehensive and affordable coverage for currently eligible populations and expanding access to coverage for still more.

First, like many other states, New York's existing Medicaid expansion program, FHP, offers coverage above the federal Medicaid gross income eligibility ceiling of 139 percent of FPL.[10] The FHP program covers parents with incomes up to 150 percent of FPL (coverage is also offered to childless adults with incomes up to 100 percent of FPL).[11] While New York could eliminate coverage for FHP enrollees above 139 percent FPL and require this population to enter the Exchange, the federal financing available for BHP would enable New York to continue to provide free or very low cost coverage to this population without expending State funds.

Second, if New York chooses to implement a BHP, the State would be able to essentially replace significant State funding for public coverage of legal, but not qualified, immigrants with federal financing for the BHP. As a result of litiga-

TABLE 3: BHP COULD CREATE AN AFFORDABLE BRIDGE BETWEEN MEDICAID AND COVERAGE ON THE EXCHANGE

Annual Premium Costs for a Family of Three (2 adults, 1 child)

FPL	Income	Medicaid	BHP		Exchange
100%	$18,530	$0	$0		$366
139%	$25,570	n/a	$0–$782	v.	$782
150%	$27,465	n/a	$0–$1,099	v.	$1,099
200%	$37,060	n/a	$0–$2,335	v.	$2,335
300%	$55,590	n/a	n/a		$5,281

tion brought over a decade ago, New York, like a number of other states,[12] currently offers public coverage to most groups of legal immigrants using State-only funds.[13] Under the ACA, all legal immigrants with incomes below 200 percent of FPL are eligible for the BHP.[14] Shifting 86,400 legal immigrant adults from New York's Medicaid program into a BHP would result in considerable savings to the State.

How Would a BHP Work in New York State?

There are substantial benefits to both the State and low-income residents which auger in favor of adopting a BHP in New York. Nonetheless, important questions remain.

- Can New York successfully operate a BHP with the funding that is likely to be available for the program?
- Who and how many people would be covered?
- What types of provider reimbursement levels would be adopted (e.g., public or commercial)?
- What are the possible cost-sharing levels and plan designs that New York might consider for its BHP, and how would they impact the financial viability of the program?
- What impact would adopting BHP have on the State Exchange and/or rates of the uninsured?

These questions and others are addressed on the right.

Who Would Participate in BHP? Membership Projections and Take-Up

Designed to coincide with the establishment of state Exchanges and the individual mandate to carry health coverage, states will have the opportunity to launch their BHP programs beginning in 2014. Individuals who fail to obtain coverage will face an annual fine (with some exceptions for financial hardships, religion and immigration status). Those earning below the income tax filing thresholds (86 percent of FPL for single filers and 128 percent of FPL for couples in 2010) will be exempt from the mandate, but this exemption would not apply to the population groups eligible for BHP, described in the following pages.

Methodology and Data Sources

This Policy Brief consists of original policy research and data analysis conducted by the Community Service Society of New York and our research partners, Gorman Actuarial and Manatt Health Solutions. Our analytical work included two substantive components: (1) population, eligibility and take-up; and (2) financing and cost modeling.

Population, Eligibility and Take-up Methodology

Baseline data on health insurance coverage, age, income and other demographics in New York State was drawn from a three-year blend of the 2008, 2009 and 2010 Current Population Survey Annual Social and Economic Supplement (CPS ASEC), adjusted forward to 2010 CPS ASEC for the overall population and for the uninsured. We then estimated the population, health insurance coverage and characteristics of New York's undocumented immigrants based on the work of Jeffrey Passel of the Pew Hispanic Center and excluded them from the CPS ASEC data to achieve a profile of potential BHP eligible uninsured.

The populations of eligible adults in several specific eligibility groups was estimated using supplemental data provided by the New York State Department of Health (NYSDOH) and other sources.

- Parents 139–150% FPL enrolled in Family Health Plus was derived from data provided by NYSDOH, distributed based on the income mix of Medicaid-enrolled parents in the CPS ASEC.
- Legal immigrant adults in state-only funded Medicaid was drawn directly from NYSDOH data.
- Adults 139–200% FPL in Healthy New York was estimated based on the 2009 Healthy New York program reports and personal communication with the New York State Department of Insurance.
- Adults 139–200% FPL in Direct Pay coverage was estimated based on personal communication with officials from the New York State Department of Insurance, distributed by income and age using the CPS ASEC. Numbers were increased

continued on next page

The following seven groups of residents would potentially enroll in New York's BHP:

(1) currently uninsured adults with incomes between 139 and 200 percent of FPL (including citizens and legal immigrants);

(2) parents with incomes between 139 and 150 percent of FPL currently enrolled in Family Health Plus;

(3) legal immigrant adults who are currently enrolled in Medicaid;

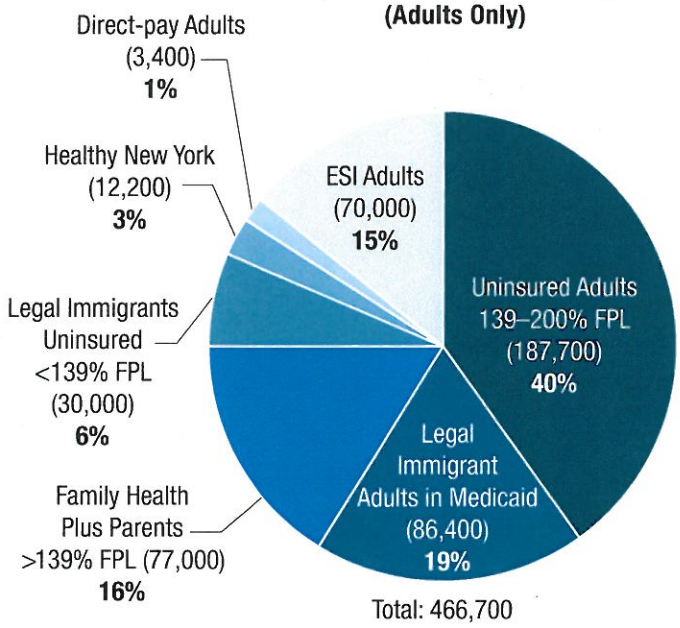
(4) legal immigrant adults with incomes below 139 percent of FPL who are currently uninsured;

(5) adults currently enrolled in Healthy NY as individuals or sole proprietors with incomes below 200 percent of FPL;

(6) adults with incomes between 139 and 200 percent of FPL who are currently insured in the Direct Pay market; and

(7) adults with incomes between 139 and 200 percent of FPL who currently have employer-sponsored insurance (ESI).

TABLE 4
New York State BHP Membership Projection by Current Coverage (Adults Only)



Methodology and Data Sources Continued...

based on the United Hospital Fund Report titled "Merging the Markets: Combining New York's Individual and Small Group Markets into common risk pools," 2008.

The take-up assumptions for each of the BHP eligible populations are discussed in detail below in the section titled "Who Would Participate in BHP? Membership Projections and Take-Up."

Financing and Cost Modeling

We estimated both the financing that would become available to New York State to fund a BHP and the costs of covering our projected BHP take-up population. For the financing component, given the extreme prices as a result of adverse selection in the individual market, we used commercial HMO and PPO small group products as a proxy for what individual premiums will be in 2014. We collected premiums for major carriers in the following locations: New York City, Buffalo, Rochester, Syracuse, Albany and Long Island. We trended these rates forward to 2014 and made several other adjustments. We estimated the premium tax credits and cost-sharing subsidies that would be available to projected BHP enrollees in the Exchange, and calculated the federal financing likely to become available to fund New York's BHP. In addition, based on data from NYSDOH and the 2009 Healthy New York program reports, we estimated several cost-saving offsets that would accrue to the State if a BHP were implemented.

To estimate the costs of covering the projected BHP population, we first gathered claims data on New York's FHP program from the State's 2009 Q4 Medicaid Managed Care Operating Reports (MMCOR). Using the FHP program as our baseline, we then estimated the relative risk and morbidity factors for each of the BHP population groups, and finally calculated a blended cost per enrollee per month based on membership projections. Full details of our cost modeling and assumptions are detailed below in the section titled, "How Much Would Offering a BHP Cost New York State?," as are a series of sensitivities and estimates of costs or savings under differing plan designs, provider reimbursement, and other program features.

Each of these seven groups of people has distinct characteristics which require a separate take-up analysis, briefly described below. This analysis uses the existing FHP program model and consequently assumes that there will be no co-premiums and very limited cost-sharing (e.g., co-payments) in a New York BHP. Because of the maintenance of effort obligation on states to continue their SCHIP programs through 2019, children are not included in this analysis.[15] All take-up estimates are based on the most current population data available for each eligible group, with no assumptions as to changes in population size or mix before 2014.

- **Uninsured adults with incomes between 139 and 200 percent of FPL:** Under the BHP, roughly 268,200 uninsured adults with incomes between 139 and 200 percent of FPL would become newly eligible for coverage.[16] However, these adults are only eligible if they do not have access to affordable insurance coverage from their employer. In this case, coverage is considered to be "affordable" if the employee's share does not exceed 8 percent of their income. Approximately 70 percent of this population (187,700) will enroll in the BHP, with the remainder taking up job-based coverage, opting to pay penalties and remain uninsured, or, in rare cases, securing an exemption from the individual mandate.[17]
- **Family Health Plus parents with incomes between 139 and 150 percent of FPL:** An estimated 77,000 parents with incomes between 139 and 150 percent of FPL were enrolled FHP in 2009.[18] This population would be eligible to transition to coverage through the BHP. If New York does not opt into a BHP in 2014, there will be strong fiscal pressures for the State to roll back the FHP eligibility level to the new federal Medicaid gross income eligibility ceiling of 138 percent of FPL. Assuming there is no co-premium for BHP, we project that 100 percent of these 77,000 FHP parents with incomes above 138 percent of FPL will enroll in the BHP.
- **Legal immigrants in State-only Funded Medicaid:** As a result of a court case[19] brought in the wake of the 1996 federal welfare reform law,[20] New York pays the entire costs of Medicaid and/or FHP coverage for approximately 86,400 legal (non-qualified) immigrant adults.[21] The State does not receive federal matching funds to help offset the costs of extending coverage to this group and, as a result, New York State currently pays the full cost of their coverage. Under the ACA, federal financing is restored for these legal immigrants who participate in BHP (including those now covered with State-only funding). Given this fiscal incentive, the State is likely to transfer 100 percent of the legal immigrants (86,400 individual adults) currently enrolled in Medicaid or FHP into the BHP.
- **Uninsured lawful immigrants with incomes below 139 percent of FPL:** Roughly 150,000 uninsured legal immigrant adults in New York have incomes below 139 percent of FPL. (Uninsured legal immigrant adults with incomes between 139 and 200 percent FPL are included in the overall numbers of uninsured adults in this income group detailed above.) These individuals are currently eligible for state-only funded Medicaid or FHP, but remain uninsured. While low-income legal immigrants will be eligible for the BHP, we estimate that only 20 percent will enroll in the program due to administrative hurdles, long-standing fears of engaging with government programs, and their exclusion from the individual mandate given their low income levels. We estimate final enrollment from this population will be 30,000.
- **Healthy NY:** As of July 2009, an estimated 12,200 individual and sole proprietor adults were enrolled in the Healthy NY program with incomes below 200 percent of FPL.[22] Under the ACA, all health plans that offer coverage in the individual and small group markets will need to include an "essential health benefits package" starting in 2014.[23] Healthy NY does not meet this standard because it does not cover treatment for mental health and substance abuse disorder services and prescription drugs. Assuming that Healthy NY is discontinued in 2014, we estimate that 12,200 or 100 percent of the individual and sole proprietor adults enrolled in Healthy NY with incomes below 200 percent of FPL will enroll in the BHP.
- **Direct Pay:** An estimated 3,600 adults with incomes between 139 and 200 percent of FPL currently purchase coverage in the individual—or "Direct Pay"—market.[24] Given the exorbitant price of insurance in this market (over $10,000 per year for an individual or $24,000 per

year for a family), typically only people who are either very wealthy or very sick pay for this type of coverage.[25] The very sickest in this group, who have already shown that they have the means to purchase this coverage despite the high premiums, are unlikely to disrupt their coverage and will likely remain in the "Direct Pay" market—even though their eligibility for coverage under the BHP would make them ineligible for subsidized coverage through the Exchange.[26] However, we project that the vast majority of this population, an estimated 3,400 people (95 percent of the total eligible) will drop their existing coverage and enroll in BHP.

- **Employer-sponsored insurance:** Roughly 375,500 adults in New York with incomes between 139 and 200 percent of FPL have employer-sponsored insurance (ESI).[27] Those with ESI would only be eligible for the BHP in the event that: (1) they are paying more than 8 percent of their income for their share of the coverage;[28] (2) their employer were to stop offering coverage to them, or; (3) their employer were to increase employee premiums to greater than 8 percent of the employee's income. Based on a review of existing literature on substitution of coverage, or "crowd out," we estimate that 70,000 current ESI members will enroll in the BHP. This equals 15 percent of the final BHP take-up population, and roughly 20 percent of current ESI enrolled adults with incomes between 139 and 200 percent of FPL.

Combining these seven groups, an estimated 466,700 adult New Yorkers will enroll in the BHP when the plan is fully implemented (see Table 5).

Is There Adequate Federal Financing to Establish a BHP in New York?

In determining the feasibility of offering a BHP, New York first must consider whether there is sufficient, and sustainable, federal funding. However, direct federal financing for a BHP is only part of the funding picture. In addition to federal financing, New York State is also likely to be able to recoup significant cost-saving offsets from eliminating or reducing State-funded expenditures by shifting certain populations (such as legal immigrants) from State-only funded programs into a BHP where federal funding is available. While such funding would not necessarily be dedicated to funding the State's BHP, New York could consider these cost-saving offsets as a financial benefit of adopting a BHP.

TABLE 5
Membership Projections (Adults Only)

	0-138% FPL	139-150% FPL	151-200% FPL	Total Eligible	Take-Up (%)
Uninsured Adults 138-200% FPL	—	28,000	240,200	268,200	187,700 (70%)
Family Health Plus Parents >138% FPL	—	77,000	—	77,000	77,000 (100%)
Legal Immigrant Adults in Medicaid	86,400	—	—	86,400	86,400 (100%)
Legal Immigrants Uninsured <138% FPL	150,000	—	—	150,000	30,000 (20%)
Healthy New York	—	1,200	11,000	12,200	12,200 (100%)
Direct Pay Adults	—	400	3,200	3,600	3,400 (95%)
Sub-Total	**236,400**	**106,600**	**254,400**	**597,400**	**396,700**
ESI Adults	n/a	n/a	n/a	n/a	**70,000**
Grand Total					**466,700**

Federal Financing Estimate

Under the ACA, the federal funding that each state will receive for a BHP is based on two components: (1) the amount of premium tax credits that BHP enrollees would have received if they enrolled in the second lowest-cost Silver plan on the Exchange, of which the state will receive 95 percent; and (2) an added offset for the cost-sharing subsidies that the same enrollees would have also received on the Exchange.[29] Under the ACA, a state must establish a trust to receive federal support for the BHP. These funds may be used to lower premiums or cost-sharing for BHP enrollees, or to provide them with additional benefits. The ACA further provides for an annual reconciliation to ensure that federal financing is used appropriately.[30] At this time, the precise nature of this reconciliation has yet to be specified by federal officials, adding a certain level of uncertainty for State officials.

Premium Tax Credits

In order to determine the premium subsidy portion of federal financing for New York's BHP, it is first necessary to estimate the cost of the second lowest-cost Silver-level plan that will be available in the State's Exchange in 2014. As an Exchange does not yet exist in New York, we began with a survey of the existing marketplace of health insurance premiums and products. We then adjusted the current premiums from 2011 to develop the estimated cost of a Silver product in 2014.

The average price for a Direct Pay product in New York State is currently over $1,000 per month for an individual.[31] Because there is so much adverse selection in the Direct Pay market, New York's small group products are perhaps a more realistic proxy for estimating costs in the 2014 Exchange marketplace.

New York's small group market has both Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) products. PPOs generally use a broader network, allow out-of-network provider utilization, and do not require referrals from primary care provider (PCPs) for specialty care. HMO products have a restricted network and require members to have a PCP act as a "gatekeeper" for specialty care, making it a less expensive product. To estimate the average cost of the second lowest-cost Silver plan in New York State, we first acquired regional pricing estimates for the most popular plans under both products with estimated actuarial values close to 70 percent. We then selected the second lowest Silver level premium for January 2011 by geographic region. Finally, we developed statewide average prices using a projected BHP distribution by region.

Table 6 shows the initial prices for the small group PPO and HMO products in New York in 2011 that would be equivalent to a second lowest-cost Silver Plan—$520 per month for a PPO and $367 per month for an HMO. By applying an

TABLE 6
Federal Funding Premium Tax Credit Estimate (Per Member Per Month Basis)

	Premium Tax Credit			
	Premiums based on PPO		Premiums Based on HMO	
	<150% FPL 0.94 AV	150-200% FPL 0.87 AV	<150% FPL 0.94 AV	150-200% FPL 0.87 AV
Second Lowest Cost Silver Plan CY 2011	$520	$520	$367	$367
Projected CY 2014 (9.9% trend)	$690	$690	$487	$487
State Mandated Benefits (6%)	-$41	-$41	-$30	-$30
Member Premium	-$50	-$89	-$50	-$89
Premium Tax Credit	$599	$560	$407	$368
95% of Premium Tax Credit	**$569**	**$532**	**$387**	**$350**

annual premium increase of 9.9 percent, the projected premiums for these products in 2014 would be $690 and $487, respectively. For the purposes of estimating federal financing, we then reduced these premiums by 6 percent to reflect New York's state-mandated benefits as, under the ACA, the federal government will not reimburse individual states for insurance benefits mandated under state insurance law over and beyond the essential benefit coverage.[32]

To determine how much these individuals are entitled to through premium tax credits, adjustments were made to subtract out the co-premium individual members would pay on the Exchange based on their income level (approximately $50 for people with incomes up to 150 percent of FPL, and $89 for people with incomes between 150 and 200 percent of FPL).[33] The remaining difference between the total and the co-premium paid is the amount of the premium credit. Finally, the premium tax credits are multiplied by 95 percent, which is the amount the federal government will pay the State for a BHP. Using a PPO rate, the amount of federal premium subsidy available is $569 per month for people with incomes below 150 percent of FPL and $532 per month for people with incomes between 150 and 200 percent of FPL. Using an HMO rate, the amount of federal premium subsidies would be $387 and $350, respectively.

Cost-Sharing Subsidy

The second component of the federal financing New York would receive for a BHP consists of the cost-sharing subsidies BHP enrollees would have been eligible for if they had sought coverage through the Exchange. Cost-sharing subsidies are expressed in the ACA as increases in the actuarial value of a 70 percent Silver-level plan to 87 percent for people with incomes between 150 and 200 percent of FPL and 94 percent for people with incomes below 150 percent of FPL.

It remains unclear as to how exactly these cost-sharing credits will be calculated, and there are several approaches that can be taken in order to calculate an estimated value.[34] We estimated the value of the cost-sharing subsidies by determining the difference between the medical claims of an individual enrolled in a 70 percent actuarial value Silver plan in the Exchange, and plans that have an actuarial value of 87 percent or 94 percent. To do so, we started with our premium estimates and subtracted out administrative costs, assuming that plans are operating at the New York State-permitted maximum of 18 percent. The remaining 82 percent of the premium represents actual medical claims. This estimate was then adjusted upward from 70 percent to the higher actuarial values of either 87 or 94 percent, with the difference being the cost-sharing subsidy (see Table 7).

Taken together, the total of the estimated premium tax credits and cost-sharing subsidies is the per member per month amount that will be available to New York for BHP financing. As described above, this amount will vary by the en-

TABLE 7
Federal Funding Cost Sharing Subsidy Estimate (Per Member Per Month Basis)

	Cost Sharing Subsidy			
	Premiums based on PPO		Premiums Based on HMO	
	<150% FPL 0.94 AV	150-200% FPL 0.87 AV	<150% FPL 0.94 AV	150-200% FPL 0.87 AV
Projected CY 2014 Silver Premium	$690	$690	$487	$487
Administrative Estimate (18%)	-$124	-$124	-$88	-$88
2014 Silver Medical Claims Estimate	$566	$566	$399	$399
Adjustment for Target Medical Claims*	$760	$703	$536	$496
Estimated Cost-sharing Subsidy	**$194**	**$137**	**$137**	**$97**

**Adjust by the ratio of 0.94/.70 for individuals up to 150 FPL and 0.87/0.70 for individuals 150 to 200 FPL*

TABLE 8
Total BHP Federal Funding Estimate (Per Member Per Month Basis)

		Total Federal Funding Estimate (With and Without 20% Utilization Reduction)			
		Premiums based on PPO		Premiums Based on HMO	
		<150% FPL 0.94 AV	150-200% FPL 0.87 AV	<150% FPL 0.94 AV	150-200% FPL 0.87 AV
No Utilization Reduction	95% of Premium Tax Credit	$569	$532	$387	$350
	Cost Sharing Subsidy	$194	$137	$137	$97
	Total Federal Funding (No Reduction)	**$763**	**$669**	**$524**	**$447**
With 20% Utilization Reduction	95% of Premium Tax Credit	$569	$532	$387	$350
	Cost Sharing Subsidy	$155	$110	$109	$78
	Total Federal Funding (20% Reduction)	**$724**	**$642**	**$496**	**$428**

rollee's income group and is dependent upon which product is used to generate the initial Silver product premium.

The previous estimates assume that the utilization patterns of the BHP population will be similar to a commercial population. However, a recent report by the Kaiser Family Foundation raises the possibility that utilization of health services by BHP enrollees might be lower than their commercially-insured Exchange counterparts.[35] Accordingly, we include a sensitivity adjustment to show the difference in the available cost-sharing subsidy with and without this 20 percent utilization reduction (see Table 8).

Total Available Federal Financing

To generate an estimate of the total financing which would be available to New York State's BHP, we multiplied the total funding per member per month by the number of people estimated to enroll or "take-up" coverage under the BHP. As described in the previous section, take-up is estimated for seven potential populations:

(1) currently uninsured adults with incomes between 139 and 200 percent of FPL (including citizens and legal immigrants);

(2) parents with incomes between 139 and 150 percent of FPL currently enrolled in FHP;

(3) legal immigrant adults who are currently enrolled in Medicaid;

(4) legal immigrant adults with incomes below 139 percent of FPL who are currently uninsured;

(5) adults currently enrolled in Healthy NY as individuals or sole proprietors with incomes below 200 percent of FPL;

(6) adults with incomes between 139 and 200 percent FPL who are currently insured in the Direct Pay market; and

(7) adults with incomes between 139 and 200 percent of FPL who currently have employer-sponsored insurance.

Depending on whether the second lowest-cost Silver plan is based on a PPO or an HMO product, we estimate that the total amount of financing available for New York's BHP is between $2.6 and $3.8 billion, assuming a 20 percent reduction for the lower utilization levels typically incurred by low-income people (see Table 9).

State Cost Saving Offsets

If New York establishes a BHP, the State will generate significant annual savings from the transfer of three groups of beneficiaries from other State programs into the new program (see Table 10).

TABLE 9
Total Available BHP Funding

	Uninsured Adults	FHP	Legal Immigrants in Medicaid	Uninsured Legal Immigrants	Healthy New York	Direct Pay	ESI	Total
Premiums Based on PPO								
Take Up	187,700	77,000	86,400	30,000	12,200	3,400	70,000	466,700
Premium Tax Credit	$1,207,491,000	$525,516,000	$589,670,000	$204,746,000	$78,451,000	$21,892,000	$450,881,000	$3,078,647,000
Cost Sharing Subsidy	$322,966,000	$179,334,000	$201,227,000	$69,870,000	$20,942,000	$5,881,000	$121,322,000	$921,542,000
Total (No Util. Reduction)	$1,530,457,000	$704,850,000	$790,896,000	$274,617,000	$99,393,000	$27,773,000	$572,203,000	$4,000,189,000
Total (20% Util. Reduction)	**$1,465,864,000**	**$668,983,000**	**$750,651,000**	**$260,643,000**	**$95,205,000**	**$26,597,000**	**$547,939,000**	**$3,815,881,000**
Premiums Based on HMO								
Take Up	187,700	77,000	86,400	30,000	12,200	3,400	70,000	466,700
Premium Tax Credit	$797,999,000	$357,530,000	$401,177,000	$139,297,000	$51,835,000	$14,475,000	$298,167,000	$2,060,481,000
Cost Sharing Subsidy	$227,721,000	$126,447,000	$141,884,000	$49,265,000	$14,766,000	$4,146,000	$85,543,000	$649,773,000
Total (No Util. Reduction)	$1,025,721,000	$483,977,000	$543,060,000	$188,563,000	$66,601,000	$18,621,000	$383,710,000	$2,710,254,000
Total (20% Util. Reduction)	**$980,176,000**	**$458,688,000**	**$514,684,000**	**$178,710,000**	**$63,648,000**	**$17,792,000**	**$366,602,000**	**$2,580,299,000**

NOTE: *Totals may not sum due to rounding*

First, in 2014, with the expansion of Medicaid to 138 percent of FPL and the establishment of an Exchange with subsidies for people with incomes above this threshold, the State will likely experience budgetary pressures to eliminate its FHP program and simply pocket the ensuing savings. While the State has no obligation to establish a BHP, if were to do so, roughly 77,000 FHP enrollees with incomes between 139 and 150 percent of FPL will be transitioned out of FHP into BHP. Currently, the State and the federal government each pay 50 percent of their health care costs in FHP. With of the adoption of a BHP, the State would no longer need to contribute its share for this population, generating $118 million annually in savings beginning in 2014.[36] Advocates for low-income people will argue that these savings should be reserved for the BHP or other health programs.

Second, New York would be able to entirely shift the cost of Medicaid coverage for 86,400 legal immigrants who are

fully State-funded. These immigrants, with incomes up to 150 percent of FPL, would be enrolled into the BHP. This move would generate savings of $378 million annually beginning in 2014.[37]

Finally, roughly 12,200 Healthy NY enrollees with incomes below 200 percent of FPL would also be expected to enroll in the BHP program. As a result, the State would no longer have to pay a stop-loss subsidy to private insurers, generating $14 million annually in State savings beginning in 2014.[38]

In total, adopting a BHP would lead to annual savings of $511 million for New York State.

In total, adopting a BHP program would lead to annual savings of $511 million for New York State. While these savings should be considered a direct benefit of implementing a BHP, there is no requirement in the ACA that these funds be spent on the State's BHP. State savings could be redirected to other programs for vulnerable populations which do not directly benefit from the Affordable Care Act (e.g., certain immigrant populations), or used to meet other State funding priorities.

TABLE 10
Projected State Savings From Adopting a BHP (CY 2014)

State Cost-Savings Offsets	Amount
Family Health Plus Parents 139%-150%	$118,385,000
Legal Immigrants with State-only Coverage	$378,306,000
Healthy NY	$14,060,000
Total	**$510,752,000**

Grand Total of BHP Financing Estimates

In summary, accounting for both available federal financing and State cost saving offsets, we project that the funding available for a BHP in New York State would fall in the range of $3.8 billion to $4.3 billion if premiums were based on a PPO product, or in the range of $2.6 billion to $3.1 billion if premiums were based on an HMO product. Under the ACA, these federal funds must be dedicated to operating the BHP and for the benefit of BHP beneficiaries.[39] The additional funding that flows from State cost saving offsets ($511 million) also could be used to benefit BHP enrollees or it could be directed to other State funding priorities (see Table 11).

TABLE 11
Total BHP Funding Estimates

	Premiums based on PPO	Premiums Based on HMO
Take-Up	466,700	466,700
Premium Tax Credit	$3,078,647,000	$2,060,481,000
Cost Sharing Subsidy	$921,542,000	$649,773,000
Total Financing (No Utilization Reduction)	$4,000,189,000	$2,710,254,000
Total Federal Financing (20% Utilization Reduction)	**$3,815,881,000**	**$2,580,299,000**
Total State Cost Saving Offsets	$510,752,000	$510,752,000
Total BHP Funding (20% Utilization Reduction)	**$4,326,633,000**	**$3,091,051,000**
Total BHP Funding (No Utilization Reduction)	$4,510,941,000	$3,221,006,000

How Much Would Offering a BHP Cost New York State?

In order to estimate how much a BHP would cost the State, CSS estimated medical and administrative costs of a potential BHP. As a starting point, we assessed the financial viability of a BHP using the existing provider reimbursement rates, benefit package, and cost-sharing levels in New York State's FHP program, which has a 98 percent actuarial value, no enrollee premiums, and modest co-payments.

To estimate BHP program costs, we began with the existing claims costs for New York's FHP program—$200 per member per month in 2009.[40] We then made the following adjustments:

- **Added in the cost of carved-out pharmacy services and maternity care:** The prescription drug benefit under the FHP program has been administered through the Medicaid Program since 2008, and there are few pregnant women and births in FHP as a result of a State policy which transfers these women to Medicaid. As benefits under the BHP will include both of these services, we adjusted the medical costs by $49.98 for pharmacy and $3.50 for maternity.
- **Adjusted for morbidity differences of the various eligible populations:** We made morbidity adjustments to the various populations by using a blend of two different methods: (1) using data from the Medical Expenditure Panel Survey and self-reported health status to calculate health expenditure risk factors,[41] and (2) using actuarial age factors.[42]
- **Adjusted for selection and pent-up demand:** Since all the other populations eligible for BHP are currently insured, we only modeled selection and pent-up demand for the uninsured population. We modeled the selection impact using baseline data on the distribution of the uninsured by self-reported health status and assigning a take-up curve by this self-reported health status distribution. We then used health expenditure risk factors to calculate a selection adjustment, which increases the cost of this population by 13 percent. We have assumed the following take-up levels by self-reported health status:
  - Assumed 95 percent of those reporting poor health status will take-up.
  - Assumed 90 percent of those reporting fair health status will take-up.
  - Assumed 85 percent of those reporting good health status will take-up.
  - Assumed 75 percent of those reporting very good health status will take-up.
  - Assumed 40 percent of those reporting excellent health status will take-up.

In addition to this selection adjustment, we have also applied a 5 percent pent up demand assumption for uninsured BHP enrollees who may initially use services at a higher rate than their insured counterparts.

- **Varying cost structures across the state:** To account for the regional differences in per member per month premiums across the state, we modeled expense assumptions based on the expected BHP distribution of enrollment in nine different regions of the state: Central Region, Finger Lakes, Long Island, Mid-Hudson, Northeast, Northern Metro, NYC, Utica-Adirondack, and the Western region. The resulting area adjustment was an increase of 4.1 percent.
- **Trend Assumption:** After making all of these adjustments, we then applied an annual trend assumption of 7.9 percent to reflect expected annual increases in medical costs between the present (2009) and 2014.[43]
- **Administrative Expenses:** Finally, to express these claims costs as a complete expense, we added an additional 15 percent to the resulting 2014 projected BHP claims costs to account for administrative expenses.[44]
- **Enhanced Provider Reimbursement:** It is possible that New York State might choose to enhance provider reimbursement above the rates currently paid in its public insurance programs, including FHP. As such, we provide two sets of BHP cost estimates—one continuing the current FHP reimbursement levels, and one with a 10 percent enhancement to provider reimbursement (i.e., a 10 percent increase in the 2014 projected claims cost).

The end result is a projected total program cost of $2.6 billion (assuming FHP provider reimbursement levels). As described in greater detail below, this is slightly less than the federal financing available to fund the program. If the State were to adopt enhanced provider reimbursements of roughly 10 percent, the BHP would cost an additional $255 million, for a final program cost of $2.8 billion (see Table 12).

The end result is a projected total program cost of $2.6 billion.

What Kind of Benefits, or Plan Design, Would a BHP Have in New York?

Under the ACA, states are accorded a great deal of flexibility in plan design. While the statute mandates a selective procurement procedure, and encourages the use of managed care, there is no requirement as to whether the plans must be commercial or not-for-profit. Ultimately, issues surrounding selection of the plans and products are mostly left to the states.

However, the ACA does specify that enrollee cost-sharing in a BHP plan must "not exceed the cost-sharing required under a platinum level plan," or an actuarial value of 90 per-

TABLE 12
Projected BHP Expenses

NY BHP Projected Expenses	Uninsured Adults	FHP	Legal Immigrants in Medicaid	Uninsured Legal Immigrants	Healthy New York	Direct-Pay	ESI	Total
Total	$253	$253	$253	$253	$253	$253	$253	$253
Morbidity Adjustment	-$39	-$50	$9	-$39	$114	$507	$0	-$18
Selection	$28	$0	$0	$28	$0	$0	$0	$13
Pent Up Demand	$12	$0	$0	$12	$0	$0	$0	$6
Total Medical Claims	$254	$203	$262	$254	$367	$760	$253	$254
Area Adjustment (4.1%)	$10	$8	$11	$10	$15	$31	$10	$10
Annual Trend Assumption (7.9%)	$124	$99	$128	$124	$178	$369	$124	$124
CY 2014	$388	$310	$401	$388	$560	$1,160	$387	$388
Admin (15%)	$68	$55	$71	$68	$99	$205	$68	$68
Total Expenses (pm/pm)	$456	$365	$472	$456	$659	$1,365	$455	$456
Membership Take Up	187,700	77,000	86,400	30,000	12,200	3,400	70,000	466,700
Total Expenses	**$1,029,191,000**	**$337,174,000**	**$488,589,000**	**$164,495,000**	**$96,532,000**	**$55,660,000**	**$381,979,000**	**$2,553,619,000**
Total With 10% Provider Reimbursement Increase	**$1,132,110,000**	**$370,891,000**	**$537,448,000**	**$180,945,000**	**$106,185,000**	**$61,226,000**	**$420,177,000**	**$2,808,981,000**

cent, for people with incomes between 139 and 150 percent of FPL, and to "not exceed the cost-sharing required under a gold plan," or an actuarial value of 80 percent, for people with incomes between 150 and 200 percent FPL. In contrast, the ACA provides that people with incomes between 100 and 250 percent of FPL who enroll in a Silver-level plan in the Exchange, can qualify for an additional cost-sharing subsidy which operates as an increase in actuarial values to 87 or 94 percent, depending on an enrollee's income.

Essentially, this would mean that the same populations entitled to 94 percent and 87 percent actuarial values in the Exchange are only entitled to 90 percent and 80 percent values in a BHP (though a state is clearly free to offer higher value plans).

This seemingly contradictory approach to plan design for people in the Exchange versus the BHP program is puzzling.[45] It is unlikely that Congress intended to provide financing for the BHP based on the higher cost-sharing subsidies available in the Exchange while simultaneously permitting the states to adopt a BHP with lower actuarial values their programs. However, it appears that it did just that. Accordingly, a state is not prevented from then using this combined financing to create a BHP with a lower actuarial value (90 and 80 percent, depending on income) than would be required for the same individuals if they were covered through the Exchange (94 and 87 percent, depending on income).

In developing a proposed BHP plan design for New York, we began with New York's FHP plan design, which has a 98 percent actuarial value, to develop our baseline cost estimates used in the section titled "Is There Adequate Federal Financing to Establish a BHP in New York?", above. As described in the proceeding paragraphs, under the ACA, New York has a number of different actuarial value plan design options. We modeled the following four plan design options: (1) a plan with a 94 percent actuarial value, as required for those with incomes between 139 and 150 percent of FPL in the Exchange; (2) a plan with a 90 percent value, which is the floor for those in BHP with incomes between 139 and 150 percent of FHP; (3) a plan with a 87 percent actuarial value, as required for those with incomes between 150 and 200 percent of FPL in the Exchange; and (4) a plan with a 80 percent actuarial value, which, as described above, is the ACA floor for those in BHP population with incomes between 150 and 200 percent of FPL (see Table 13).

TABLE 13
Plan Design Options

	FHP	BHP Option 1	BHP Option 2	BHP Option 3	BHP Option 4
Inpatient Co-pay	$25	100	250	500	1000
PCP Office Visit Co-pay	$5	10	10	15	35
Specialist Co-pay	$5	10	15	20	50
ER Co-pay	$3	50	75	75	100
Outpatient Surgery Co-pay	$0	0	125	250	500
Radiology	$1	5	5	10	20
Lab	$0.50	5	5	10	20
Pharmacy:					
▪ Generic	$3	5	10	10	10
▪ Brand	$6	15	15	25	35
▪ Non Formulary	$6	15	15	25	50
Estimated Actuarial Value	**98%**	**94%**	**90%**	**87%**	**80%**

TABLE 14
BHP Plan Design Scenarios and Their Respective Additional Savings

Benefit Analysis	BHP Baseline Scenario	BHP Scenario 1	BHP Scenario 2	BHP Scenario 3	BHP Scenario 4
Up to 150 FPL	0.98	0.94	0.90	0.94	0.90
150 to 200 FPL	0.98	0.94	0.90	0.87	0.80
Total Government Expenses	$2,553,619,000	$2,449, 390,000	$2,345,161,000	$2,349,896,000	$2,203,026,000
Monthly Member Cost	$456	$437	$419	$420	$393
Percent Savings		-4.1%	-8.2%	-8.0%	-13.7%
Total Dollar Savings		**$ (104,229,000)**	**$ (208,459,000)**	**$ (203,724,000)**	**$ (350,593,000)**

Adopting any one of the BHP plan design options in Table 13 would yield additional program cost savings because our original cost estimate of $2.6 billion was based on the current FHP program, which has a 98 percent actuarial value plan for all enrollees. The potential savings from each of these plan designs are displayed as "Scenarios" in Table 14, as follows:

- Under Scenario One, all BHP enrollees would be enrolled in a plan design with a 94 percent actuarial value, and the program would have an additional 4 percent in savings, or $104 million.
- Under Scenario Two, all BHP enrollees would be enrolled in a plan design with a 90 percent actuarial value, and the program would generate 8 percent savings, or $208.5 million.
- Under Scenario Three, BHP enrollees would be split according to income, so that people with incomes below 150 percent of FPL would enroll into a plan with a 94 percent actuarial value, and people with incomes between 150 and 200 percent of FPL would enroll into a plan with an 87 percent actuarial value. Under Scenario Three, the program would generate 7.9 percent in savings, or $203.7 million.
- Under Scenario Four, people with incomes below 150 percent of FPL would enroll into a plan with a 90 percent actuarial value, and people with incomes between 150-200 percent of FPL would enroll into a plan with an 80 percent actuarial value. Under Scenario Four, the program would generate 13.8 percent in savings, or $350.6 million.

Accordingly, the ACA offers significant latitude to the states to design a plan with varying levels of enrollee cost-sharing. The conditions in a high-cost-of-living state, like New York, where low-income families have little, if any, disposable income, would militate towards adopting either the Baseline Scenario or BHP Scenario 1.

What Impact Would a BHP Have on New York Rates of Insurance?

New York policymakers have asked what impact the adoption of a BHP would have on the number of people remaining uninsured after the ACA is fully implemented in 2014. As discussed throughout this paper, even with premium and cost-sharing subsidies, buying coverage in the Exchange remains cost-prohibitive for many, if not all, low-income New Yorkers.

If New York does not adopt a BHP, Exchange enrollees would have to pay premiums ranging from 3 percent to 6.25 percent of family income on the Exchange, even after receiving premium tax credits. Given these substantial premiums, and especially given that these families are at near-poor income levels, it is likely that significantly fewer eligible uninsured would take-up coverage in the Exchange than would take-up free coverage under a BHP.

There are two major groups of BHP-eligible New Yorkers who would face the dilemma of trying to find coverage on the Exchange within their family budgets: (1) the 268,200 uninsured adults with incomes between 139 and 200 percent

TABLE 15
Impact of BHP on Rates of Uninsurance (Includes Uninsured 139-200% and FHP Parents 139-150%)

	With BHP	Without BHP – Exchange Only		
		Scenario 1	Scenario 2	Scenario 3
Eligible Uninsured & FHP population	345,200	345,200	345,200	345,200
Take-up rate	77%	60%	50%	40%
Insured	264,700	207,100	172,600	138,100
Remaining Uninsured	80,500	138,100	172,600	207,100
Additional Uninsured without a BHP	—	**57,600**	**92,100**	**126,600**

of FPL; and (2) the 77,000 FHP enrollees with incomes between 139 and 150 percent of FPL. Earlier in this Issue Brief, we assumed a 70 percent take-up rate in the BHP program for eligible uninsured people with incomes between 139 and 200 percent of FPL, and 100 percent take-up rate for the FHP enrollees. The overall take-up rate we estimate between the two groups is 77 percent.

Offering free (or low-cost) coverage through BHP would result in between 57,600 and 126,600 fewer uninsured New Yorkers

It is difficult to estimate the exact number of additional individuals who would opt to pay penalties rather than purchase insurance. Nonetheless, using three simple price sensitivity scenarios, we have produced a range of estimates for how many New Yorkers are likely to remain or become uninsured if absent the adoption of free or low-cost BHP.

Table 15 shows varying levels of take-up for these two groups combined, from a high of 77 percent in a free BHP program to set of hypothetical take-up Scenarios in the Exchange, which describe take-up levels ranging from 40 to 60 percent. As the table shows, if New York adopts a BHP, we estimate that roughly 80,500 New Yorkers from these two eligibility groups would remain uninsured.[46] If New York does not adopt a BHP, we estimate that there will be somewhere between 138,100 and 207,100 uninsured New Yorkers, depending on how many people take-up coverage in the Exchange.

In summary, offering free (or low-cost) coverage through a BHP would result in between 57,600 to 126,600, or a midpoint of 92,100, fewer uninsured New Yorkers.

What Impact Would a BHP Have on New York's Exchange?

There are two threshold questions that must be addressed in determining the impact New York's adoption of a BHP would have on the future State Health Insurance Exchange:[47] First, would the development of a BHP adversely impact the Exchange's viability and purchasing power? Second, would the adoption of a BHP undermine the Exchange's ability to adequately spread risk and avoid adverse selection?

BHP's Impact on Exchange Viability and Purchasing Power

Many policymakers legitimately question whether the adoption of a BHP would remove large number of enrollees from New York's Exchange and consequently have the unintended consequence of diluting the Exchange's potentially formidable purchasing power. These policymakers rightfully note that the number of participants in the Exchange is a critical factor in whether insurance carriers will be motivated enough to participate in the Exchange and bid competitively for members.

New York's Exchange should be large enough to have adequate purchasing power with a parallel BHP program. A commonly cited rule of thumb is that a threshold enrollment of 100,000 people in the Exchange should ensure adequate purchasing power.[48] Estimates indicate that as many as 650,000 to 1.4 million New Yorkers may enroll in the Exchange.[49] As described above, we estimate that 466,700 people will be eligible for BHP.

Therefore, BHP would represent a significant portion, roughly one-third, of potential Exchange enrollment.[50]

The potential transfer of a large population group out of the Exchange into a BHP might be cause for concern in smaller states. But this is not necessarily a concern for a large state, like New York. Even if New York were to adopt a standalone BHP program outside the Exchange, there would be anywhere from 400,000 to 900,000 New Yorkers left in the Exchange.

Accordingly, while a BHP would not necessarily compromise the viability of New York's Exchange, the issue of the impact the adoption of BHP would have on the Exchange's purchasing power needs further study by State policymakers.

BHP's Impact on Health Risk of the Exchange Population

A second important question raised by policymakers relates to whether the adoption of a BHP will adversely affect the medical underwriting risk of the enrollees left in New York's Exchange. The answer to this question can only be resolved once we know whether the BHP population is sicker or healthier than their Exchange counterparts. If the BHP enrollees are healthier than their Exchange counterparts, than their removal from the Exchange into a separately rated BHP program, would drive up the cost of coverage in the Exchange. Conversely, if BHP members are sicker than the remaining Exchange population, it is possible that the addition of a BHP could lead to lower costs in the Exchange by removing the relatively higher-costing BHP population. In either event, the adoption of a BHP leads to increased uncertainty about costs in the Exchange.

But, a close reading of the ACA indicates that the BHP population does not necessarily have to be separated from the Exchange's risk pool.[51] Instead, some experts argue that it is both possible and potentially desirable for states, like New York, to pool the risk by including the BHP in a risk adjustment program between BHP and Exchange members.[52] While pooling risk in this way could resolve concerns about the BHP's adverse impact on Exchange premiums, the actual mechanics of this shared pooling are unknown at this time and require further study by State and federal policymakers.

Assuming that it is possible to combine these two risk pools, this option could improve the overall risk in the Exchange. Most notably, enrollees in a free or very low-cost BHP would experience higher take-up and less adverse selection than the Exchange, with its relatively expensive co-premiums and substantially higher out of pocket costs. As discussed above, under a pooled risk scenario, the Exchange would additionally benefit because another 57,600 to 126,600 more people will opt for BHP coverage. These individuals would both increase the size of the risk pool, and would also represent healthier risk than the Exchange population overall, since absent a BHP, only sicker individuals among this low-income population are likely to pay the relatively expensive co-premiums required in the Exchange.

Accordingly, if pooled with the Exchange, a BHP would both increase the size of the risk pool overall, and would to a significant extent mitigate adverse selection among the large low-income uninsured population with incomes below 200 percent of FPL in the Exchange.

Additional Factors to Consider about Adopting a BHP in New York

The opportunity presented by adopting a BHP is not without costs. Low-income New Yorkers would have fewer choices amongst subsidized coverage and would not be able to access the subsidized commercial products in the Exchange. Commercial products are thought to have more comprehensive networks. To increase these concerns about inadequate provider capacity, we recommend that the State strengthen the program through increasing provider reimbursements by 10 percent, for an additional cost of $255 million. Some of the costs of improving provider networks through reimbursement increases could be offset by offering a BHP plan with a 94 percent actuarial value, instead of the full FHP benefit (with a 98 percent actuarial value). This would engender $104 million in savings (see Table 16).

In addition, adopting a BHP has risks. As described throughout this report, several key questions have yet to be addressed by the federal regulators (see sidebar). Guidance from federal regulators is urgently needed on key financing questions related to how valuations will be set for the Silver-level premiums and cost-sharing subsidies. Additional questions arise about what type of benefit plans will be acceptable to federal regulators in state-run BHP programs. Most

importantly, states need guidance about how to administer the risk pool for BHP: namely, can and should the BHP risk pool be combined with a state's Exchange risk pool? To do so would alleviate the concern that adopting a BHP would undermine the viability of a state's individual market.

Finally, state policymakers continue to express an uncomfortable level of uncertainty related to the concern that federal regulators could significantly revise the financing of a BHP after its adoption. This uncertainty, and the other issues raised above, should be addressed by federal regulators through the rapid promulgation of BHP regulations.

Conclusions & Recommendations

In 2008, the New York State Legislature authorized the State to seek federal financing in order to offer our popular, high quality and affordable FHP program to all New Yorkers with incomes below 200 percent of FPL. The passage of time and the historic enactment of the ACA have overtaken that effort. But now the ACA provides New Yorkers the proverbial "second bite at the apple" to cover these same families with federal funding.

Adopting a BHP would provide significant fiscal relief to those low-income New York families who otherwise would face substantial co-premiums for coverage purchased through the Exchange. If adopted, a BHP could offer coverage to around 466,700 New Yorkers. It would also result in approximately 92,100 fewer uninsured New Yorkers than if there were only an Exchange—in other words, 92,100 more New Yorkers would find the cost of insurance within reach if given the option of enrolling in a BHP Plan.

Financially, the State is also likely to benefit should it adopt a BHP. Table 16 on the next page describes three possible financing scenarios if New York adopts a BHP: (1) a Best Case scenario; (2) a Worst Case scenario; and (3) CSS's Best Estimate. In all three scenarios, the program costs are the same—approximately $2.5 billion.

Federal financing for the program could range from a Best Case scenario of $3.8 billion. In the Best Case scenario, federal officials would use of PPO small group rates as a proxy for an individual market rate in 2014. The Worst Case scenario, there would be federal financing in the amount of $2.6 billion, which assumes the use of less expensive HMO small group rates to generate financing estimates (see Table 16).

As for State savings, in the Best Case scenario, the State is also able to use its $511 million in savings to fund its BHP. In the Worst Case scenario, the State uses the $511 million in savings for purposes unrelated to providing affordable health care to low-income families.

Our Best Estimate assumes that the HMO small group rate is adopted as a proxy for financing BHP. This leaves BHP with a program operating margin of $27 million. CSS also assumes that the State savings of $511 million will be used to increase provider reimbursement rates by 10 percent, for a cost of

Issues Requiring Federal Regulatory Resolution

Several issues requiring resolution by federal regulators before a state can proceed with a BHP are identified by this Issue Brief:

- How will federal regulators project a Silver-plan premium for BHP financing in the states?
  - What products and markets will regulators use as a premium basis for states, like New York, where individual market premiums are inflated?
- How will federal regulators value the cost-sharing subsidies?
  - Will they be pegged at 100% or 95% level?
  - What method will be used for delivering them?
  - What utilization and cost basis will be used for calculating them?
- Will states be able to offer BHP plans at the lower 90/80 percent AVs; or will federal regulators recommend the 94/87 percent AVs, consistent with the Exchange?
- Can states opt to combine the BHP and Exchange risk pools? If so, what is the recommended method for risk adjustment between carriers?
- Can federal regulators propose a reliable method of annual financing reconciliation to address states' anxieties about the fiscal uncertainty of the BHP program?

TABLE 16
Best and Worst Case Scenarios Financing Estimates Should New York Adopt a BHP

	Best Case	Worst Case	Best Estimate
Federal Financing Available	$3,815,881,000	$2,580,299,000	**$2,580,299,000**
BHP Program Costs	$2,553,619,000	$2,553,619,000	**$2,553,619,000**
Sub-Total: BHP Net Operating Margin	$1,262,262,000	$26,680,000	**$26,680,000**
State Cost Savings Offsets	$510,752,000	n/a	**$510,752,000**
Increase in Provider Reimbursement (10%)			**($255,362,000)**
Plan Design Scenario 1 (AV for all beneficiaries would be 94%)			**$ 104,229,000**
Net Financial Impact of BHP for New York State	$1,773,014,000	$26,680,000	**$386,299,000**

$255 million. We then assume that the State adopts a 94 percent actuarial value plan for BHP instead of the baseline FHP product, which has a 98 percent actuarial value. Using Plan Design Scenario 1 would generate an addition $104 million in savings. Accordingly, in our Best Estimate scenario, we find that the total net impact of adopting a BHP would result in an additional $386 million in State revenue.

Despite the considerations and unknowns identified in the prior section, we recommend that New York adopt a BHP. Our Best Estimate indicates that there would be approximately $2.6 billion in federal financing, with costs on the order of $2.5 billion, for a net operating margin of $27 million. Importantly, some experts have argued that a state's operating margin will improve over time because federal financing for BHP is pegged to commercial Silver-tier plan costs which are likely to increase at a faster rate than increases in Medicaid (or a publically modeled BHP) costs.[53] The State's savings of $511 million is not included in this positive net operating margin.

Besides saving the State money, offering a BHP ensures that low-income families would not face extreme eligibility cliffs between the federal Medicaid baseline and the relatively cost-prohibitive coverage in the Exchange. Building off of public coverage would ensure that fewer low-income families would face coverage disruptions than they would if they were moving between Medicaid and the Exchange.

In summary, the adoption of BHP could generate significant savings for the State annually. In addition, offering a BHP would ensure that New York maintains its tradition of offering high quality, affordable coverage to its low-income families. It would also ensure that these families have greater continuity of care due to their fluctuating incomes, thereby avoiding inevitable disruptions in coverage as they migrate between Medicaid and the Exchange. Finally, offering a BHP ensures that roughly 92,000 more New Yorkers are likely to enroll in coverage than would have it they were only offered relatively expensive products in the Exchange.

In summary, the adoption of BHP could generate significant savings for the State annually. In addition, offering a BHP would ensure that New York maintains its tradition of offering high quality, affordable coverage to its low-income families.

Adopting a BHP offers New York an important opportunity to continue its leadership in offering quality, affordable coverage to its low- and moderate-income families while generating State savings. It is an opportunity worth seriously exploring.

Notes

1. T.S. Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues," The Commonwealth Fund, July 2010.
2. Congressional Budget Office, "Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)," March 2011.
3. P. Boozang, M. Dutton, A. Lam and D. Bachrach, "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010.
4. The BHP option was modeled and named after Washington State's Basic Health, a state-sponsored program which provides low-cost health insurance options for low-income people using private health plans.
5. Section 1331(d) of the Affordable Care Act (ACA) lays out the available funding for a BHP as: "...equal to 95 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle." There is a lively debate as to whether this provision should be interpreted as 95% of the premium tax credits and 95% of the cost-sharing, or if the comma separating the two means that the cost-sharing credits are not subject to the 95% rule and, in fact, will be paid in full. *Compare*, R. Carey, "Health Insurance Exchanges: Key Issues for State Implementation," RWJF State Coverage Initiatives, September 2010 *with* Milliman, "Planning Washington's Health Benefit Exchange, The potential impact of three key decisions," January 2011, *and* S. Dorn, "The Basic Health Program Option Under Federal Health Reform: Issues for Consumers and States," RWJF State Coverage Initiatives, March 2011.
6. ACA §1331(b).
7. The statute requires that the State-based "competitive process" for procuring plans to consider: innovation; health and resource differences of enrollees and access to local health providers; encouragement to contract with managed care plans; and performance measures to encourage the provision of quality of care and improved health outcomes. ACA § 1331(c).
8. Community Service Society of New York, The Unheard Third Survey, "Hardships and Personal Worries for Low-Income New Yorkers," December 2010, *available at* http://www.cssny.org/userimages/downloads/UnheardThird2010HardshipsandPersonalWorries.pdf.
9. B. Sommers & S. Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," 30 HEALTH AFFAIRS 238-36, February 2011.
10. Eight states offer Medicaid-like products above the federal Medicaid floor: CT, DC, ME, MN, NY, RI, VT, WI. Eighteen others offer something other than Medicaid: CA, CT, DC, HI, IN, IA, ME, MA, MN, NJ, NM, OR, PA, UT, VT, VA, WA, WI. Still more states have disease- or service-specific programs that are state-only funded. Kaiser Family Foundation, "Income Eligibility – Low Income Adults," *available at* www.statehealthfacts.org, January 2011.
11. In addition, New York's State Children's Insurance Program (SCHIP)—Child Health Plus—offers subsidized coverage to children in families who earn up to 400 percent of FPL. This program is subject to maintenance of effort requirements through 2019, and thus does not face the same risks, at least not during the first five years following implementation of the ACA. See Children Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-13, § 2113, 123 Stat. 37.
12. Thirty-three states provide state-only funding for varying classes of legal immigrants: AL, AR, CA, CO, CT, DE, FL, HI, IL, IO, LA, ME, MD, MA, MI, MN, MO, NE, NJ, NM, NY, NC, OH, OR, PA, RI, TN, TX, VA, WA, WI, WY. National Immigration Law Center, "Guide to Immigrant Eligibility for Federal Programs: Medical Assistance Program for Immigrants in Various States," July 2010, *available at* www.nilc.org.
13. As a result of *Aliessa v. Novella*, New York offers public coverage to legal immigrants who are ineligible for federal Medicaid matching funds, including recent Green Card holders and people who are permanently residing under color of law (PRUCOL immigrants). *Aliessa v. Novello*, 730 N.Y.S.2d 1 (2001).
14. In implementing the ACA, the U.S. Department of Health and Human Services has determined that the term "lawful immigrants" covers a broad category of immigrants, including: Lawful Permanent Residents ("green card holders") during their first five years, people who are permanently residing under of color of law (PRUCOLs) and, more broadly than what is currently deemed eligible for public coverage in New York State, some additional non-immigrant visa holders. See 75 Fed. Reg. 45930 (July 30, 2010) (to be codified at 45 C.F.R. pt. 152.2).
15. *Supra* n. 11.
16. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (CPS ASEC), 2008-2010 three-year blend adjusted to 2010 uninsurance levels, controlling for immigrant status. Estimates include legal immigrants but exclude undocumented immigrants. The size and characteristics of these immigrant populations are estimated based on the work of Jeffrey Passel. *See*, e.g., J. Passel and C. D'Vera Cohn, "A Portrait of Unauthorized Immigrants in the United States," Pew Hispanic Center, April 2009.
17. In developing this take-up function, Gorman referred to papers written by Ku/Coughlin and Gruber. See: L. Ku and T.A. Coughlin, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," Inquiry, Volume 36, Number 4 (2000): pp 471-490; J. Gruber, "Tax Policy for Health Insurance," National Bureau of Economic Research, Working Paper 10977, December 2004. In addition, Gorman engaged in direct discussions with Dr. John Gruber to clarify his modeling techniques. However, the final model was not reviewed by Dr. Gruber, and Gorman Actuarial takes full responsibility for the resulting analysis. These results are supported by the recent Kaiser Family Foundation report. See: J. Holahan and I. Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults Below 133% of FPL," Kaiser Commission on Medicaid and the Uninsured, May 2010.
18. Data tabulation provided by New York State Department of Health, February 2011. FHP parent membership distributed by income based on analysis of Medicaid enrollee demographic data from a three-year blend of data from the 2008-2010 Current Population Survey, Annual Social and Economic Supplement.
19. *Supra*, n. 13.
20. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193, 8 U.S.C. 1601-22 (Title IV).
21. Data tabulation provided by New York State Department of Health, February 2011.
22. The New York State Department of Insurance estimates that roughly 15% of sole proprietors and individuals enrolled in Healthy NY have

incomes below 200 percent of FPL (personal communication with the authors). We also removed children (roughly 20% of the Healthy NY individual and sole proprietor enrollment) from our calculations. Burns & Associates, "Independent Report on the Healthy NY Program for Calendar Year 2009," January 2010.

23. ACA §1302.
24. As of January 2011, there were approximately 24,450 HMO/POS Direct Pay members, according data provided to the authors by the New York State Department of Insurance. We have estimated 19,250 "Other" Direct Pay members as of January 2011 using the HMO/POS trends. We have estimated that total Direct Pay membership is approximately 44,000. These direct pay members were then distributed by income and age using demographic data on direct pay members from the Current Population Survey, Annual Social and Economic Supplement, 2008-2010 three-year blend.
25. CSS analysis of New York State Department of Insurance data, "Premium Rates for HMO Standard Individual Health Plans – May 2011," available online at: http://www.ins.state.ny.us/ihmoindx.htm.
26. The presence of a BHP may be detrimental to the very sickest individuals in the Direct Pay market, an issue policymakers should consider in advance of adopting a BHP.
27. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010.
28. ACA §1331(e). An estimated 80% of people with employer-sponsored insurance with incomes between 139 and 200 percent of FPL pay some co-premiums for their insurance coverage, and an estimated 30 percent pay co-premiums of more than 8 percent of their family income. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Household Component, 2004-2006 blend, Northeast Region.
29. Section 1402 of the ACA states that individuals with incomes between 100 and 400 percent of FPL who enroll in a Silver-level plan on the Exchange will get a reduction in the out-of-pocket cap on spending outlined in §1302 (c)(1). ACA §1402(c)(1). It further states that those individuals with incomes between 100 and 250 percent of FPL will receive an additional reduction in their cost-sharing by having the actuarial value of their plans increased from 70 percent to between 73, 87 or 94 percent, depending on income. ACA §1402(c)(2).
30. *See* ACA §1331(d)(3).
31. *Supra* n. 24.
32. ACA §1311(d)(3).
33. Section 1401 of the ACA amends the Internal Revenue Code of 1986 by setting a cap on how much a household will be required to pay in health insurance premiums in any given year. The difference between this cap and the actual premium cost for insurance on the Exchange will be allowed as a credit against taxes imposed. For people with incomes below 139 percent of FPL, the premium cost is capped at 2 percent of household income. For people with incomes between 139 and 150 percent of FPL, the premium cap is 3 to 4 percent of income. For those between 150 and 200 percent of FPL, the premium cap is 4 to 6.3 percent. For those between 200 and 250 percent, the cap is 6.3 to 8.05 percent of income. For those between 250 and 300 percent, the cap is 8.05 to 9.5 percent. For those between 300 and 400 percent FPL, the cap is at 9.5 percent.
34. There is no federal guidance about how the cost sharing subsidy will work. Accordingly, we have identified three methods, described in order of increasing complexity. First, the simplest approach would be to enroll eligible individuals in richer plan designs and then the cost sharing subsidy would be the premium difference between the second lowest costing Silver plan and the 94 percent (or 87 percent) AV plan. But this approach may overstate the subsidy as insurers may overstate the premiums for the higher AV plans. Second, insurers could adjudicate claims for these members twice (e.g., first for a 70 percent AV plan and second for 94 percent AV plan) with the federal government paying the difference in claims costs. CSS estimated cost-sharing subsidies using this second approach. Third, the consumer could receive funds directly from the federal government to pay for the cost-sharing difference. However, this would seem to contradict §1402(c)(3), which states that payments will be made directly to the health plan. Moreover, this would be a burdensome process for consumers and insurers alike. All of these approaches might need to be supplemented with some sort of risk adjustment to ensure consistency and fairness in financing for insurance carriers.
35. Kaiser Family Foundation, "A Profile of Health Insurance Exchange Enrollees," Focus on Health Reform series, March 2011.
36. The State's share of 2009 capitation rate for FHP was $229 per member per month. We assumed a 5 percent annual trend rate. We assumed that FHP members are only enrolled for 10.5 months, despite the fact that beginning in 2012 enrollees will have guaranteed continuous enrollment for 12 months, generating a savings of $192 million annually, beginning calendar year 2014. Capitation rate and enrollment data provided to authors by New York State Department of Health, March 2011.
37. In 2009, medical expenses for legal immigrants enrolled in public coverage was $327 per member per month. Assuming an annual trend of 5 percent and a shift of 86,400 legal immigrants currently on public coverage, results in a savings of $378 million beginning in calendar year 2014. Capitation figures and enrollment data provided to authors by New York State Department of Health, March 2011.
38. In 2009, the State funding for the Healthy NY stop loss subsidy was $86 per member per month. See Healthy NY 2010 Annual Report at page 94. Using this subsidy for 12,200 members with a five percent annual trend, we estimate a savings of approximately $14 million in calendar year 2014.
39. ACA §1331(d)(2).
40. Based upon Fourth Quarter 2009 Medicaid Managed Care Operating Reports, provided to CSS by the New York State Coalition of Public Health Plans.
41. This method was used by Milliman in a recent analysis issued for Washington State, "Planning Washington's Health Benefit Exchange: The Potential Impact of Three Key Decisions," January 2011.
42. Age adjustments analysis performed by Gorman Actuarial.
43. This estimate is based on an analysis on the FHP population over a three year period.
44. To be conservative, CSS overstated these costs as 15 percent annually, the maximum amount allowed under the BHP statute. The current (2009) MMCOR report indicates administration costs in the FHP program are running between 11 and 13 percent annually.
45. It is unclear if it was the intention of lawmakers to allow states to offer higher cost-sharing to the same population under the BHP than they would face otherwise in the Exchange. The original ACA bill defined the required cost-sharing subsidies for this population on the Exchange as increases in actuarial value from the 70 percent Silver level to the 90 percent Platinum and 80 percent Gold levels, corresponding with that which was required for the same population under a BHP. ACA §1302(d). It was only through the Health Care and Education Reconciliation Act that the cost-sharing subsides were revised to the higher values and a discrepancy was established. Health Care and Education Reconciliation Act of 2010, Pub. L. 111-52, §1323, 124 Stat. 1029.
46. This analysis does not account for potential employer-sponsored insurance take up.

47. Once these two threshold questions are addressed, the State would have to address a host of administrative and administrative cost questions relevant to the nexus between BHP and the Exchange.
48. A. Enthoven, et al, "Making Exchanges Work in Health-Care Reform," Committee for Economic Development, December 14, 2009, *available at* http://www.ced.org/images/library/reports/health_care/exchangememohc09.pdf. *See also*, T. Jost, *supra* n. 1; S. Dorn, *supra* n. 5.
49. *Compare*, P. Boozang, M. Dutton, A. Lam, D. Bachrach, "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010, *with* M. Buettgens, J. Holahan, C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," prepared for the Robert Wood Johnson Foundation State Coverage Initiatives by the Urban Institute, March 2011.
50. The Kaiser Family Foundation and Robert Wood Johnson Foundation have generated similar estimates as to the size of New York's BHP-eligible population. *See* E. Trish, et al., "A Profile of Health Insurance Exchange Enrollees," Kaiser Family Foundation, March 2011, *available at* http://www.kff.org/healthreform/upload/8147.pdf and Buettgens et al, March 2011.
51. The section of the ACA that describes how much the federal government shall pay the states says: "The Secretary shall make the determination ... on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and the cost-sharing reduction that would have been provided to eligible individuals...including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for the health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payment and reinsurance payments that would have been made if the enrollee had enrolled in a quality health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled." ACA §1331(d)(3)(ii). Rather than affirmatively stating BHP risk is to be separately rated, as is required under the "actuarial soundness" provision in the federal Medicaid regulations, it strongly implies that risk between BHP and the Exchange is expected to be pooled and adjusted for an establish list of factors. *See* 42 C.F.R. §438.6 (actuarial soundness regulation for Medicaid).
52. S. Dorn, "The Basic Health Program Option under Federal Health Reform: Issues for Consumer and States," Academy Health/Robert Wood Johnson Foundation, March 2011.
53. Milliman, "Healthcare Reform and the Basic Health Program Option, Modeling Financial Feasibility," April 2011.

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The Federally-Funded Basic Health Program

Under current law states have two options to deliver coverage to adults with low incomes not eligible for Medicaid. Adults and their dependents with incomes between 133% and 200% of the Federal Poverty Line (FPL) are eligible for either: (1) subsidized commercial insurance via an "Exchange" or (2) enrollment in the "Basic Health Program" ("BHP").

The Basic Health Program is the Best Choice for Illinois

- **No Cost to the State** – 100% funded by the federal government at 129% of estimated Illinois Medicaid costs. The State will capitate payments to health plans, which will minimize the financial risk to the State.

- **Self-Sustaining** – Federal subsidies for the BHP are expected to exceed costs for more than 25 years based on current trends. Federal payments to the State to cover 400,000 Illinoisans in the BHP should be no less than $1.45 billion. This amount is based on an estimated $3,624 per individual, which was the national average cost incurred by Medicaid managed care organizations in 2010 to cover an individual. Because the BHP funding is based on the second lowest cost Silver tier plan in an Exchange, the expected federal payments should not be lower than $1.45 billion, as the plans operating in an Exchange will not offer a commercial plan at lower than Medicaid rates. **Federal payments should exceed the expected costs of the BHP by $510 million as many experts approximate annual funding to be over $4,900 per individual in the BHP, or $1.96 billion.** Because BHP funding is tied to an Exchange (i.e., commercial insurance), projected payments from the federal government are expected to increase faster than the costs of the BHP, as commercial insurance costs have historically risen at a faster rate than Medicaid costs.

- **Savings to the State on the Existing Medicaid Program** – Significant State budget savings could occur, as permitted by the ACA beginning on January 1, 2014, if the State terminated optional Medicaid coverage for adults with modified adjusted gross income above 133% FPL. They could be transferred to the BHP without increasing their health care costs or reducing their benefits. **These savings would not occur in an Exchange.**

- **Higher Participation Rate** – Studies show that premium costs and high out of pocket costs deter low income individuals from purchasing health insurance. The relatively high cost sharing and premium costs inherent in an Exchange will most likely limit elective enrollment. Thus, a significant number of individuals eligible for subsidies in an Exchange will choose not to participate. **The BHP will be structured to eliminate or significantly reduce out of pocket costs to such individuals, resulting in a greater number of members electing to be insured.**

- **Provider Continuity** – It is estimated that 35% of all low income adults will experience a change in income every 6 months and be eligible to enter or leave the Medicaid program. Studies show that provider continuity is clinically significant. The BHP will utilize the same provider network as the Medicaid program. **Thus, the BHP will provide stability of coverage to families and continuity in terms of their provider network.**

- **Enhanced Provider Payments** – Provider payments will be higher than Medicaid rates. These payments will result in a net increase to the State in tax dollars, as well as increased reimbursement to providers.

- **Greater Benefits to Enrollees** – Federal funding is in the form of an advanced lump sum given to the State at the beginning of each federal fiscal year with the potential funding for Illinois approaching $2 billion annually. The State would collect interest on the undistributed monies that would be dispersed to health plans on a monthly basis over the course of the year. The interest may be used to offer additional benefits to enrollees, or it may be used as a rainy day fund to hedge against the risk of rising health care costs.

The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States

by Stan Dorn
Prepared for State Coverage Initiatives by the Urban Institute

March 2011

AcademyHealth

State Coverage Initiatives
Robert Wood Johnson Foundation

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) offers states the option to implement the Basic Health Program (BHP). BHP gives states 95 percent of what the federal government would have spent on tax credits and subsidies for out-of-pocket costs for two groups:

- Adults with income between 133 and 200 percent of the federal poverty level (FPL); and
- Legally resident immigrants with incomes below 133 percent FPL whose immigration status disqualifies them from federally matched Medicaid.

If a state implements BHP, these two groups of consumers cannot receive subsidized insurance in the exchange. Instead, the state covers them by contracting with health plans or providers. Such contracts must provide at least the minimum essential benefits under ACA, and consumers may not be charged more than what they would have paid in the exchange.

Rather than analyze the full range of state options for implementing BHP, this paper focuses on strategies that reduce health care costs for low-income residents. Of course, ACA's tax credits and other subsidies will make coverage much more affordable to the uninsured, but research suggests that the amounts charged in the exchange could still deter many low-income consumers from signing up for coverage. A further deterrent to enrollment could be consumers' fear of owing money to the Internal Revenue Service at the end of the year if their annual income turns out to exceed what consumers anticipated when health insurance tax credits were paid during the course of the year. Finally, among some low-income adults who sign up for coverage, out-of-pocket costs could delay or prevent utilization of necessary care.

The BHP option permits states to sidestep these obstacles by giving low-income residents "Medicaid look-alike" coverage or "CHIP [Children's Health Insurance Program] for adults," with lower consumer costs than will be charged in the exchange and without any risk of beneficiaries incurring year-end tax debts. In many, if not most, states, the federal government would pay all the costs of such coverage. Primarily because provider payments are higher with private insurance than with Medicaid, federal BHP payments are projected to exceed by 29 percent what it would cost Medicaid to cover BHP-eligible adults in the average state.

This projection assumes that plans in health insurance exchanges will charge premiums like those in current private markets. If premiums in the exchange—hence, tax credits—exceed anticipated levels, then federal BHP payments will be higher than the amounts estimated here. Conversely, if premiums are lower than expected—for example, if an exchange obtains low premium bids, or inexpensive Medicaid plans join an exchange and cause tax credits to be set at low levels—then federal BHP funding will fall below projected levels.

Notwithstanding these factors, if premiums in the exchange are similar to those charged by today's insurers, a state may be able to integrate BHP, Medicaid, and CHIP into a single, rebranded program serving all uninsured residents with incomes up to 200 percent FPL. Although cost-sharing could rise modestly as income increased above 133 percent FPL, the same health plans would provide coverage so long as income remained below 200 percent FPL, thus improving continuity of care. In addition, if "safety net" plans with a history of operating in low-income communities do not offer coverage through the exchange, they could nevertheless continue serving low-income consumers when incomes rise above Medicaid levels.

This approach would let states save money by eliminating optional Medicaid eligibility for adults above 133 percent FPL, who include pregnant women in most states. Of course, states could achieve the same savings by ending Medicaid for adults above 133 percent FPL and moving them into the exchange. But BHP could give the state equivalent savings without increasing costs or reducing benefits for currently eligible, low-income adults.

From the consumer's perspective, a serious disadvantage of this "Medicaid/CHIP lookalike" approach to BHP is that, in most states, provider payment—hence, the breadth of provider networks—would be lower than in the exchange. However, if federal BHP payments to states exceed baseline Medicaid costs, BHP provider reimbursement could likewise exceed Medicaid amounts. As with many CHIP programs, provider participation could fall between Medicaid and private levels.

Another strategy for BHP implementation would let consumers choose between Medicaid plans and subsidized coverage in the exchange. Such a "two-way" bridge between public programs and the exchange would promote continuity of coverage and consumer flexibility. However, plan choices could be overwhelming to many consumers, and states would need to guard against adverse selection and compensate plans for the difference between BHP payments and subsidies in the exchange.

From the state's perspective, implementing BHP using any of these approaches will have the disadvantage of reducing the size of the exchange. Instead of covering 8 percent of non-elderly residents, the average state's individual market in the exchange would serve 6 percent. As a result, the proportion of residents receiving either individual or group coverage through the exchange would decline from 16 to 14 percent. Such reductions are unlikely

to threaten exchange viability, but they would decrease the number of participants among whom exchanges spread fixed administrative costs.

BHP implementation could affect the average risk level of the remaining individual enrollees in the exchange, but the net effect will probably be modest in most states. ACA requires insurers to pool all customers in the individual market, inside and outside the exchange. If ACA's insurance rules work as intended, BHP implementation will change risk levels in the entire individual market. As a result, the impact on average costs will be less than if BHP's effects were limited to the exchange.

That impact might be eliminated entirely if the U.S. Department of Health and Human Services (HHS) permits states to adopt policies requiring BHP plans to share risk with insurers offering individual coverage. Under this approach, a state-licensed insurer that participates in BHP would pool its BHP members with its other individual enrollees. And whether or not a BHP plan is sponsored by a state-licensed insurer, it would participate in state-administered risk-adjustment and reinsurance mechanisms. If HHS allows such policies and they succeed, BHP implementation would simply shift enrollees among plans that share risk, without changing average costs per consumer.

A full analysis of BHP implementation along the lines described here requires state-specific information, building on the national estimates presented in this paper. Further, federal authorities have not yet settled important questions about the meaning of relevant ACA provisions. And, without doubt, some states will pursue approaches to BHP that differ greatly from the general directions described here. That said, for state officials interested in improving affordability and continuity of coverage for low-income residents while maximizing state budget savings, using BHP to build on the existing infrastructure of Medicaid and CHIP is an option that deserves serious consideration.

Introduction

The Patient Protection and Affordable Care Act (ACA) offers states the option to implement the Basic Health Program (BHP) for low-income residents who are ineligible for Medicaid. This paper describes ACA's rules for BHP, explores selected approaches that states could take to implement BHP, and analyzes key issues that such approaches would raise for consumers and states.

What is the Basic Health Program?

Structure and federal funding

In a state that implements BHP, eligible consumers may not obtain subsidized coverage in the exchange. Instead, they are covered through state contracts with health plans or providers. To support these contracts, the state receives 95 percent of what the federal government would have spent if BHP enrollees had received tax credits and subsidies for out-of-pocket (OOP) costs in the exchange. The federal dollars are placed in a state trust fund and may be used only "to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in" BHP.[1] The U.S. Department of Health and Human Services (HHS) makes one BHP payment to a state before a federal fiscal year begins, based on the best available projections. If the amount turns out to be too high or too low, HHS makes an offsetting correction in the next year's payment. Although the issue has not been resolved by HHS, it seems likely that federal BHP funds may be used to pay BHP administrative costs.[2]

Eligibility

To qualify for BHP, consumers must have the following characteristics:[3]

- They are U.S. citizens or lawfully present immigrants under age 65;
- Their income does not exceed 200 percent of the federal poverty level (FPL);[4]
- They do not qualify for coverage available through Medicare, Medicaid, or the Children's Health Insurance Program (CHIP); and
- They are not offered employer-sponsored insurance (ESI) that meets ACA's standards for affordability and comprehensiveness.[5]

BHP thus covers two distinct groups of otherwise uninsured consumers:

- Adults[6] with Modified Adjusted Gross Incomes (MAGI) between 133 and 200 percent FPL; and
- People with incomes at or below 133 percent FPL who are ineligible for federally matched Medicaid because of immigration status—for example, because they were granted status as lawful residents within the past five years.[7]

If Congress fails to fund federal CHIP allotments beyond 2015, a third group might also qualify for BHP—namely, children with incomes between 133 and 200 percent FPL who would have received CHIP if federal allotments had continued. Without BHP, such children could presumably go into the exchange,[8] much like adults in the same income range.

Coverage

To implement BHP, a state uses a competitive process to contract with health plans or provider groups that meet the following requirements:

- All minimum essential benefits under ACA are covered.
- The BHP consumer is not charged premiums that exceed what the consumer would pay in the exchange.[9]
- The consumer receives coverage with an actuarial value that meets or exceeds certain minimum thresholds.[10]
- The plan is either a "managed care system …" or a "system … that offer[s] as many of the attributes of managed care as are feasible in the local health care market."[11] This provision does not require the state to contract with a risk-bearing insurer, however. For example, states could implement a form of managed care that is common in Medicaid, which combines fee-for-service reimbursement with "primary care case managers" who receive monthly payments for coordinating care.[12]
- The state negotiates to have the plan or provider implement innovations that include "care coordination and care management," "incentives for use of preventive services," and efforts to "maximize patient involvement in health care decision-making" combined with "incentives for appropriate utilization."[13]

  "To the maximum extent feasible," the consumer is offered a choice of plan options.[14]
- If it is operated by an insurer:
  - The plan must report on state-selected performance measures that focus on quality of care and improved health outcomes, sharing results with consumers and the state; and
  - The plan's medical loss ratio—that is, the proportion of premium payments that go to health care and quality improvement rather than to administration—may not fall below 85 percent.

How states can use BHP to make coverage more affordable for low-income residents

As the previous section makes clear, the BHP option gives states considerable flexibility to design coverage for their low-income residents in ways that depart from some of ACA's national rules. States could thus use the option to realize, with the

Table 1. Minimum premium costs and the actuarial value of coverage for a single, uninsured adult at various income levels qualifying for subsidies under ACA

Percentage of FPL	Monthly Pre-Tax Income	Minimum Monthly Premium	Actuarial Value
150	$1,354	$54.15	94%
175	$1,579	$81.34	87%
200	$1,805	$113.72	87%
225	$2,031	$145.70	73%
250	$2,256	$181.63	73%

Notes: Dollar amounts assume 2010 FPL levels. If future FPL levels rise per Congressional Budget Office projections of increases to the Consumer Price Index[15], monthly pre-tax income and minimum monthly premiums in 2014 will be 6.4 percent higher than the amounts shown here. Actuarial value represents the average percentage of covered health care services paid by the insurer, taking into account deductibles, copayments, and co-insurance.

BHP population, many different visions for covering the low-income uninsured.

This paper does not explore the full range of possible approaches to BHP. Rather, it focuses narrowly on policies that, without spending any state funds, make low-income consumers' coverage significantly more affordable than subsidized insurance in the exchange. After describing key affordability issues, this section explains why, in most states, federal BHP dollars could exceed Medicaid costs for BHP adults. It then shows how states could use BHP to improve the affordability of coverage and care for low-income residents without spending state dollars. It concludes by exploring trade-offs that consumers would face under these approaches.

Affordability of subsidized coverage in the exchange

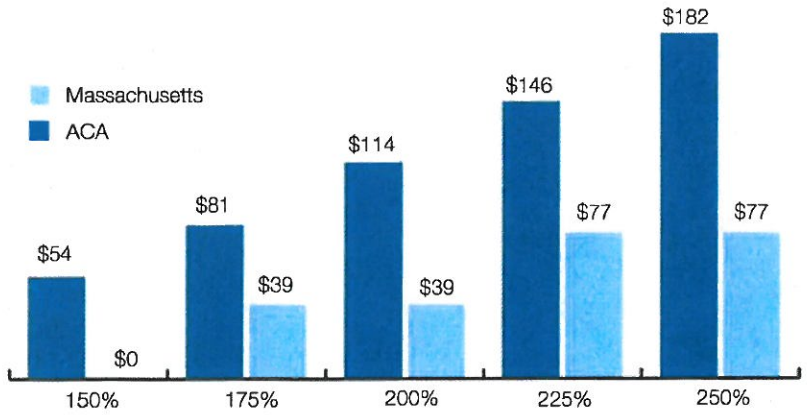
Subsidy levels and limits

Without BHP in place, low-income subsidy recipients with incomes too high to qualify for Medicaid will make premium payments in the exchange and qualify for coverage with the actuarial values shown in Table 1.

Low-income consumers' premium payments are likely to increase slowly after 2014. Beginning in 2015, ACA caps premium subsidies to increase no faster than personal income, which has historically risen more slowly than health insurance premiums.[16] If that pattern continues, subsidy recipients in the exchange will experience small annual increases in the percentage of household income required for premium payments.

An additional limit on premium tax credits involves year-end reconciliation with the Internal Revenue Service (IRS). If credits provided during the year turn out to be too low, based on annual income reflected on federal tax returns, consumers receive a refund. But if tax credits are too high, beneficiaries must repay the excess, up to a "safe harbor" maximum that varies by income—$600 for a family at or below 200 percent FPL, $1,000 between 200 and 250 percent FPL, and so forth.[17]

Figure 1. Minimum monthly premium payments for a single adult at various FPL levels, 2010: ACA versus Massachusetts CommCare



Source: Massachusetts Commonwealth Connector 2010.[21]

Moving from premiums to OOP costs, actuarial value (AV) refers to the percentage of health care costs that an insurer pays for an average population by offering specific covered benefits, copayments, deductibles, co-insurance, and limits on OOP costs. Many combinations of cost-sharing rules and benefits fit each AV, complicating efforts to analyze the affordability of OOP costs for low-income consumers under ACA.

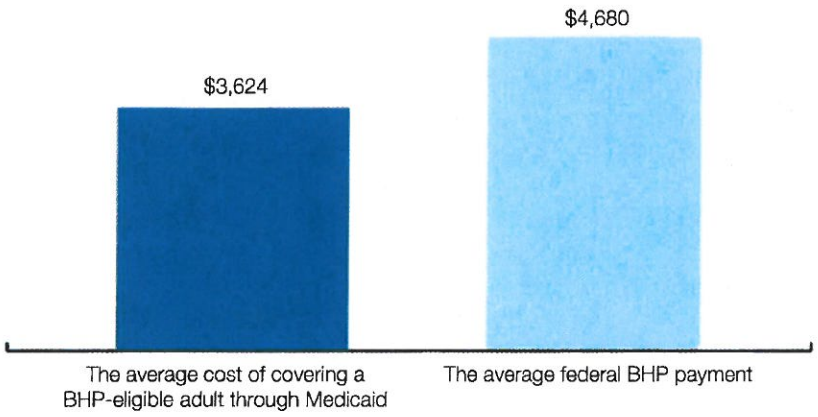
One potentially fruitful approach looks at examples of coverage at applicable AV levels. According to the Congressional Research Service (CRS),[18] the typical, employer-sponsored Health Maintenance Organization has an AV of 93 percent, which is approximately the AV for adults in the exchange with incomes at or below 150 percent FPL. Such a plan has:

- No annual deductible;
- $20 office visit co-payments;
- A $250 co-payment for inpatient hospitalization; and
- Prescription drug co-payments of $10, $25, and $45 for generic, preferred name-brand, and non-preferred name-brand drugs, respectively.

At the AV level for consumers with incomes between 150 and 200 percent FPL, the federal Blue Cross/Blue Shield plan has an AV of 87 percent, according to CRS, with coverage that involves:

- A $250 annual deductible;
- $15 office visit co-payments;
- A $100 co-payment for inpatient hospitalization, plus a requirement to pay 10 percent of all remaining hospital costs;
- A requirement to pay 10 percent of all laboratory and X-ray costs; and
- A requirement to pay 25 percent of all prescription drug costs.

Figure 2. BHP federal payments versus the cost to cover BHP members through Medicaid: national averages



Source: Health Insurance Policy Simulation Model (HIPSM) 2011. Notes: These results show what would happen if ACA were fully implemented in 2010, with small employer and individual coverage merged into a single market. BHP payments would still exceed Medicaid costs, though by a smaller margin, if the two markets remained separate. Medicaid costs include both federal and state dollars and take into account the risk profile of BHP members. The average federal BHP payment equals 95 percent of what the federal government would pay in tax credits and OOP cost-sharing subsidies if BHP consumers had received coverage in the exchange.

Potential effects on consumers

To some degree, it is a matter of opinion whether these premiums and OOP costs exceed what low-income consumers can afford. However, two facts are not in dispute:

- ACA's subsidies will make coverage and care substantially more affordable for low-income adults who lack access to ESI; but
- In the past, premium and OOP costs such as those imposed by ACA have deterred many low-income consumers from enrolling into coverage and from using necessary care, sometimes with adverse effects on health status.[19]

Prior research showing the effects of premiums on low-income consumers' enrollment took place without any legal requirement to purchase coverage, which will increase participation. As with ACA, the 2006 Massachusetts reform law imposed such a requirement, which helped reduce the percentage of uninsured residents to the lowest level ever observed in any state.[20] But consumers' premium costs in Massachusetts's subsidized Commonwealth Care (CommCare) program were less than what will be charged in the exchange under ACA, as Figure 1 illustrates. Premium costs under ACA may thus lead to enrollment levels that are lower than those in Massachusetts, notwithstanding ACA's requirement to purchase coverage.

As noted earlier, ACA exempts preventive services from point-of-service cost-sharing. Accordingly, cost-sharing in the exchange may prevent some consumers from seeking treatment for illness, injury, or other health problems, but it should not affect check-ups, immunizations, and screenings.

Some low-income consumers may be deterred from seeking tax credits during the year because year-end reconciliation could endanger tax refunds or require payments to IRS that many low-income people might view as unaffordable. Such reconciliation is one reason that no more than 3 percent of low-income workers who receive Earned Income Tax Credits claim those credits during the year, in advance of filing year-end returns.[22] Put simply, the combination of limited subsidies in the exchange and the potential for adverse tax consequences could reduce the gains in coverage and access that low-income consumers would otherwise experience under ACA.

Federal BHP payments and state costs

A starting point for thinking about how BHP could make coverage more affordable for low-income residents without spending state money is that, in many states, federal BHP payments are likely to exceed Medicaid costs (including both state and federal shares). Mainly because of low Medicaid reimbursement rates for providers, private insurance is significantly more expensive than Medicaid, according to research that takes into account health status.[23] For example, among working adults, private insurance premiums exceed Medicaid costs by an average of 29.5 percent. It thus comes as no surprise that, according to the Urban Institute's microsimulation modeling of ACA,[24] average federal BHP payments, based on the cost of subsidies for private insurance in the exchange, will exceed by 29 percent what it would cost Medicaid to cover BHP-eligible individuals (Figure 2).

The differential shown in Figure 2 reflects more than low Medicaid provider payments, however. BHP adults, who tend to be young, will have higher premiums in the exchange (hence, higher BHP payments) than is warranted by their health care claims. With modified community rating, ACA permits the oldest adults to be charged no more than three times what the youngest adults pay for the same coverage, even though their health care costs vary by more than that ratio.[25]

Figure 2's comparison between BHP payments and Medicaid costs assumes that plans offered in the exchange charge premiums generally typical of today's private insurance.[26] Tax credits (hence, BHP payments) are pegged to the premium charged for the second–lowest-cost plan at the "silver" level, which involves a 70 percent AV. If such a reference plan is more costly than what would be expected in today's private markets, federal premium subsidies (hence, BHP payments) will rise above the amount shown in Figure 2. If the reference plan is less expensive, BHP payments will fall below projected levels; such a reduction could occur if, for example, a Medicaid-based plan that charges very low premiums becomes the reference plan[27] or the exchange obtains surprisingly low bids from participating insurers.[28] **Accordingly, how a state operates its exchange could greatly affect federal BHP payments.**

Moreover, federal BHP payments will probably decline slowly over time relative to health care costs. BHP payments are based on the tax credits for premiums and OOP cost-sharing subsidies that BHP members would have received in the exchange. After 2014, premium tax credits will be indexed to changes in annual income,[29] which historically has grown more slowly than Medicaid costs. On the other hand, ACA's subsidies for OOP costs are not limited by indexing. As a result, BHP payments, which reflect both premium tax credits and OOP cost-sharing subsidies, will decline—relative to projected Medicaid spending—more slowly than tax credits alone. **If trends from 2000 through 2007 continue, a state with federal BHP payments and Medicaid costs like those shown in Figure 2 would see its BHP payments continue to exceed Medicaid costs for more than 25 years.**[30]

Possible approaches to BHP implementation

States could use federal BHP resources in several ways to make coverage more affordable for low-income residents. Examples follow:

Using BHP to furnish more affordable coverage without building on existing public programs. A state might negotiate with private insurers to provide benefits like those offered in the exchange but with lower premiums and OOP cost-sharing. The precise approach would depend on policymakers' goals. For example, some states might give beneficiaries financial incentives to join programs that address obesity, tobacco use, and substance abuse; other states might cover translation services, transportation, and case management that connects beneficiaries to social services.

One disadvantage is that developing a new program requires administrative resources. After years of serious budget problems, many states will find it difficult to do even the minimum amount required to implement ACA, without designing and implementing a new, state-run program for low-income adults. In future years, creating such a program may be more feasible, but, in the short term, it is probably be more realistic for most states to adopt one of the approaches described next, each of which builds on existing programs rather than creates a new system from scratch.

Using BHP to provide "Medicaid look-alike" coverage.[31] BHP consumers enroll in the same managed care organizations that already contract with Medicaid.[32] BHP consumers receive the benefits and cost-sharing protections that apply to Medicaid, even though applicable federal rules and funding arrangements differ.

Using BHP to fund a separate program styled as "CHIP for adults." A state could raise cost-sharing slightly above Medicaid levels for consumers with incomes between 133 and 200 percent FPL. If a separate CHIP program is opened up to serve low-income parents and other adults, OOP costs will typically be lower than charges in the exchange, and covered benefits might be more generous. Provider payment could also rise above Medicaid levels, particularly if federal BHP payments exceed Medicaid costs.

A state taking this approach could experiment with innovations such as value-based insurance design and cost-sharing that gives consumers incentives to use more efficient providers.[33] Similar initiatives could apply in CHIP to create a single system of innovative coverage serving both adults and children with incomes too high for Medicaid but too low to easily afford subsidized coverage in the exchange.

Combining funding from BHP, Medicaid, and CHIP into a single, integrated program that serves all low-income residents. ACA does not require all BHP members to receive the same benefits and cost-sharing protections or to use the same provider networks. A state could thus operate a program with the following characteristics, shown in Table 2:

- The program serves all otherwise uninsured[34] state residents with incomes up to 200 percent FPL.
- A single set of health plans provides coverage. Benefits could either be the same for all enrollees or grow more limited as income rises.
- For consumers with incomes above 133 percent FPL:
  - Cost-sharing may increase above Medicaid levels, though the amounts would still be far below what is charged in the exchange; and
  - Provider payment levels may likewise increase, particularly if federal BHP payments exceed otherwise applicable Medicaid costs.
- Federal funding varies by enrollee:
  - Below 133 percent FPL:
    - Medicaid matching funds pay for citizens and most lawfully resident immigrants, with enhanced payments for newly eligible adults; but
    - BHP pays all costs for lawfully resident immigrants who do not qualify for federally matched Medicaid.
  - Above 133 percent FPL:
    - The federal government entirely funds adults' coverage through BHP;
    - Medicaid or CHIP pays standard matching rates for children who qualify for those programs; and
    - BHP pays for any children ineligible for Medicaid and CHIP.

Differences between Medicaid, CHIP, and BHP would primarily be a matter of "back room" accounting to maximize federal funding.35 From the consumer's perspective, a single program would provide coverage so long as income does not exceed 200 percent FPL. Officials in Connecticut have proposed a similar strategy.36

A state pursuing such an approach could "rebrand" low-income coverage to increase its appeal to consumers, the general public, and policymakers. Many states took similar steps in the late 1990s when they implemented CHIP by combining federal CHIP and Medicaid funds into a

Table 2. Combining BHP, Medicaid, and CHIP into a single program serving low-income, uninsured residents: one illustrative policy, 2014

Income, citizenship, and immigration status	Federal Funding			Benefits	Cost-Sharing	Provider Payment
	Adults Newly Eligible for Medicaid	Children Meeting CHIP's Age and Income Requirements	Other Adults and Children			
0 to 133 percent FPL				Medicaid		
Citizens	100% Medicaid match	Traditional CHIP match	Traditional Medicaid match			
Immigration status qualifies for federally matched Medicaid/CHIP	100% Medicaid match	Traditional CHIP match	Traditional Medicaid match			
Legally resident immigrants ineligible for federally matched Medicaid/CHIP	n/a	100% BHP payment	100% BHP payment			
134 to 200 percent FPL				For children: CHIP For adults: Comparable to CHIP		
Citizens	n/a	Traditional CHIP match	100% BHP payment			
Immigration status qualifies for federally matched Medicaid/CHIP	n/a	Traditional CHIP match	100% BHP payment			
Legally resident immigrants ineligible for federally matched Medicaid/CHIP	n/a	100% BHP payment	100% BHP payment			

Notes: After 2016, adults newly eligible for Medicaid will receive less than 100 percent federal funding. That percentage will gradually decline to 90 percent in 2020 and subsequent years. At some point after 2015, some CHIP-eligible children above 133 percent FPL may receive 100 percent BHP payments if Congress fails to provide new CHIP allotments. "n/a" in a cell indicates that the row includes no adults who are newly eligible for Medicaid.

single program that served all low-income children.

Using BHP as a two-way bridge between Medicaid and the exchange. A state could offer BHP consumers a choice between Medicaid look-alike coverage and subsidized plans in the exchange. A state pursuing this strategy would need to require plans in the exchange to offer identical coverage in BHP. Because such plans would need to discount their premiums by 5 percent, a state taking this approach might let insurers compensate for BHP premium shortfalls by slightly increasing the premiums they charge in the exchange.[37]

Such a policy would have the advantage of letting each BHP consumer decide which factor is more important, given his or her circumstances: the greater affordability of Medicaid or the broader provider networks likely to be available in the exchange. This approach would also promote continuity of coverage and care. If a Medicaid consumer's income rose above 133 percent FPL, the consumer could stay in a Medicaid plan; if an exchange participant's income fell below 200 percent FPL, he or she could remain in the exchange plan.

On the other hand, such a two-way bridge could confuse consumers by requiring them to sort through a large number of plans and two highly dissimilar subsidy systems. It could also raise concerns about destabilizing spikes in health care claims and risk segmentation, as the number of BHP enrollees in any particular plan could be quite small, and BHP consumers might sort themselves into Medicaid and exchange plans differently, depending on their health status. As a result, this approach would require effective policies that pool BHP risk with broader markets, as discussed below.

Trade-offs for consumers

The strategies described in the previous section could reduce premiums and OOP costs below levels charged to low-income consumers in the exchange; provide more generous benefits than those offered in the exchange (including some tailoring of service delivery to meet the special needs of low-income populations); and avoid any risk of consumers losing year-end tax refunds or owing money to the IRS.[38] Such approaches could also increase the number of families whose members can all join one program rather than enrolling children in public programs while parents participate in the exchange.[39]

At the same time, approaches that use Medicaid plans to cover all residents up to 200 percent FPL could improve continuity of coverage and care and reduce "churning." With the income threshold for transitioning between public programs and

the exchange set at 133 percent FPL, more than 35 percent of all low-income adults will need to change between Medicaid and the exchange at least once every six months.[40] For two reasons, raising the income threshold to 200 percent FPL would reduce the number of subsidy recipients moving between programs. First, many more people will qualify for subsidies at lower income levels, where ESI offers are less frequent.[41] Second, significant income volatility is more widespread at lower income levels,[42] where unstable and shifting employment arrangements are more common.

Continuity will be greatly shaped by how a state implements BHP. If a state covers adults through health plans that do not overlap with Medicaid—for example, if a state enrolls adults in a separate CHIP program that uses non–Medicaid plans—continuity might not improve and could even worsen. Conversely, a state that uses the "two-way bridge" approach described earlier would maximize consumers' ability to achieve continuous coverage and care.

On a different front, many consumers would experience a serious disadvantage if a state used BHP to extend existing public programs to additional low-income adults—namely, they would typically have much more limited access to providers than they would enjoy in the exchange. In most states, Medicaid pays low reimbursement rates that greatly limit participation by many types of providers.[43] Provider payment levels, hence participation problems, could easily worsen during the next few years as states continue to grapple with severe budget deficits.[44]

On the other hand, if federal BHP payments turn out to exceed baseline Medicaid costs, the excess could be used to raise capitated payments and provider reimbursement above Medicaid levels, without spending state general fund dollars.[45] Using any such excess in this way would help a state meet the statutory requirement that federal BHP payments must be spent on BHP members.[46]

Even if federal funding through BHP does exceed baseline Medicaid costs by a margin consistent with current private markets, using the additional dollars to raise reimbursement rates is unlikely, in most states, to replicate fully the breadth of provider networks offered by typical commercial insurance. Nevertheless, as in some CHIP programs, access to care could exceed that provided by Medicaid.

More generally, if low-income consumers receive BHP through the plans and providers currently serving Medicaid and CHIP, they will lose access to some private plans in the exchange. However, BHP may preserve consumers' access to "safety net" plans and affiliated providers that, in the past, specialized in serving low-income communities through Medicaid and CHIP but that may not be offered in the exchange.[47] If a state implements BHP along the lines discussed here, plans experienced in working with low-income communities could continue doing so with low-income consumers whose incomes exceed Medicaid levels.

One final consumer issue is important. BHP, like subsidies in the exchange, is limited to individuals without access to affordable, comprehensive ESI, as explained above. Medicaid eligibility does not impose that limitation. If adults with incomes above 133 percent FPL lose Medicaid, those offered affordable, comprehensive ESI will become ineligible for federally funded subsidies, whether or not their state implements BHP.

Issues for states

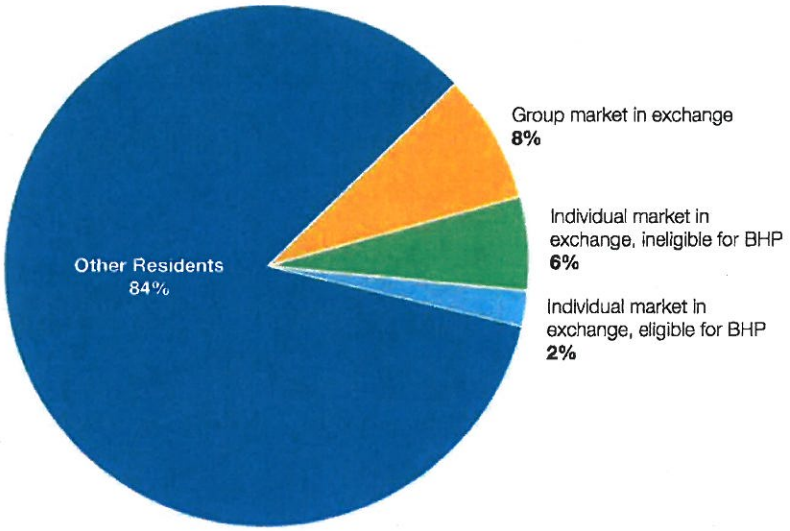
Budget savings

Using BHP to provide low-income adults with coverage similar to that furnished by Medicaid or CHIP would let states terminate optional Medicaid coverage for adults with MAGI above 133 percent FPL, without increasing such adults' health care costs or cutting their benefits. For example, pregnant women in most states receive Medicaid up to at least 185 percent FPL.[48] Federal Medicaid law forbids charging such women premiums or OOP cost-sharing for pregnancy-related services. If these women lose Medicaid and shift to the exchange, the state would save money, but the women would be charged more and might receive less prenatal care. If such women instead were covered through BHP, the state would save the same amount by terminating their Medicaid eligibility, but BHP coverage could be structured to shield affected women from increased costs.[49]

Similar results apply in states that, today, cover parents (or other non-elderly adults) with MAGI between 133 and 200 percent FPL. When Connecticut developed its above-described proposal for BHP implementation, for example, Dr. Jonathan Gruber of the Massachusetts Institute of Technology projected that it would save approximately $50 million a year in general fund expenditures for Medicaid-eligible parents without increasing their premiums or OOP costs and without reducing benefits.[50]

Medically needy coverage provides an additional opportunity for state savings, one that does not involve cutting back eligibility.[51] Offered in most states, medically needy programs cover a combination of long-term care, catastrophic medical expenses, and chronic care after a beneficiary incurs a certain level of health care costs ("spend-down").[52] Under ACA, medically needy, non-elderly adults between 133 and 200 percent FPL will receive comprehensive coverage through the exchange. This will save money for medically needy programs, as formerly uninsured adults will take longer to meet Medicaid spend-down requirements. However, to increase such savings by further delaying the point when such requirements are met, a state could implement BHP to lower OOP costs below levels in the exchange and to cover some long-term care services that fall outside traditional private insurance.[53]

Figure 3. Among non-elderly U.S. residents, projected coverage through health insurance exchanges under full ACA implementation, by insurance market and potential BHP eligibility



Source: Urban Institute, 2010.[54] Notes: This figure shows the effects of national ACA implementation (hence, ACA implementation in the average state) based on HIPSM estimates. It classifies people as BHP-eligible if they have modified adjusted gross income at or below 200 percent FPL and, without BHP, they would receive subsidized, individual coverage in a health insurance exchange.

Exchange size

If a state implements BHP, fewer individuals will be covered through the exchange. Urban Institute microsimulations of the effect of ACA suggest that, in the average state, BHP implementation would reduce from 8 to 6 percent the proportion of non-elderly residents receiving individual coverage through the exchange (Figure 3). With exchange group markets projected to reach an additional 8 percent of non-elderly residents, BHP will reduce total enrollment in the average exchange from 16 to 14 percent of all residents.

Such shrinkage should not imperil exchanges. For example, the Massachusetts commercial exchange, Commonwealth Choice, has been stable with fewer than 40,000 enrollees, or less than 1 percent of the state's non-elderly population.[55] Inapplicable to ACA, which resembles the Massachusetts reform law, are suggestions that as many as 100,000 covered lives are needed for exchange viability. Jost explained this concern as follows:

> "Small insurance pools, being potentially volatile and susceptible to destabilization by large claims, are problematic for insurers. According to one expert view, a risk pool of at least 100,000 covered lives would probably be necessary to be viable."

Under ACA, an insurer serving the individual market must pool all of its enrollees both inside and outside the exchange. It is this combined risk pool, not exchange participants alone, that must have the stability insurers require before they will offer coverage. Jost continued:

> "If insurers cover a number of lives outside of the exchange, however, the size of the pool offered by the exchange may be less important. Moreover, once risk-status underwriting is eliminated, a universal insurance-purchase mandate goes into effect, and reinsurance and risk adjustment are implemented, the risk faced by a single plan will be considerably diminished ...."[56]

On the other hand, if an exchange spreads fixed administrative costs over a smaller pool of enrollees, costs per enrollee rise. Any resulting premium increase would mainly affect federal costs, but it could also increase amounts that non-subsidized consumers[57] (and perhaps employers) pay in the exchange. In addition, implementing BHP could decrease an exchange's leverage to improve quality, lower premiums, and achieve goals such as reforming health care delivery, increasing portability, improving consumer information, and holding insurers accountable.[58]

Leverage would play out differently in a state that lowers spending by coordinating its purchasing of services through multiple state-administered programs. Adding BHP-covered lives to state employee insurance, Medicaid, CHIP, mental health services, health care for prisoners, and so forth could modestly increase such a state's ability to lower prices and improve quality across the full range of state-purchased care. Instead of trimming federal subsidies, the leverage provided by BHP-eligible covered lives could reduce state costs.

Still other states may combine all covered lives, both in the exchange and state-purchased coverage, to encourage reforms. For example, a state interested in interoperable electronic health records could require specified levels of performance from any health plan or provider that seeks to participate in either the exchange or state-purchased coverage. Such a state's leverage to accomplish these goals would not be affected by whether adults with incomes between 133 and 200 percent FPL are covered through state-purchased BHP coverage or the exchange.

Risk

If a state implements BHP, the risk pool in the exchange's individual market may change as its lowest-income members depart. The precise nature of that change will depend on state demographics, of course. But it will also depend on state policy decisions. Based on previous Urban Institute microsimulations of ACA's national effects,[59] BHP implementation would likely affect the exchange's risk pool in the average state as follows:

- If a state combines the small group and individual markets, the size of the exchange would grow to the point that implementing BHP would probably have little effect.

- In a state that does not combine those markets:
  - If the state preserves existing Medicaid coverage for adults with income above 133 percent FPL, health care costs will be lower for BHP members than for other individuals in the exchange because BHP members will tend to be younger. As a result, implementing BHP could modestly raise the average cost of individual coverage in the exchange.
  - If the state shifts non-elderly adults above 133 percent FPL out of Medicaid, BHP would include some pregnant women and people with disabilities who formerly qualified for Medicaid.[60] As a result, implementing BHP could either leave unchanged or slightly reduce the average cost of adults receiving individual coverage in the exchange.

Risk effects in either direction should not be exaggerated. As noted, ACA requires each insurer to pool all of its individual market enrollees. If BHP members are healthier than average and leave the exchange, costs will rise in the remaining individual market as a whole. The resulting increase in average costs will be less than if BHP's impact were absorbed by the exchange alone.

Such effects might be avoided entirely if states enact policies that share risk among BHP plans and the individual market. Depending on how HHS interprets ACA, a state might be able to use its regulatory authority to subject a state-licensed insurer that operates a BHP plan to the same rules that govern the individual market. That would require such an insurer to pool BHP enrollees with its other customers in the individual market. In addition, whether or not a BHP plan is sponsored by a state-licensed insurer, a state might be able to include the plan in its risk-adjustment and reinsurance systems.[61] Under that approach, a BHP plan with lower average risk levels than the rest of the individual market would make payments accordingly, thus lowering the burden borne by other individual market plans. If BHP enrollees turn out to be sicker than the average individual market enrollee, BHP plans would receive risk-adjustment and reinsurance payments that make up the difference. If such a policy is allowed by HHS and achieves its goals, BHP implementation should not affect the overall risk level of the individual market because it would simply move consumers between plans that share risk together.

Conclusion

In some ways, this paper's analysis is necessarily tentative. State decisions about whether to implement the BHP option will be affected by guidance the federal government has not yet issued to interpret ACA. The characteristics of each individual state will also be important in shaping the impact of BHP on both consumers and state government. That said, it is clear, even at this early stage, that the BHP option deserves serious consideration by states seeking to provide their low-income residents with affordable and continuous coverage while improving state fiscal circumstances in 2014 and beyond.

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Endnotes

1 ACA §1331(d)(2).

2 Another potential source of administrative dollars for BHP is some of the funding that otherwise would have covered exchange administration.

3 It is not completely clear whether states have the option to extend BHP to some but not all individuals described in the statute. While this is one of many issues that will need to be resolved by the U.S. Department of Health and Human Services (HHS), the most direct reading of the statutory language is that a state implementing the BHP option must cover all individuals who meet the four criteria listed in the text. See ACA §1331(a)(1) and (e).

4 Another question requiring HHS interpretation is whether, in applying the 200 percent FPL cut-off, the same method is used to calculate income as applies to Medicaid; that is, will 5 FPL percentage points be subtracted from Modified Adjusted Gross Income (MAGI)? Presumably, at the lower-income bound for BHP eligibility, the same method will apply as defines the upper-income bound of Medicaid eligibility. It is not clear whether a different approach will apply at the upper-income bound for BHP.

5 This is the same "ESI firewall" that limits eligibility for tax credits and other subsidies in the exchange. Put differently, a consumer may neither receive BHP nor qualify for subsidies in the exchange if he or she is offered ESI that has (1) a worker premium cost at or below 9.5 percent of family income and (2) an actuarial value of 60 percent or more.

6 In states that set the upper limit for CHIP eligibility below 200 percent FPL, BHP could cover children with incomes that are between the CHIP limit and 200 percent FPL.

7 In addition, for purposes of ACA, "lawful presence" includes some immigration status categories that fall outside those permitted under most types of federally matched Medicaid eligibility.

8 It is not completely clear how such CHIP children would be treated if federal funding is not renewed. The Social Security Act §2105(d)(3)(B), added by ACA §2101(b), says that when a state's CHIP allotments have run out "the State shall establish procedures to ensure that the children [who qualify for a separate CHIP program] are enrolled in a qualified health plan that has been certified by the Secretary" to offer benefits and out-of-pocket cost-sharing like that formerly offered by CHIP. This provision raises many questions. For example, may a family enroll a child in the same plan that serves the parents through the exchange, in which case the child would likely receive less generous coverage than under CHIP? If the child is enrolled in an HHS-certified plan, must the family pay the full difference in premium between that plan and the second–lowest-cost "silver" plan, to which premium subsidies are pegged? (Silver plans have an AV of 70 percent.) If a CHIP-eligible child has access to affordable, comprehensive ESI, is the child barred from subsidized coverage in the exchange? And what happens if a state's exchange offers no HHS-certified plan?

9 This analysis presumes that the consumer receives all available subsidies and enrolls in the second–lowest-cost "silver" plan, which is the benchmark to which tax credits are pegged.

10 The statute may be read in two ways: either (1) BHP consumers may not receive coverage with an AV below the level they would receive in the exchange; or (2) at or below 150 percent FPL, BHP consumers may not receive coverage below the platinum level and, above 150 percent FPL, BHP AV may not fall below the gold level. Compare §1331(a)(2)(A)(ii) (platinum and gold AV) with the unnumbered language at the end of §1331(a) (premium determined after reduction for "any premium tax credits and cost-sharing reductions allowable with respect to either [BHP or the second-lowest-price silver value plan in the exchange]").

11 ACA §1331(c)(2)(C).

12 In a related variant, some Medicaid programs combine fee-for-service payment with a "patient-centered medical home" through which a primary care provider may (either directly or by working with a community health team) perform functions that include care coordination and patient education. After implementing such an approach, North Carolina's Medicaid experienced significant cost savings and quality gains. Samantha Artiga, *Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid*, Kaiser Commission on Medicaid and the Uninsured, May 2009.

13 ACA §1331(b)(2)(A).

14 ACA §1331(c)(3)(A).

15 Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2011 to 2021*, January 2011.

16 From 1990 through 2008, private insurance premiums per capita rose, during the median year, by 6.1 percent, whereas personal income grew by 5.5 percent. Author's calculations from CMS Office of the Actuary, *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2008 to 1960;* Bureau of Economic Analysis, U.S. Department of Commerce, "Personal Income and its Disposition," *National Income and Product Accounts Table*, last revised on January 28, 2011.

17 Medicare and Medicaid Extenders Act of 2010, P.L. 111-309, amending IRS §36B(f)(2)(B). For adults filing individual returns, maximums are 50 percent of the amounts shown in the text.

18 Chris L. Peterson, *Setting and Valuing Health Insurance Benefits*, Congressional Research Service, April 6, 2009. The description in the text does not include out-of-pocket cost-sharing limits because the discussion focuses on the initial deterrent effect of cost-sharing on utilization of care, not on the cumulative financial burden of cost-sharing.

19 See, e.g., Katherine Swartz, *Cost-sharing: Effects on Spending and Outcomes*, Research Synthesis Report No. 20, Robert Wood Johnson Foundation, December 2010; Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, March 2003; Bill J. Wright, Matthew J. Carlson, Heidi Allen, Alyssa L. Holmgren, and D. Leif Rustvold, "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs*, December 2010; 29(12):2311–2316; Dana P. Goldman, Geoffrey F. Joyce, and Yuhui Zheng, "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health," *Journal of the American Medical Association*, July 4, 2007; 298(1):61–69; Becky A. Briesacher, Jerry H. Gurwitz, and Stephen B. Soumerai, "Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature," *Journal of General Internal Medicine*, June 2007; 22(6):864–871; Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences*, Kaiser Commission on Medicaid and the Uninsured, May 2005.

20 E.g., Sharon K. Long and Paul B. Masi, "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," *Health Affairs*, Web Exclusive, May 28, 2009: w578–w587; Sharon K. Long and Karen Stockley, "Sustaining Health Reform in a Recession: An Update on Massachusetts as of Fall 2009," *Health Affairs*, June 2010; 29(6):1234–1241.

21 Massachusetts Commonwealth Connector, *Member Monthly Premium*, 2010, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Connector%2520Programs/Benefits%2520and%2520Plan%2520Information/Enrollee_Contributions.pdf.

22 Joanna Stamatiades and James Cook, GAO, Eric Larson, Internal Revenue Service, *Demographic and Noncompliance Study of the Advance EITC (AEITC)*, Presented at the 2008 IRS Research Conference, June 11, 2008; Government Accountability Office, *Advance Earned Income Tax Credit: Low Use and Small Dollars Paid Impede IRS's Efforts to Reduce High Noncompliance*, GAO-07-1110, August 2007. As with ACA, the EITC statute limits the size of possible tax debts to IRS, although it does so by capping the amount of the EITC that may be paid in advance rather than by limiting the amount subject to reconciliation. Factors other than reconciliation, including workers' desire for year-end tax refunds, are also important in deterring use of the advance EITC.

23 Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, Winter 2003/2004; 40(4):323–342.

24 The Urban Institute estimates described in this report are based on the Health Insurance Policy Simulation Model (HIPSM), which uses national survey data and economic analyses of individual and business behavior to examine how employer-sponsored insurance, private non-group coverage, and Medicaid and CHIP are likely to change in response to policy modifications. For a description of HIPSM, see Urban Institute Health Policy Center, *The Urban Institute's Health Microsimulation Capabilities*, July 19, 2010, www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf.

25 According to the Medical Expenditure Panel Survey Household Component (MEPS-HC), average health care costs in 2008 among adults obtaining any health care were $2,277 for adults ages 19 to 24, $2,818 at ages 25 to 34, $3,508 at ages 35 to 44, $4,460 at ages 45 to 54, and $7,402 at ages 55 to 64. At the same time, the percentage of adults using care ranged from 70 percent at ages 19 to 24 to 92 percent at ages 55 to 64. Data tables may be accessed at www.meps.ahrq.gov.

26 HIPSM projects that, in the exchange, premiums could differ from those charged for comparable coverage today because of factors such as administrative efficiencies, risk pool changes, and ACA insurance reforms. But HIPSM does not include the type of premium savings that would result from substituting Medicaid plans for typical private insurance, aggressive negotiation by the exchange that lowers premiums by a substantial percentage, delivery system and payment reforms that have a dramatic effect on cost growth, and so forth.

27 Of course, the decision about whether to encourage Medicaid plans to offer coverage in the exchange involves many factors other than BHP implementation. Such participation in the exchange would give families the option to keep the same health plan when they shift between Medicaid and the exchange, thereby promoting continuity of coverage and care. On the other hand, including inexpensive Medicaid plans in the exchange could, by lowering the reference premium, make it more costly for tax credit beneficiaries to enroll in standard commercial insurance. In addition to making an income-based payment, beneficiaries choosing a plan more costly than the reference plan must pay the full difference in premiums.

28 If private premiums in the exchange fall, the federal government will achieve savings, but state government will be unaffected, as will most subsidy recipients. As noted elsewhere in this paper, consumer premium costs will be based on income if they avoid plans more costly than the reference plan. In addition, unsubsidized individual enrollees in the exchange would benefit from lower premiums, as would employers in a state that merges the small group and individual markets.

29 Internal Revenue Code §36B(a)(3)(A)(ii), added by ACA §1401(a). After 2018, if the total national volume of tax credits and OOP cost-sharing subsidies exceeds a specified percentage of the Gross Domestic Product during a year, the following year's indexing of tax credits will be based on the Consumer Price Index rather than on income growth.

30 Annual Medicaid cost increases per enrollee averaged 4.8 percent from 2000 through 2007. John Holahan and Alshadye Yemane, "Enrollment Is Driving Medicaid Costs--But Two Targets Can Yield Savings," *Health Affairs*, September/October 2009; 28(5):1453–1465. Over that same period, national income rose by an average of 3.64 percent per year. Author's calculations, U.S. Census Bureau, *Current Population Survey, Annual Social and Economic Supplements, 2001-2008*, March 2010. If those same trends continue and federal BHP payments were indexed to income, then the difference between federal BHP payments and Medicaid costs shown in Figure 2 would gradually shrink with each passing year, finally converging in 24 years. If unindexed cost-sharing subsidies raised the annual increase in federal BHP payments by just one-tenth of 1 percentage point above changes to national income, BHP payments would exceed Medicaid costs for 26 years.

31 A "look-alike" approach is required for both Medicaid and CHIP because ACA §1331(b)(1) forbids BHP plans from serving non–BHP consumers. Just as some states used a "Medicaid look-alike" approach for CHIP separate programs, through which CHIP children received Medicaid benefits and cost-sharing and enrolled in the same health plans that served Medicaid children—albeit with CHIP rather than Medicaid federal funds and without an individual entitlement—so too a "look-alike" approach here would serve BHP enrollees through Medicaid health plans offering Medicaid benefits and OOP cost-sharing but with different underlying federal payments and governing statutes.

32 A state with fee-for-service Medicaid could extend such coverage to BHP adults, using the same covered benefits and cost-sharing limitations that apply to Medicaid.

33 Jane Beyer, personal correspondence, November 2010. In fact, ACA's BHP provisions encourage such steps. See ACA §1331(c)(2)(A).

34 This is shorthand for the following rules: (1) ESI receipt does not end Medicaid eligibility, although when a Medicaid beneficiary has ESI, Medicaid becomes the secondary insurer; (2) Medicaid and CHIP eligibility is unaffected by an individual's rejection of an ESI offer (with certain exceptions that apply to CHIP children offered ESI by public employers); but (3) BHP eligibility is limited to people who are either (a) not offered ESI or (b) have ESI offers that fail to meet ACA requirements of affordability and comprehensiveness, as explained earlier.

35 Section 1331(f)(1) requires BHP members to go through the same verification process that applies to subsidies in the exchange, which should help with such "back room" sorting.

36 The approach proposed in Connecticut would extend that state's HUSKY program to 200 percent FPL for all adults; under current law, parents are covered up to 185 percent FPL. For all adults, cost-sharing and benefits would be identical to those provided by Medicaid. Children up to 300 percent FPL would continue to be covered through HUSKY, using a combination of funding through Title XIX and Title XXI of the Social Security Act. This proposal would not reduce adults' benefits or increase their costs as income rises above 133 percent FPL. See *Report to the Connecticut General Assembly from the SustiNet Health Partnership Board of Directors* (SustiNet Report), January 2011, www.ct.gov/sustinet/lib/sustinet/sn.final_report.cga.010711.pdf.

37 One problem with this approach is that the additional premium charged in the exchange could perhaps count against an insurer in calculating its compliance with Medical Loss Ratio (MLR) requirements. A state might be able to get around this problem by (1) supplementing BHP dollars so that the total state payment equals what the federal government would have provided in the exchange and (2) funding such supplement by levying a fee on plans offered in the exchange. Under interim final regulations issued by HHS, certain state taxes and assessments may be subtracted from premiums in determining insurers' MLR. See 45 CFR §158.161(b)(1) in *Federal Register* 75(230): 74864–74934, December 1, 2010.

38 Year-end reconciliation would change the flow of funds from the federal government to states. However, under the approaches to BHP that are the focus of this paper, low-income families would not be required to make year-end payments based on income changes throughout the year. Rather, such changes could be addressed as under Medicaid and CHIP.

39 Beyond administrative efficiencies for the state and increased convenience to families, the benefits of a single health plan for all family members may not be great. Often, adults and children are served by different provider networks, even within the same plan. And while research shows that, when parents receive health insurance, children are more likely to enroll in coverage and obtain care, no published studies show any measurable gains when parents and children receive the same health insurance (as opposed to health coverage through different plans). Amy Davidoff, Lisa Dubay, Genevieve Kenney, and Alshadaye Yemane, "The Effect of Parents' Insurance Coverage on Access to Care for Low-Income Children," *Inquiry*, Fall 2003; 40(3):254–268; Lisa Dubay and Genevieve Kenney, "Addressing Coverage Gaps for Low-Income Parents," *Health Affairs*, March/April 2004; 23(2): 225–234.

40 Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges," *Health Affairs*, February 2011; 30(2):228–236.

41 Lisa Clemans-Cope and Bowen Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005*, prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, December 2006.

42 Neil Bania and Laura Leete, Income Volatility and Food Insufficiency in U.S. Low Income Households, 1991 2003, draft paper prepared for presentation at the USDA/National Poverty Center Conference: Income Volatility and Implications for Food Assistance Programs–II, November 16–17, 2006, Economic Research Service, U.S. Department of Agriculture, October 2006.

43 E.g., Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends in Medicaid Physician Fees, 2003–2008," *Health Affairs*, May 2009; 28(3):w510–w519.

44 It is true that, for 2013 and 2014, ACA provides 100 percent federal funding for the cost of raising Medicaid payments to Medicare levels for evaluation and management services furnished by primary care providers. It is also true that ACA increases the total capacity of community health centers. In addition to increasing appropriations for such centers, ACA reduces the burden of uncompensated care on community clinics, and health centers are likely to garner additional revenue from ACA's requirement that all plans participating in the exchange must contract with health centers and pay them cost-based reimbursement. That said, with ACA's maintenance-of-effort requirements preventing eligibility reductions in Medicaid and CHIP, many states facing severe budget shortfalls are likely to cut Medicaid provider payments further. Moreover, starting in 2014, a major new influx of Medicaid adults will begin demanding services from an already overburdened network of Medicaid-participating providers.

45 In addition, a state could, through two steps, raise the amount of reimbursement received by providers, given a fixed per member per month (PMPM) amount paid to health plans: first, increasing OOP cost-sharing slightly above Medicaid amounts would reduce claims volume, thus allowing higher average payment per claim; and, second, raising medical loss ratios would increase total provider payments for a given PMPM.

46 Because of this federal requirement, BHP dollars could not be used to raise Medicaid reimbursement rates for all enrollees; the increase would need to be limited to BHP consumers, even though their income will be higher than that of most Medicaid beneficiaries. To boost payments for providers serving Medicaid beneficiaries, a state would need to use Medicaid dollars.

47 ACA apparently requires a plan in the exchange's individual market to be offered to all enrollees, including those with incomes too high for subsidies. See ACA §§1311(d)(2)(A) and §1312(f)(1). For a discussion of the operational and mission-related challenges that participation in the exchange would pose to Medicaid/CHIP safety net plans, see Walter A. Zelman, *Community-Based Nonprofit Medicaid Plans and the New Health Insurance Exchanges: Opportunities and Challenges*, State Coverage Initiatives, October 2010.

48 Donna Cohen Ross, Marian Jarlenski, Samantha Artiga, and Caryn Marks, *A Foundation for Health Reform:Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents during 2009*, Center on Budget and Policy Priorities and Kaiser Commission on Medicaid and the Uninsured, December 2009.

49 For women with incomes above 200 percent FPL, for whom BHP is not available, a state could limit OOP costs that plans in the exchange may charge for maternity care services received by pregnant women who would have qualified for Medicaid under rules in effect before ACA. While such a state would pay the resulting increase in federal subsidies, those expenses would be lower than the state's share of all Medicaid costs for the affected pregnant women.

50 Of course, the state could achieve equivalent savings by terminating the parents' Medicaid coverage and moving them into the exchange. But that would reduce these adults' benefits and increase their costs, without saving any additional money for the state. SustiNet Report, op cit.

51 This analysis assumes that, to preserve current access to long-term care by non-elderly people with disabilities, states will continue medically needy eligibility.

52 For information about one state's medically needy coverage, see California HealthCare Foundation, *Share of Cost Medi-Cal*, September 2010.

53 As another example of cost savings, some states could reduce their spending on the coverage they provide to poor and near-poor immigrants who received satisfactory immigration status within the past five years. A state that currently uses state and local dollars to cover such immigrants could continue to furnish them with Medicaid-type coverage under BHP while shifting the cost of their coverage to the federal government. Likewise, a state that, today, extends optional Medicaid coverage to pregnant women within the first five years after they receive satisfactory immigration status could, without eliminating any benefits or cost-sharing protections, end these women's Medicaid eligibility and have the federal government pay for their coverage via BHP. Of course, such a state could achieve equivalent savings by terminating its current coverage for these immigrants and shifting them into federally subsidized coverage in the exchange, but doing so would raise their premiums and OOP costs without providing any additional state savings.

54 Matthew Buettgens, Bowen Garrett, and John Holahan, *America under the Affordable Care Act*, prepared by the Urban Institute for the Robert Wood Johnson Foundation, December 2010.

55 Massachusetts Commonwealth Connector, op cit.; Massachusetts Commonwealth Connector, *Report to the Massachusetts Legislature, Implementation of the Health Care Reform Law, Chapter 58, 2006-2008*, October 2, 2008; U.S. Census Bureau, *State & County QuickFacts: Massachusetts*, last revised August 16, 2010. While Commonwealth Choice has grown over time and its stability is unquestioned, some observers have been disappointed by the program's small size, believing that an exchange with more covered lives could have a more significant impact on the state's health insurance markets.

56 Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, prepared by Washington and Lee University School of Law for The Commonwealth Fund, July 2010. While, as Jost notes, an insurer must have enough covered lives to obtain favorable rates from providers, a plan could condition access to all of its enrollees on provider agreement to accept specified reimbursement levels. At the same time, plans selling coverage both within and outside the exchange could offer the same provider network to all enrollees, just as many insurers do today in leveraging their existing provider networks to gain new business.

57 As explained earlier, a subsidized consumer typically pays premiums based on two factors: (1) household income and (2) the difference between premiums for the consumer's plan and premiums charged by the second–lowest-cost plan with silver actuarial value. If premiums rise by the same amount for all individual market plans in the exchange, the federal government will pay more in tax credits, but most subsidized consumers will be unaffected.

58 Stan Dorn, *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals*, prepared by the Urban Institute for State Coverage Initiatives, updated September 3, 2010, www.statecoverage.org/files/SCI_Dorn_Report_2010_Updated_9.3.2010.pdf.

59 These are preliminary conclusions. Further modeling would be required to yield conclusive estimates.

60 Some former Medicaid eligibles would have MAGI above 200 percent FPL and would therefore qualify for subsidies in the exchange rather than for BHP. However, BHP would pick up most adults who lose Medicaid coverage because of MAGI above 133 percent FPL.

61 Unlike ACA's risk-adjustment and reinsurance mechanisms, the legislation's risk-corridor program is federally administered. States may thus have less ability to shape the latter program, which seeks to guard against unforeseen spikes in claims rather than the concentration of prospectively identifiable, high-risk consumers in a single plan. A state could pursue the risk-corridor program's goals through other methods if HHS bars some BHP plans from participation (and after the temporary risk-corridor program ends). For example, a state could require BHP premiums to include funding for stop-loss coverage.

Crossroads Coalition Community - Agent / Broker Partnership

Partnership White Paper

August 18, 2011

Written by: *A collaborative effort between the members of Crossroads Coalition and* the *Illinois Insurance Agent and Broker Health Exchange Stakeholder Working Group*

Crossroads Coalition Community – Agent / Broker Partnership Executive Summary

On July 23, 2011, the State of Illinois legislature passed the Illinois Health Benefit Exchange Act, which established their intent to create a State Health Benefit Exchange. In accordance with the federal Affordable Care Act, the primary goal of the Illinois Health Benefit Exchange is to make health insurance more affordable and accessible for individuals and small businesses hoping to thereby decrease the number of uninsured individuals. The Health Benefit Exchange will act as an information and resource tool for individuals, families and small employers (currently under 50 employees) seeking insurance coverage. It will also be a portal for private insurers to offer a standardized set of health insurance programs in compliance with the state and federal mandated package of essential health benefits. Purchasers will also be able to determine if they qualify for any state/federal public aid programs or subsidies for coverage through the Exchange.

The Exchange will rely on two important distribution partners. Navigators, who consist primarily of organized community groups, will inform the hard to reach, underserved, culturally and ethnically responsive populations of the offerings through the Health Benefit Exchange. They will then direct interested members to the proper resources to facilitate exploration of options and enrollment. Navigators will require Certification through training as outlined by the Illinois Department of Insurance. The other distribution partner will be through existing and an expanded number of licensed Agents and Brokers. In addition to their normal licensing, they will also need to be Exchange Certified. Their function will be to advise, enroll, and fulfill the ongoing service needs of the insured.

Throughout the past year, stakeholder groups met separately with the Department of Insurance to review the Health Benefit Exchange concept. In anticipation of the need, the *Illinois Insurance Agent and Broker Health Exchange Stakeholder Working Group* reached out to and met multiple times with *Crossroads Coalition*, an organized community group and potential Navigator whose membership is quite diverse and whose geographic area mirrors that initially identified by the state for the Health Information Exchange as Medical Trading Area 14. As a result, it was recognized how critical both roles of Agents / Brokers and Navigators would be to the success of the Illinois Health Benefit Exchange.

In an unprecedented manner, our group came together to prepare a vision for the training, expectations, duties and compensation of both. Additionally, we have identified a number of unique opportunities for Navigators and Agents/Brokers to collaborate and partner in order to meet a number of common goals.

We developed a common Mission - To improve access to healthcare coverage and services for all Illinoisans, with particular focus on access through the Illinois Health Benefit Exchange.

We developed common goals starting with bridging the gap between agents/brokers and community organizations. Our collaboration also sought to decrease impediments to access; link hard-to-reach populations to vital information and resources regarding qualified health insurance plans; establish effective business community and civic collaborations; and ultimately develop benchmarks to measure performance and create accountability.

The attached partnership white paper includes an extensive description of how we hope to achieve our goal. Included in it is a detailed description of the role, qualifications and compensation of the Navigator and Agent/Broker. Beyond that we have identified a number of additional areas that these two groups might be able to partner and collaborate in the future to attain further progress on our common goals.

This document is considered a work in progress realizing the needs of the community, healthcare providers, healthcare delivery systems and state/federal funding programs can change. In addition there are several - yet to be defined provisions of the Affordable Care Act which could have an impact.

Table of Contents

I. Preamble

On July 23, 2011, the State of Illinois legislature passed the Illinois Health Benefit Exchange Act, which established their intent to create a State Health Benefit Exchange. In accordance with the federal Affordable Care Act, the primary goal of the Illinois Health Benefit Exchange is to make health insurance more affordable and accessible for individuals and small businesses hoping to thereby decrease the number of uninsured individuals. The Health Benefit Exchange will act as an information and resource tool for individuals, families and small employers (currently under 50 employees) seeking insurance coverage. It will also be a portal for private insurers to offer a standardized set of health insurance programs in compliance with the state and federal mandated package of essential health benefits. Purchasers will also be able to determine if they qualify for any state/federal public aid programs or subsidies for coverage through the Exchange.

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This document is considered a work in progress realizing the needs of the community, healthcare providers, healthcare delivery systems and state/federal funding programs can change. In addition there are several - yet to be defined provisions of the Affordable Care Act which could have an impact.

II. Our Mission:

Develop a Community Partnership working to improve access to healthcare coverage and services for all Illinoisans, with particular focus on access through the Illinois Health Benefit Exchange.

III. Goals and Objectives:

- Bridge the gap between agents and brokers and community organizations.
  1) Define the role of the Navigator
  2) Development of a Navigator program
  3) Define the role of the Agent / Broker as it pertains to the Illinois Health Benefit Exchange
  4) Define the relationship between Agents / Brokers and Navigators

- Decrease the impediments to access
  1) Address cultural, linguistic, and other barriers that impeded the enrollment of individuals in qualified health insurance plans.
  2) To provide culturally and ethnically appropriate information on the health insurance enrollment requirements of healthcare reform (PPACA).
- Link hard-to-reach populations to vital information and resources regarding qualified health insurance plans.

- Establish effective business / community and civic collaborations.
  1) To support the enrollment of individuals in qualified health insurance plans.
  2) Develop a community based advisory board.

- With Guidance from the Illinois Department of Insurance and Illinois Health and Human Services, develop benchmarks to measure performance and create accountability.

IV. Defining the Navigator Role, Compensation and Training

- Role of the Navigator:
  1) Develop a Plan in collaboration with the community to reach out to target audience.
  2) Facilitate Community Information Presentations to raise awareness of the availability of qualified health plans.
  3) Provide referrals to Exchange certified insurance agents or brokers to enroll individuals in a qualified health insurance plan.
  4) Refer individuals with complaints or grievances to the insurance agent or broker that originally placed the business or if that not apply, to the appropriate agencies.
  5) Education on Accessibility to: Providers, Certified Agents & Brokers, Public Agencies.
  6) Managing expectations – What does it mean to be insured.
  7) Assist with understanding and development of wellness initiatives to create a culture that fosters healthier, safer and more productive employees / individuals which can mitigate rising health care costs.

Compensation: We expect navigators to be hired by non-profit community based entities that will apply for and obtain annual grant money from the Exchange specifically designated for the Navigator program.

Training Requirements:

- Navigator Certification
- Insurance Exchange Certification - Knowledge of Exchange requiring an additional 8 CE hours
  1) Exchange Programs
  2) Role of a Navigator
  3) Community / Culture Awareness
  4) Subsidies
  5) HIPAA Privacy Training
  6) Graham Leach Bliley (Financial Privacy) Act

Qualifications:

- GED or High School Graduate, College preferred
- Must be able to pass and maintain a Certified Background Check
- Proficient in Reading, Writing and Speaking English
- Comfortable speaking to group setting
- Legally eligible to work in the state of Illinois

Certificate Training Program:

Model proposed contingent on funding capabilities and approved by the Department of Insurance.

A Twelve Week Program made up of Classroom and Practical experience.

- **Program consists of:**
  1) **Class Time**
     a) Three times per week, three hours per day
  2) **Practical Experience**
     a) Weeks 11 and 12 devoted to field training
  3) **Curriculum:**
     a. Insurance: How Insurance works, provider options and how claims get filed and paid.
     b. HIPAA: What is HIPAA? Why is Privacy so important? How it applies to Navigators and the Insured.
     c. The Gramm-Leach Bliley Act -(Financial Privacy)
     d. Ethics
     e. Personal Health Management: How it applies to Navigator and the Insured.
     f. Navigating: Guiding the client to the correct resources will aid them to combining the correct Insurance coverage and the clients Personal Healthcare management will lead to healthier outcomes. (Consider How the Exchange works. Behind the scenes view of plans, subsidies)
     g. Health home: What does it mean to coordinate care, select primary care provider and coordinate resources
     h. Public Speaking: Navigator candidate should be able to demonstrate competency in communicating to groups of 25. Note: Optimal training class size is 20.
  4) **Practical Experience:**
     a) The Navigator Candidate will work within the Community under supervision for two weeks demonstrating skills to certification Mentor. Note: Certification time may be shortened if candidate validates competencies within a shorter period of time.

Renewal of Certification Requirements:

- Bi-Annual Continuation Education 12 hour program to be established to maintain a working knowledge of Emerging Trends in Health Insurance.
- Maintain registration with the Exchange.
- Maintain original Qualifications
- Meet all continuing education requirements for re-certification.

V. Defining the Agent Broker Role, Compensation and Training

Role of the Agent / Broker:

- Develop a Plan in collaboration with Navigators to reach out to target audience.
- Partner with Navigators to facilitate Community information presentations to raise awareness of the availability of qualified health plans.
- Educate the Insured on Accessibility to: Providers, Certified Navigators and Public Agencies.
- Manage expectations based on plans the Individual purchases or is qualified through subsidies.

In addition, the following 8 categories commonly describe the day to day functions of an Agent/Broker:

1) **Assessment and Review**
   a) Assess clients' current position and challenges (i.e. budget, potential subsidy, personal or business needs, location – provider accessibility, and if a business: benefit philosophy and collective bargaining - contractual requirements);
   b) Discuss Affordable Care Act, explain the differences of Grandfather vs. Non-Grandfathered plans;
   c) Review ACA timetable;
   d) Review risk tolerance (e.g. high deductible – HSA, HRA);
   e) Review of market trends to ensure plan compliance; and
   f) If a business: periodic review of plan service performance and cost-versus-industry/region benchmarks. The Agent/Broker usually purchases benchmark data from third party resources.
2) **Plan Design Consultation**
   a) Plan design consultation, market trends and benefit benchmarking.
   b) If a business: benefit and cost analysis, including detailed claims (if available) or utilization spend studies;
   c) If a business: contribution modeling (i.e. help develop employer-employee premium cost share models; strategies can include multiple plan offerings and/or incentive-based programs for wellness).
3) **Administration**
   a) Ensure accurate implementation of new policy and/or changes with carrier(s) / Insurance Exchange:
      i) Billing
      ii) Eligibility
      iii) Carrier on-line resources and tools;
   b) Assist with individual and group applications, which can run from 10 – 15 pages long per applicant.
   c) Renewal contracts and plan summaries reviewed for accuracy (e.g. insurance carrier summary plan descriptions or certificates and group applications);
   d) Assist with simplification of administrative procedures.
4) **Consumer Claims Advocacy, Employee Communication**
   (a) Act as a HIPAA compliant Consumer Advocate resource for difficult claim situations and escalated issues.
   (b) Serve as a resource for insurance exchange / carrier and health care provider questions or issues;
   (c) Act as a consumer advocate resource for clients with carriers to accommodate hardship provisions, if business: late entrants, missed COBRA or State Continuation applicants; and
   (d) If a business: On-site benefit communication (involved in initial roll-out of new carrier, new plan or new product, as well as renewals) including: preparation of materials and of formal presentation, face-to-face presentations or webinars for multi-shift or multi-site employers. This also includes ongoing updates relating to carriers, vendors, providers, and legislation. On the employee level, education on understanding benefits, health care consumerism, plan utilization, and provider-interaction;
5) **Compliance Assistance**
   a) Filings and model plan notices to remain compliant with ACA i.e. Grandfathered status, etc.;
   b) Help Individuals and Employers of all sizes ensure compliance and serve as a resource for state and federal laws including COBRA, ARRA, CHIP, ongoing CMS reporting, HIPAA Privacy, Mental Health Parity requirements, Section 125, Small business Tax credits, and Individual Subsidies. On larger groups FMLA.
   c) If business: communication with management, human resources/ benefit personnel regarding benefits program issues;
   d) Legislative and regulatory updates with communication regarding state and federal mandates – This happens quite frequently under ACA.

e) On-staff (if available) or outsourced legal expertise many times required due to ACA changes.
f) If business: client education seminars on new legislation;
Educate individuals on the use of HRA and HSA plans to help mitigate rising costs, if business: also FSA. Coordination of benefits at the time of claim, regarding the interaction of workers compensation with COBRA, FMLA and ADA compliance.

6) **Renewal Marketing Analysis (Individual and Group)**
   a) Renewal preparation (current insurance carrier) with plan changes, alternative options, and cost summaries; Most carriers offer over 100 plan design options with the largest offering 252 on small group and close to 100 on individual. Many times these options are needed due to collective bargaining or contractual requirements.
   b) Review of market analysis that shows alternate insurance carrier quotations and options;
   c) For larger groups, conduct provider network efficiency study and provider disruption/discount analysis
   d) Review coverage and service compatibility analysis- what changes can the individual / group expect in coverage and service with a change of carriers or plan design.
7) **Proactive Wellness and Health Risk Management**
   a) Assist clients with understanding and development of wellness initiatives to create a culture that fosters healthier, safer and more productive employees / individuals which can mitigate rising health care costs..
   b) Review and implementation of proven health cost containment and disease management support services.
   c) For businesses: assist clients with educating employees on importance of becoming engaged in the health care process through proactive wellness and a consumer driven purchasing mindset.
   i) This can include onsite health screenings, planned seminars, planned activities and a multitude of health awareness promotions.
   ii) Introduce incentive programs to gain 90%+ participation in wellness screening and activities.
8) **Claims Analysis – Large Groups 100+ lives**
   a) Plan performance reviews with claim analysis and claim trends;
   b) Annual detailed claims analysis using carrier data with drill-down analysis capabilities;
   c) Benchmarking and trend data research and analysis for measurement and comparison to client-specific experience data; and
   d) Carrier experience reporting (interpretation, explanation and summarization for executive overview).

Compensation: We expect agents and brokers to continue to be compensated in the form of commissions paid by insurance carriers who are offering programs through the Exchange. So to avoid any adverse selection/steering carriers should offer the same level of commission in and out of the exchange.

Training Requirements for Agent / Broker:
As approved by The Department of Insurance

Exchange Certification:

- Knowledge of Exchange requiring 8 CE hours
- Exchange Programs
- Role of a Navigator
- Community / Culture Awareness
- Subsidies

License Requirements

- Agent/Broker -- Life, Accident and Health Licensing
  1) Pre licensing education requirement of 20 hours per line of authority; 7.5 of the 20 hours must be completed in a classroom setting.
  2) Required to show proof of completion of pre-licensing at the test center before being allowed to sit for the exam.
  3) Sit for and pass exam at a qualified test center

License Renewal Requirement:

- Agent/Broker – Life, Accident and Health Licensing (24months)
  All resident producers are required to have 24 hours of CE on file with the Department: three of which must be classroom ethics prior to requesting an extension of an insurance producer license.

VI. Joint Navigator – Agent / Broker Activities:

- Promote resources enabling greater access to care and services
  1) **Illinois Insurance Exchange**
  2) **Qualified Exchange Partner**
     a) Navigator
     b) Agent / Broker
     c) Provider Network

  The role of exchange partners is to help set up information dissemination activities with their communities. Exchange partners will also participate in other marketing and promotion activities designed to raise awareness of the need for individuals to sign up for a qualified health insurance plan.

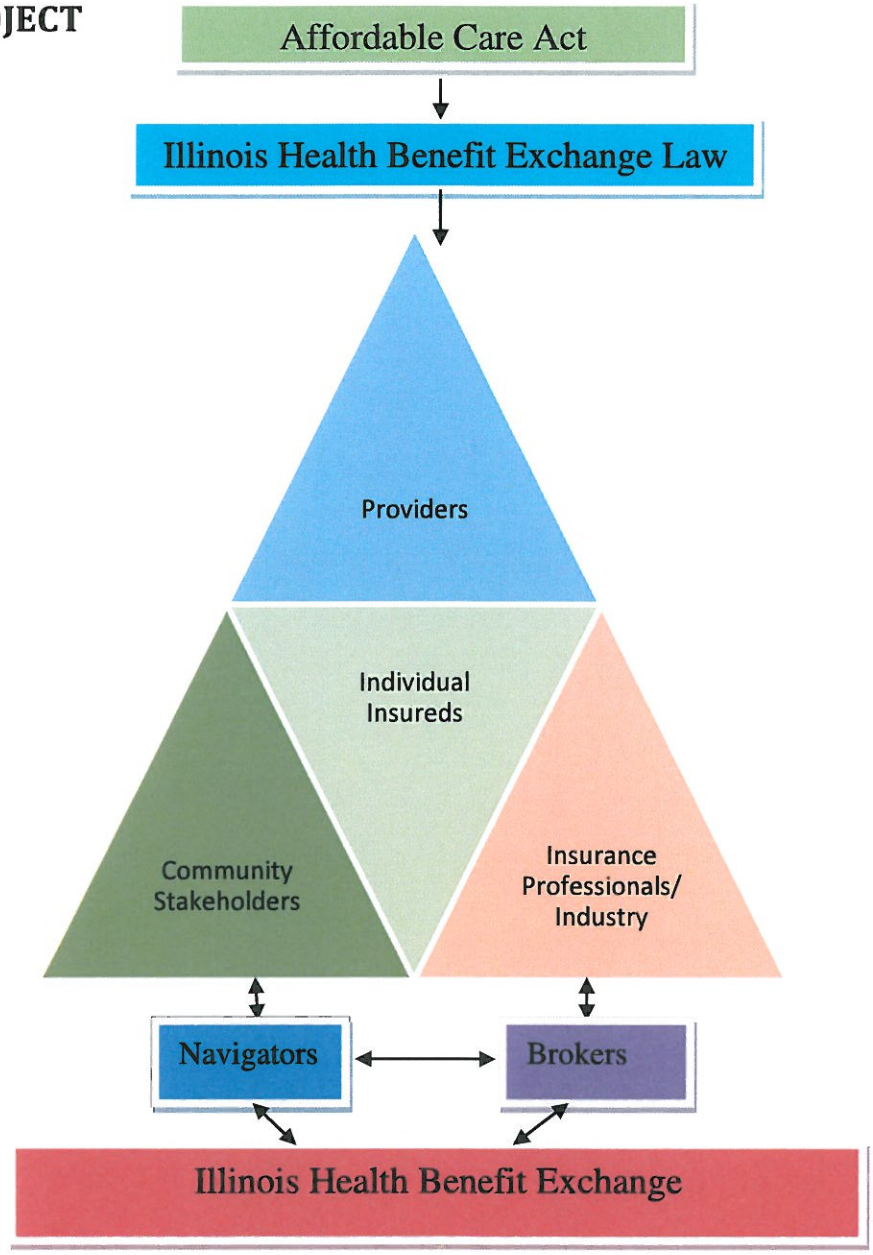
- Organize Community Meetings
  1) Community Based Organizations
  2) Faith – Based Organizations
  3) Professional Organizations

  Information Presentations - The work of the Exchange will consist of conducting information presentations in community and faith-based settings. These session will discuss the need for individuals to enroll in a qualified health insurance plan, answer any questions or concerns individuals might have regarding enrolling in a health insurance plan, and provide information on Exchange partner brokers who can assist individuals in selecting the right plan and enrolling in that plan. Navigators will facilitate the information sessions. Where possible, brokers will also be present to answer questions and concerns.

- Understanding of What the Exchange is
- Basic Understanding of Benefits
- Wellness Benefits Available
- Resources

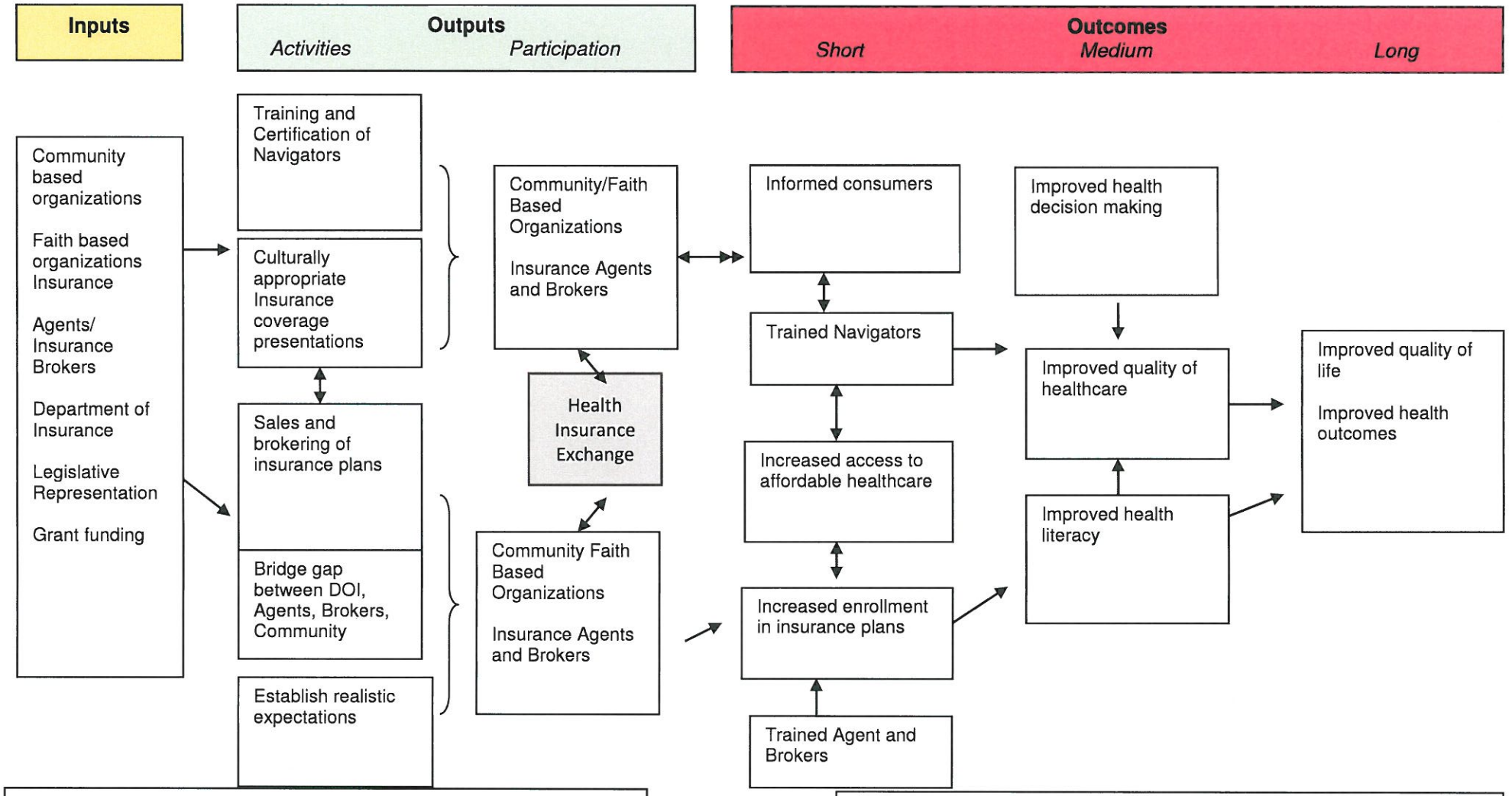
* Navigator – as defined by ACA with modifications to State and Community needs

VII. FLOW CHART of PROJECT



VIII. Logic Model

Program: Crossroads Community/Agent/Broker Partnership Logic Model
Mission: Develop a Community Partnership working to improve access to healthcare coverage and services for all Illinoisans.
Objective: Establish an Exchange Navigator Program



Assumptions
Funding for Navigators by the Exchange
Agents/brokers continue to be paid commissions by insurance carriers

External Factors
Number of individuals deemed qualified for exchange
Ongoing support from community outreach organizations

IX. Committee Members of the Partnership

Members Representing Crossroads Coalition

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Aetna®

September 15, 2011

TESTIMONY OF GEOFFREY SANDLER, FSA, MAAA
SENIOR ACTUARY, AETNA

AND

ELENA BUTKUS
REGIONAL VICE PRESIDENT, GOVERNMENT AFFAIRS
AETNA, MID-AMERICA

PROVIDED TO THE

ILLINOIS HEALTH BENEFITS EXCHANGE LEGISLATIVE STUDY COMMITTEE

Aetna is pleased to continue working with the State of Illinois on Exchange issues as the State analyzes its options for establishing a health insurance exchange under the requirements of the Patient Protection Affordable Care Act (PPACA). Aetna is one of the nation's leaders in health care, dental, pharmacy, and other employee benefits. We have 18.6 million medical members nationwide and of most import is that we want to continue to provide our products in the State of Illinois. Thus, how the Exchange is established and under what market rules is of critical importance.

Earlier this year Aetna provided the Department of Insurance (DOI) and its consultants with carrier and market information to support the State in the development of its exchange. We have also participated in the Administration's hearings on the issue last year and met with the DOI numerous times regarding Exchange development.

Embodied in all our comments is that there must be parallel systems whereby the Exchange is available for certain coverages and a parallel system continues to exist outside of the Exchange. In Massachusetts most individuals and small businesses finding access to and enrolling in coverage are doing so outside of the Exchange. According to statistics from the Massachusetts Health Connector, 3.5% of the total insured population in Massachusetts are enrolled through the Exchange. The reason the Exchange is important is that 85% of individuals enrolling through the mechanism are eligible for subsidies. Similarly, the Congressional Budget Office estimates that about 81 percent of individuals purchasing Exchange coverage in 2019 will receive subsidies. As we advance in our analysis of Exchanges, there are several critical issues that we wish to raise with the Health Benefits Exchange Legislative Study Commission today:

- Adverse Selection
- Promoting Competition
- Avoiding Unnecessary Cost Increases

In these categories we have included our comments regarding design issues of the Exchange and mitigating market disruption.

ADVERSE SELECTION

Adverse selection is one of several key challenges that all Exchanges will have to address if states are to offer affordable health insurance products. It is also critical to recognize that the risk pools of insurance sold inside and outside of an Exchange are linked. Therefore, if the Exchange suffers price increases due to adverse selection – this will impact the overall individual and small group markets in Illinois. The future of the two markets are inextricably linked. Given that adverse selection played a key role in the demise of earlier Exchanges and purchasing cooperatives, it is important that Illinois mitigate this issue.

To this end, for the Illinois Exchange to be successful we must be prepared to mitigate the impact of insurance reforms that will likely occur and we must limit the eligibility to truly small employers and not combine the individual and small group Exchanges.

I. Mitigate impact of insurance reforms

Adverse selection played a key role in the demise of earlier state experiments with Exchanges and purchasing cooperatives. Although the ACA does impose the new element of an individual mandate, this mandate is far from bullet-proof, and as you know it is under significant judicial and political pressure. Thus, it is critically important that the State mitigate adverse selection in tandem with Exchange implementation in 2014. Among the concrete steps we recommend to combat adverse selection in a new insurance market including Exchanges are the following items that were included in a recent GAO report:

(1) Modify open enrollment periods
(2) Expand employer role in auto enrollment and facilitating employee enrollment
(3) Public outreach and education campaign
(4) Provide broad access to personalized assessment for enrollment
(5) Impose taxes to pay for uncompensated care
(6) Allow greater age premium variation
(7) Condition government services on proof of insurance
(8) Use brokers differently
(9) Require or encourage credit rating agencies to use coverage status as a factor in credit rating.

Other issues are important as well – the Illinois Exchange should focus aggressively on working with the Department of Health and Family Services (DHFS) to identify and verify member eligibility for public subsidies and/or Medicaid.

II. Limit eligibility to small employers and don't combine individual and small group Exchanges:

Also critical to curbing adverse selection is keeping the Exchange participation limited to very small groups. Under the ACA, states are directed to offer Exchange eligibility to at least group up to size 50 in 2014 and up to group size 100 in 2016. Beginning in 2017, states have the option to allow even larger employers to join the Exchanges. Larger employers currently either self-fund or are rated based on their own experience. Those that would choose to go to the Exchange which would be a community rated environment would do so most often because their own experience is worse than the average which would then lead to higher premiums for the employers most in need of improved affordability – the smallest employers.

Although self-funding is typically perceived to be an option exercised by only the largest employers (e.g., those with several hundreds of employees), the fact is, self-insurance is rapidly becoming a more popular option among smaller employers. According to a report quoted in the Wall Street Journal recently; small-to-midsize employers are driving growth in self-insured health plan enrollment. Indeed, over the previous five years, membership in self-funded insurance plans grew 11 percent, while enrollment in insured plans fell by 13 percent – causing overall self-funded membership to surpass that of fully insured plans. Currently about 58 percent of groups size 200 to 999 self-fund and about 80 percent of employers 1,000 to 4,999 self-fund.

Just as important is that individual and small group Exchanges must not be combined. When we have seen these populations combined, the individual experience tends to be poorer than the small group's experience. This effectively transfers the cost of covering poor risk individuals to small group employers. We do not think that is a fair situation for small employers.

Specifically, small employers are very price sensitive and already have relatively low offer rates. Only 59 percent of employers under size 10 offered coverage to their employees in 2010 and 76 percent of employers 10 to 25 offered coverage. Combining the individual market into the small group market would increase premiums for the small group market. Even more important is that if the individual mandate is repealed and guaranteed issue remains, the cost shift to the small group market could be much greater than we have seen in Massachusetts, for example. As we mentioned previously, the Exchange markets and outside markets are linked. Pooling the individual and small group markets could have damaging effects to small group coverage sold both inside and outside of the Exchange.

PROMOTING COMPETITION

Today, consumers and small employers are frustrated by a lack of competition in many state individual and small group markets. A 2009 NAIC report found that 20 states had only three or fewer carriers with individual health insurance members. A 2009 AMA market share analysis showed that Blue Cross Blue Shield plans held over 50% market share in over half of the states surveyed. In fact, the September, 2011 Deloitte report on the Illinois Health Coverage Marketplace commissioned by the State shows Health Care Service Corporation or Blue Cross Blue Shield of Illinois with 49% market concentration which means we have a "highly concentrated" marketplace.

Thus, when constructing Exchange rules, we respectfully ask that you recognize that if the cost of entering the Illinois Exchange is too high – many insurers will not participate. This is especially true of insurers whose membership is distributed across many states. As a result, certain carriers may have a relatively small membership in any particular state and this small membership pool cannot support significant administrative costs associated with participating in that state's Exchange.

State Exchanges that fail to increase choices and competition are likely to be viewed as failures by state residents. Therefore, we ask you to consider four issues:

1) Pilot employee choice as an option for insurers, not a requirement

The ACA allows states to adopt Exchanges that continue to follow the traditional small group purchasing method – where an employer chooses a health plan for their employees. ACA also includes "employee choice." Under this, an Exchange would allow employees within a participating small employer to choose any plan in the Exchange. The Illinois Exchange should make provision of an "employee choice" product optional for insurers. Given the complexities of the employee choice model, Exchanges that rely solely on this approach may be unable to offer viable coverage to small employers at all. The state of Massachusetts struggled for several years to develop an employee option. At its height it attracted only 42 employers and it was eventually abandoned in favor of an employer choice model.

2) Avoid re-creating existing regulations

A subject of recurring uncertainty among state policymakers is the degree to which Exchanges should or should not assume direct regulatory or administrative responsibility in particular areas. For many Exchange standards -- such as provider network standards, marketing rules, and review of rates -- the ACA merely spells out functions that the Exchange shall assure are being performed and/or standards that shall be met. The ACA does NOT require that the Exchange itself must establish and/or itself supervise such functions or standards.

To this end, please consider deferring to DOI or other applicable agency that has current statutory authority to enforcing existing state consumer protection standards both inside and outside of the Exchange. If Illinois empowers its Exchange to establish and enforce their own standards, this will deter many insurers from participating in the Exchange. Specifically, separate Exchange standard enforcement would increase start-up costs for insurers; impose duplicative costs on taxpayers; and create inequities and confusion for consumers. Generally, consumers buying coverage from the same company would face differing protections depending on whether they purchased coverage inside or outside of the Exchange. This is likely to confuse consumers – especially in the nongroup market where turnover is very high and consumers move out of coverage on a regular basis.

3) Provide choice, not standardization

Consumers and small employers will expect state Exchanges to provide enhanced choice of coverage – not a reduction in choice. We do not believe that Illinois should require that benefit

offerings be standardized in the Exchange. In our opinion, states that are considering such a move should realize that it would deter insurer participation in the Exchange and slow innovation.

With respect to deterring insurer participation in the Exchange, we have designed existing insurance products based on focus groups and market demands. In addition, we have invested significant expenditures in the system architecture to support these benefits as well as the substantial costs of filing forms, rates and other oversight requirements for these products. If Exchanges require that insurers create a new set of products (along with all of the associated filing and approval costs) it would not be financially viable to do so for all state Exchanges. States with unique standardization rules will have fewer insurers than other states.

With respect to slowing innovation, private health plans -- spurred on by the employer community -- have led the way in implementing innovative benefit plan designs, disease management programs and other programs for members with complex chronic conditions. These innovations have been driven by market demands and evidence-based research and are focused on improving quality while controlling costs. By contrast, government-managed programs have consistently lagged behind the private market with respect to benefit design and cost and quality programs.

4) Adopt standard health information technology (IT) and quality rules

Insurers must invest in a variety of IT and related infrastructure in order to participate in Exchanges. It is important that the federal government establishes, and that the states adopt standardized data and quality rules and definitions to form the core of any Exchange. Otherwise the administrative costs associated with participating in multiple state Exchanges could be wasteful and deter insurer participation. The adoption by states of national infrastructure and quality standards could be essential to administrative efficiency and feasibility.

AVOIDING UNNECESSARY COST INCREASES

The primary objective of the Illinois Exchange must be to provide access to affordable health insurance coverage.

The Exchange market as well as the overall individual and small group markets will be facing changes in rating and benefit design required under ACA that will create upward pressure on pricing. The CBO anticipates a 27-30 percent average premium increase in the individual market to occur as a result of the ACA's essential benefit requirements and actuarial value "buy up." For those who have existing health conditions, there will be financial relief. However, many will face premium increases as a result of the changes.

To this end, we believe that the Illinois Exchange should be financed by a broad-based financing mechanism that is not limited to insurer assessments. We ask that Illinois evaluate all available funding sources to support continuing administrative and operational expenses, including grants, fees, assessments and taxes. Broad-based funding will help maintain the Exchange and protect consumers and small employers from cost over-runs that further increase premiums.

In addition Exchange funding should be strictly limited to the needs of the Exchange and any assessments from the industry should not be used to fund any Exchange services that are performed on behalf of other state or federal programs.

CONCLUSION

We are very hopeful that the Illinois Exchange will be implemented in a manner that preserves a level and competitive marketplace and provides consumers and employers a choice among companies and affordable products.

Thank you for the opportunity to provide this input and we look forward to continuing to working with you and the State.

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United Power
FOR ACTION AND JUSTICE

4848 N. Clark St., Chicago, Illinois 60640
312-925-6505

Illinois General Assembly
Legislative Study Committee on the Health Benefits Exchange

Testimony of United Power for Action and Justice
Submitted September 15, 2011

About United Power for Action and Justice:
United Power for Action and Justice is an independent, non-partisan, organization of 40 churches, synagogues, mosques, civic, neighborhood, health, and ethnic institutions from across Cook County. These institutions of civil society have joined together to fight for social justice and the common good on issues of shared concern. United Power is an affiliate of the Industrial Areas Foundation (IAF), the oldest and largest network of community organizations in the country.

United Power's Health Care Work:
United Power began to address the specific health care needs of people without health insurance in the 1990s. The campaign had a three-pronged strategy: Expand coverage, increase enrollment, and expand services for people without health insurance. As a result of these efforts:

- The State of Illinois' Family Care health insurance program expanded to 400,000 from 250,000.
- Our Gilead Center enrolled over 100,000 consumers into state health insurance programs
- State funds were secured to supplement federal funds to expand community health centers.

UPAJ won additional health care victories with the expansion of breast and cervical cancer screening and treatment, and young adult coverage. In addition, UPAJ has been a staunch ally of the immigrant and refugee community in protecting All Kids coverage for undocumented children.

United Power's Interest in the Health Benefits Exchange:
Earlier this year, United Power began hearing from its members that people were experiencing problems with the health insurance coverage. To get a better sense of the

extent and nature of these problems, a survey was developed and distributed to our members - both on-line and in paper form. We are finalizing our report on that survey now and will be releasing it by the end of the month.

Here's a sample of what we will be reporting: United Power asked "have you or your family encountered the following problems with health insurance in the last five years?" **72% reported at least one problem** with their health insurance. Of those reporting problems:

- **Over half** (51.1%) said they had experienced **large increases in premium costs**.
- **Over a third** (33.8%) said they had seen a **large increase in their deductable amount**.
- **Nearly a third** (31.9% reported **large increases in prescription drug costs**.
- **One in four** (24.6%) said they had **lost insurance coverage completely**.

Based on our survey of members and our years of work in improving health care in Illinois, United Power knows that the health benefits exchange is of immense importance to Illinois families and small businesses. If Illinois fails to create a strong, effective health insurance exchange, hundreds of thousands of individuals and small businesses will lose out. And it's important that we complete health care reform in Illinois because the current health care market place is not working.

Against that background, United Power has four points to make to this committee:

First, creating a strong and effective Health Benefits Exchange during the fall veto session is critical to Illinois individuals and small businesses – and voters.

- Illinois residents continue to struggle to find adequate private health insurance as is evidenced by the above survey.

- Illinois insurance companies are making record profits.
  - Blue Cross Blue Shield made $1.1 billion in profit last year, doubling 2009 results (Source: *Crain's Chicago Business,* 6/20/11)

Second, the Illinois Health Benefits Exchange (done right) can expand access to insurance and control costs.

- Consumer- and market-friendly exchanges have been successful in Massachusetts and are being set up in a diverse array of states including Utah, Colorado, and California. They are like the Travelocity or Orbitz travel websites and allow "apples to apples" comparisons, phone assistance lines and "navigators" to help customers.

- The Exchange should be able to negotiate prices with insurance companies, set quality standards for participation, and oversee the benefits offered and the appeals process.

- The Exchange should help lower-income people move between public health care programs and private health insurance as their job and income status change.

Third, a well-designed Health Benefits Exchange needs effective governance through an appointed board of directors with strong consumer representation.

- The Exchange should be a quasi-government entity similar to the Illinois Comprehensive Insurance Plan (ICHIP).

- A majority of the Exchange Board's membership should be individuals, families, and small businesses who seek coverage from the Exchange – not insurance company employees or agents.

Fourth, an effective Health Benefits Exchange must be sustainable and funded in a manner that does not burden consumers or taxpayers.

- A small fee on every health insurance policy in Illinois would be the best way to fund the Exchange.

Thank you for your time and for your work on making the Illinois health benefits exchange a success for the people of Illinois.

Alec Harris
President, GIA Publications, Inc.
Member, United Power for Action and Justice

September 15, 2011

Illinois PIRG
Standing Up
To Powerful Interests

Illinois Public Interest Research Group
328 S. Jefferson, Ste. 620 Chicago, IL 60661
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Testimony before the Health Benefits Exchange Legislative Study Committee
Brian Imus, Illinois PIRG Education Fund
September 15, 2011

Thank you for the opportunity to testify. My name is Brian Imus, and I'm the Director of the Illinois Public Interest Research Group. Illinois PIRG is a non-profit consumer advocacy and research organization primarily funded through dues paying citizen members from across the state. As a public interest organization concerned with defending the rights of Illinois consumers our focus is on addressing changes to the private insurance marketplace to increase competition. That means policies that ensure more choices, easier comparison and leveraging the buying power of individual consumers and small businesses.

Unfortunately, the experience for too many Illinois consumers involves take-it-or-leave-it insurance deals, important information about coverage buried in the fine print and, unlike most other markets, no effective way to shop around. For small businesses in Illinois, who lack the advantages possessed by larger businesses, the problem is particularly acute. Small businesses pay on average 18% more for insurance[i] than their larger competitors and have seen repeated double digit premium increases.

An organized, competitive insurance marketplace created by an exchange – one where there is a single place (or portal) where a consumer can go to shop for health insurance – can help solve these problems. Done well, it's a place on-line where there will be a clear array of health coverage options, with helpful quality and customer service rankings and useful tools that allow someone shopping for insurance for their family the ability to easily compare prices and estimate potential out-of-pocket costs.

However, this new competitive exchange marketplace should be much more than "Expedia for health care." In giving consumers better choices and offering the help they need in navigating the insurance market, it can act like the human resources department of a large employer. It should negotiate on behalf of small businesses and individuals and give them the tools they need to pick the right program and educate them about their options.

These benefits to consumers and small businesses are not guaranteed. The effectiveness of the exchange will depend on the policies that govern and operate it. While the exchange will have to make countless decisions in order to best serve consumers and the public, I would like to focus

on two of the most important areas; governance – because it must be accountable and free from conflicts of interest – and its finances – since it must be self-supporting and stable.

GOVERNANCE

To fully realize the benefits of increased competition and choice provided by the exchange, it must be transparent, accountable and responsive, and governed by those the exchange is intended to serve: consumers and small businesses.

There are three key policy considerations critical to achieve this goal.

First, to make clear its priorities, the exchange's legislative mandate and mission statement should clearly state that the program is to be operated for the benefit of individuals, businesses and their employees, not the insurance and health care industry. The exchange will make many decisions, and can play many different roles. Delivering affordable, high-quality coverage to the greatest number of eligible Illinoisans must be the foundation of those decisions.

Second, the exchange operates for the benefit of the individuals and businesses that pay the premiums for health coverage. As such, the exchange should be governed by a quasi-governmental board that draws on those the exchange is intended to serve: consumers and small businesses. Those who could potentially benefit financially from the exchange should not be on the board.

Board members should be free from conflicts of interest and represent policyholders as primary stakeholders, supplemented with technical experts as needed. The "revolving door" should also be avoided by enacting legislation or incorporating by reference existing state legislative provisions that would prohibit exchange managers or board members from moving directly to or from the insurance industry.

Industry stakeholder groups, including insurers, should have opportunities for meaningful input into technical and workability decisions. A separate advisory board could represent insurer, producer, and provider interests.

Third, the exchange should require all board meetings to comply with open meeting laws and to allow groups to gather information and hear about the decisions made by the board. Information used or discussed at board meetings, including agendas and meeting minutes and other supporting documents, should be made available to the public. Consumers and the public will need to trust that the Exchange is looking out for their best interests, and transparency and accountability are the best way to achieve that goal.

Other important governance considerations include:

- The exchange marketplace should be staffed with or have immediate access to *experienced experts* who can resolve issues quickly and make recommendations to the exchange board. This includes access to economic, legal, and health care expertise, and knowledge about the insurance industry, state and federal laws governing the insurance industry, purchasing, the individual and small group health insurance markets, potential

interactions with public programs (Medicaid, SNAP, etc.), benefit design, consumer outreach, and the overall consumer experience of buying coverage.

- Terms of board members should be staggered so that there will also be a mix of newer and more experienced board members.

- The exchange marketplace should maintain its independence from all state agencies such as the Department of Insurance and the Department of Healthcare and Family Service while also maintaining good working relationships with them.

FINANCIAL SUSTAINABILITY

While there is opportunity for federal funding to cover the cost of setting up Illinois' exchange, the program must be self-sustaining by 2015. There are two key policy considerations to achieving this goal.

First, most of the operational funding for the exchange should come from an assessment on all insurers in the health insurance market.

Assessing a fee solely on exchange plans should be avoided, because it could undermine the exchange, and increase the risk of adverse selection. This is danger regardless of whether the assessment is paid primarily by the insurer, or passed on to the consumer. In the former case, insurers will have a positive incentive to steer enrollees into non-exchange plans to avoid the assessment; in the latter, consumers would face slightly higher prices on the exchange, and would similarly be more likely to go to the outside market. In both cases, the effect is likely to be strongest for the healthiest enrollees, who are likely to be most sensitive to small differences in premium, which would pose the risk that sicker enrollees would be concentrated in the exchange, threatening its stability. Assessing the fee on all insurers would eliminate this danger.

The assessment should be shared by everyone in the market because the exchange benefits all the market players. The outreach and engagement generated by the exchange will increase participation inside and outside the exchange, increasing the number of customers. The exchange website will allow for plan comparisons and easy consumer experience that people getting coverage outside the exchange might use as well (like looking for books on Amazon then going out and buying them at a brick and mortar store). The exchange is likely going to be administering some risk adjustment programs that will help keep risk pools stable across the entire market.

Federal law requires insurers to charge the same price for a product whether it's offered on the exchange or not, so if the inside-exchange version has a fee attached, but the one outside doesn't, that means the insurer may be charging an unjustifiably high price in the outside market since the exchange isn't getting that extra "fee" revenue.

Finally, the exchange will also expand insurance markets, benefiting all insurers. The more enrollees in the exchange, the less the assessment will need to be.

Second, a clear provision of the enabling legislation should bar the use of general revenue funds to pay for the operation of the exchange marketplace. Conversely, no revenue generated should be used for general state government operations. The revenue should only be for the operation of the exchange. Clearly separating the funding will help preserve the program's independence, so that it is self-sustaining and truly operated for the benefit of the customers it is intended to serve.

OTHER IMPORTANT POLICY CONSIDERATIONS

Policies that ensure strong negotiating power: Just as any big business negotiates with insurers, using the bargaining power of its employees to push for lower premiums, so too a strong exchange marketplace must have the power to negotiate for better choices and lower costs. That means it must have the authority to exclude plans that fail to deliver robust consumer protections, quality care, and reasonable costs, particularly if the plan has a history of unreasonable rate increases. And because the bigger the exchange, the greater its negotiating power, Illinois should plan to open the exchange Marketplace to employees of large businesses as soon as possible, and work to enroll as many eligible consumers as possible.

Policies that promote innovations in cost and quality: Research and the experience of innovative providers across the country have identified game-changing strategies to hold down costs by providing higher-quality, coordinated care to patients: medical homes, chronic disease management, accountable care organizations, and bundled payments.

The exchange, in its negotiations with insurers, can drive them to adopt these proven strategies. Once plans have initially agreed to adopt these reforms, the exchange must monitor their implementation, so that insurers disclose information on the impact which the reforms actually have on quality of care and coverage, cost, outcomes, and adherence to best practices. The exchange should provide a special "seal of approval" for the plans that do the best job at providing high quality care, and provide consumers with easily understandable information about what these reforms mean and how consumers can best make use of them.

Policies that ensure stability: If the exchange is not designed correctly, sicker enrollees can congregate within the exchange, while healthier enrollees remaining outside. Because sicker enrollees cost more to insure, this drives up premiums, leading more healthy people to drop coverage which in turn sends premiums up again. Policymakers must prevent this dynamic from ruining the exchange's potential to improve consumer choices and hold down costs. Illinois must require insurers to offer "mirror" versions of their products, on both the exchange marketplace and the market outside the exchange. The state should prohibit insurers or brokers from steering people either onto or off of the exchange, through setting different broker commissions, adopting targeted marketing strategies, or by any other method. And because a larger Marketplace exchange will have more stability, Illinois should conduct strong outreach and enrollment and widen the eligibility rules for the exchange.

Policies that ensure a consumer-friendly experience: The consumer experience is an important prerequisite for the exchange's success. Its web portal must be well-designed, ensuring that the language used is straightforward, avoiding jargon as much as possible and addressing the diverse language needs of enrollees. The exchange must also help those without high-speed internet to

find coverage, providing a toll-free hotline and face to face assistance through its Navigator program. It should take steps to help consumers make informed choices, by allowing them to make apples to apples comparisons of their options and making it easy to search for products that meet a consumer's particular needs. The exchange must safeguard consumers' privacy, by ensuring that identifiable personal information is not shared, internally or externally, with those who do not have an immediate, legitimate need for it.

Policies that make health care work for small businesses: For smaller businesses, if one employee gets unexpectedly sick, premiums for the entire business can jump. The exchange can help mitigate this problem; by bringing the small business into a much larger pool, comprised of individuals and other small businesses, changes in the age or health status of a few employees will no longer have as much of an impact on overall costs. And untangling the confusing array of plan options available to small businesses today can be a full time job by itself. By standardizing insurance products within tiers, and creating decision tools to allow for easy apples-to-apples comparisons, the exchange can allow even small businesses without much time or expertise to make choices that are right for them. But to make sure the exchange delivers value for small businesses, it must provide for input from small business owners and their employees.

CONCLUSION

This is by no means meant to be a comprehensive list of recommendations for the exchange, but rather the key policies most important when first laying the foundation to get an effective exchange up and running in Illinois.

The task before you is an important one. The creation of a new health insurance exchange offers Illinois the chance to build a better marketplace for health care. I appreciate your commitment to helping make that happen as a member of the Health Benefits Exchange Legislative Study Committee.

Thank you

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[i] http://www.smallbusinessmajority.org/_pdf/SBM-economic_impact_061009.pdf

Building a Better Health Care Marketplace

Illinois PIRG Education Fund

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With public debate around important issues often dominated by special interests pursuing their own narrow agendas, Illinois PIRG Education Fund offers an independent voice that works on behalf of the public interest. Illinois PIRG Education Fund, a 501(c)(3) organization, works to protect consumers and promote good government. We investigate problems, craft solutions, educate the public, and offer Americans meaningful opportunities for civic participation.

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Executive Summary

Consumers across the state know that the health insurance marketplace is broken. Insurers don't compete for their business, instead offering take-it-or-leave-it deals. Important information about coverage is buried in the fine print, making it hard to know what's really covered. Instead of working to lower costs and improve quality, too many insurers focus on covering healthy enrollees and dumping the sick. And costs are continuing their unsustainable rise. Nationally, the great majority of individual-market policyholders—77% —saw a premium increase from early 2009 to early 2010, with an average rate hike of 20%. Small businesses, too, pay 18% more for insurance than their larger competitors and have seen repeated double digit premium increases.

The creation of a new health insurance exchange offers our state the chance to build a better marketplace for health care. The exchange can help individuals and small businesses by increasing competition and improving choices in the state's insurance market. By providing better options and better information, and negotiating on behalf of its enrollees, the exchange can level the playing field for consumers.

Success is not assured, however, as states confronting the task of setting up their exchange must grapple with important policy questions. This report is a blueprint for creating a strong, pro-consumer exchange that lives up to its promise of a better marketplace.

Accountability and Transparency

The exchange must be accountable to the public, and individual and small business consumers, not the special interests. The exchange's legislative mandate and mission statement should clearly state that the exchange is to be operated for the benefit of individuals, businesses and their employees, not the insurance and health care industries. It should be run and overseen by representatives drawn from the consumer and small business communities that the exchange is designed to serve, not insurers

or providers who could benefit financially from the exchange's decisions.

The Power of Negotiation

Just as any big business negotiates with insurers, using the bargaining power of its employees to push for lower premiums, so too a strong exchange must have the power to negotiate for better choices and lower costs. That means it must have the authority to exclude plans that fail to deliver robust consumer protections, quality care, and reasonable costs, particularly if the plan has a history of unreasonable rate increases. And because the bigger the exchange, the greater its negotiating power, the state should plan to open the exchange to employees of large businesses as soon as possible, and work to enroll as many eligible consumers as possible.

Promoting Innovations in Cost and Quality

Research and the experience of innovative providers across the country have identified game-changing strategies to hold down costs by providing higher-quality, coordinated care to patients: medical homes, chronic disease management, accountable care organizations, and bundled payments. The exchange, in its negotiations with insurers, can drive them to adopt these proven strategies. Once plans have initially agreed to adopt these reforms, the exchange must monitor their implementation, so that insurers disclose information on the impact which the reforms actually have on quality of care and coverage, cost, outcomes, and adherence to best practices. The exchange should provide a special "seal of approval" for the plans that do the best job at providing high quality care, and provide consumers with easily understandable information about what these reforms mean and how consumers can best make use of them.

Ensuring Stability

If the exchange is not designed correctly, sicker enrollees can congregate within the exchange, with healthier enrollees remaining outside. Because sicker enrollees cost more to insure, this drives up premiums, leading more healthy people to drop coverage which in turn sends premiums up again. Policymakers must prevent this dynamic from ruining the exchange's potential to improve consumer choices and hold down costs. They can require insurers to offer "mirror" versions of their products, on both the exchange and the market outside the exchange. The state should prohibit insurers or brokers from steering people either onto or off of the exchange, through setting different broker commissions, adopting targeted marketing strategies, or by any other method. And because a larger exchange will have more stability, states should conduct strong outreach and enrollment and widen the eligibility rules for the exchange.

Designing a Consumer-Friendly Exchange

The consumer experience is an important prerequisite for the exchange's success. Its web portal must be well-designed, ensuring that the language used is straightforward, avoiding jargon as much as possible and addressing the diverse language needs of enrollees. The exchange must also help those without high-speed internet to find coverage, providing a toll-free hotline and face to face assistance through its Naviga-

tor program. It should take steps to help consumers make informed choices, by allowing them to make apples to apples comparisons of their options and making it easy to search for products that meet a consumer's particular needs. The exchange must safeguard consumers' privacy, by ensuring that identifiable personal information is not shared, internally or externally, with those who do not have an immediate, legitimate need for it.

Coordinating with Public Programs

The exchange will be only one piece of the state's larger health care landscape, which will continue to include public programs like Medicaid and the Children's Health Insurance Program (CHIP). Coordinating these various programs will require careful attention to issues of eligibility, enrollment, and transition, but will allow states to save money due to increased efficiency, and give consumers an easier experience getting their coverage. Whatever door a consumer enters through—applying to the exchange or a public program—they should quickly and easily receive the appropriate coverage. The state's system should obtain updated information from enrollees in both public programs and the exchange each year, and if the enrollee's eligibility has not changed, their coverage should be automatically renewed. If the enrollee instead becomes newly eligible for some other coverage source, the exchange should present the enrollee with their new choices, and automatically enroll them unless they opt out.

Also, the exchange has the opportunity to create ratings, comparison tools, standardized forms, and other services to allow consumers to easily understand their coverage options when purchasing coverage through the exchange's web portal. Some of them might also be helpful for allowing public program beneficiaries to understand their coverage, so states may want to incorporate these aspects of the exchange's systems into those of their public programs. Similarly, exchanges should encourage private insurers to adopt reforms to how they pay for care that would reward high-quality, lower-cost care. The impact of these reforms will be heightened if similar reforms are also instituted in, and coordinated with, the public programs administered by the state.

Making Health Care Work for Small Businesses

The small businesses who will get coverage through the exchange will see important benefits. For smaller businesses, if one employee gets unexpectedly sick, premiums for the entire business can jump. The exchange can help mitigate this problem; by bringing the small business into a much larger pool, comprised of individuals and other small businesses, changes in the age or health status of a few employees will no longer have as much of an impact on overall costs. And untangling the confusing array of plan options available to small businesses today can be a full time job by itself. By standardizing insurance products within tiers, and creating decision tools to allow for easy apples-to-apples comparisons, the exchange can allow even small businesses without much time or expertise to make choices that are right for them. But to make sure the exchange delivers value for small businesses, the exchange must provide for small business owners and their employees to have a voice in its decisions.

Introduction

In the year since the passage of the federal health reform law, the Patient Protection and Affordable Care Act (or ACA),[1] states across the U.S. have gotten to work implementing the new law's provisions and pursuing their own reforms—and the stakes could not be higher.

Consumers across America know that the health insurance marketplace is broken. Insurers don't compete for their business, instead offering take-it-or-leave-it deals. Important information about coverage is buried in the fine print, making it hard to know what's really covered. Instead of working to lower costs and improve quality, too many insurers focus on covering healthy enrollees and dumping the sick. And costs are continuing their unsustainable rise. Nationally, the great majority of individual-market policyholders—77% —saw a premium increase from early 2009 to early 2010, with an average rate hike of 20%.[2] Small businesses, too, pay 18% more for insurance than their larger competitors and have seen repeated double digit premium increases.[3]

The creation of a new health insurance exchange, authorized by the ACA, offers the states the chance to build a better marketplace for health care. The exchange can help individuals and small businesses by increasing competition and improving choices in the state's insurance market. By providing better options and better information, and negotiating on behalf of its enrollees, the exchange can level the playing field for consumers.

Success is not assured, however, because the exchange is both challenge and opportunity. Very few states currently run anything resembling an exchange, meaning they will very quickly have to develop their expertise. Additionally, the ACA leaves states substantial leeway to define critical aspects of the exchange, including who is eligible to buy coverage through it, how aggressively it will set standards and negotiate with insurers, and who will run it. Some of these choices will allow the state to improve on the law, but others could undermine the exchange's ability to deliver better choices and lower costs.

All told, state policymakers, including those eventually tasked with setting up and

running the exchange, will have to make a large number of critical decisions and implement them efficiently to ensure that the exchange is effective and up and running by 2014, when it will open for business.

Exchange Basics

It's long been true that large businesses get a better deal on health insurance than small businesses, because of the increased bargaining power they bring to the table. The same is true when it comes to individual health insurance, since a single consumer does not have much ability to negotiate. This lack of negotiating power also means there is less competition among insurers on these markets. Finally, costs are higher on the individual market because of the lack of economies of scale: each plan contract must be individually sold and administered.

The ACA's solution to this problem is the exchange, a state-created competitive marketplace where individuals and small businesses can come together into a purchasing pool. If properly designed, the exchange will allow consumers to combine their bargaining power when buying private insurance. Its greater size will also help reduce administrative costs, since insurers will not need to process each individual coverage application.

But the exchange is more than just a purchasing pool. It can help to organize the health insurance marketplace, so that consumers will have more information

Spotlight on Small Business

While many Americans struggle with the rising costs and eroding quality of health care, the plight of small businesses stands out—lacking the advantages possessed by larger businesses, they face unique challenges. Without the bargaining power to negotiate with insurers for better rates, they often get a worse value for their health care dollars. Because smaller businesses often lack a human resources department, they are often left alone to negotiate an often-confusing insurance market. And because in many states insurers can refuse to cover individuals with pre-existing conditions, some would-be entrepreneurs never start up the small business of their dreams, because to do so could mean their family would go without health coverage.

In tandem with other reforms in the new federal health care law, states can design their exchange to help address all of these problems, giving small businesses and their employees access to a meaningful choice of higher-value, more affordable coverage options, and promoting the creation of new small businesses. Not only will this benefit the small businesses themselves, but the lower cost they pay for their coverage can have a significant positive impact on the state's economic health and job creation rates.[4]

Throughout this report, sidebars will highlight some of the benefits the exchange can have for small businesses, as well as focusing on policy issues specific to them.

about the plusses and minuses of different plans. Consumers will be able to use these easy-to-understand comparisons to make better choices, which will make insurers compete on cost and quality. And by negotiating with insurers and setting strong standards for consumer protection and quality improvement, the exchange can lower costs by driving reforms throughout the entire health care system.

To ensure that the exchange is stable, the state must take action to make sure it has a large risk pool of healthy as well as sick enrollees. And because the exchange will be one part of a larger health care landscape that includes other public programs, it will also be important to coordinate eligibility, enrollment, and other interactions. Finally, to succeed, it must be accountable to the public and the consumers it serves, and insulated from special interest influence.

What the ACA says about Exchanges

States have a large amount of flexibility to adapt the exchange to their particular goals and the state's market and policy environment, but the federal law does provide some important guidelines and requirements, including:

Timeline: Federal reform gives states the responsibility to establish exchanges for individuals and small businesses by 2014. If states do not establish an exchange by 2014, the federal government will establish one for them.[5]

Funding: States can apply for federal grants to help set up exchanges. By 2015, however, exchanges must be self-sustaining.[6]

Eligibility: Individuals without group coverage will be able to use the exchange, as will small businesses of up to 100 employees, once the law's full provisions go into effect in 2014. States that currently define a small business as one with 50 or fewer employees may first open the exchange to these smaller businesses and then expand to businesses with up to 100 workers by 2016. Further, states are explicitly authorized to open the exchanges to larger employers starting in 2017. The state may run separate exchanges for individuals and businesses, or combine them.[7]

How consumers connect to the exchange: The federal government will make a template internet portal available to states.[8] States are required to create a website to help consumers compare plans, and operate a toll-free hotline to answer questions.[9]

Helping consumers compare plans and sign up: The law directs the federal government to develop ranking systems on cost and quality, as well as an enrollee satisfaction survey tool, for states to use to help consumers compare plans in the exchange.[10] It also requires states to use a standardized format to present health plan options, enroll applicants eligible for Medicaid or another public program into that program, and offer an electronic calculator to help consumers evaluate their expected premiums after any tax credits or other benefits are factored in.[11]

Benefit package: The federal government will establish an essential health benefits package and levels of coverage, from bronze (the lowest level) to platinum (the highest), and a "catastrophic" plan only available to people under 30 or who are exempt from the requirement to have coverage.[12] States can require additional benefits, but must assume the cost for any subsidies for the additional benefits.[13]

Subsidies: Consumers who make too much to qualify for Medicaid but cannot afford coverage are eligible for sliding scale assistance to pay for premiums. These subsidies are only available on, and will be delivered through, the exchange.[14]

Criteria for health plans: The law directs the federal government to set criteria for an insurance plan to be a "qualified health plan" and allowed into the exchange. Criteria will include having sufficient choice of providers and implementing a quality improvement program. The law delegates the enforcement of the certification of qualified health plans to the state exchange.[15] Aside from some narrow exceptions, states may develop and enforce additional criteria for qualified health plans, to better serve the interests of enrollees. For example, the state can empower the exchange to set additional quality standards, negotiate on costs, and engage in selective contracting. The exchange may also exclude plans with premium increases that are unjustified.[16]

Reinsurance and Risk Adjustment: The law directs states to establish a reinsurance mechanism by 2014, to protect insurers in the individual and small group markets from having to raise rates because too many of their enrollees are sicker than average. For similar reasons, it also provides for risk corridor and risk adjustment programs.[17]

Process: The law requires state exchanges to consult with a range of interests, including health care consumers, small businesses and the self-employed, and requires the exchange to be transparent regarding its costs.[18]

Outside of these fairly limited provisions, states can make their own decisions about what their exchange should look like and who should run it.

The States' Next Steps

Across the country, states are beginning to grapple with their choices. To get an exchange up and running by 2014 will require states to take quick action—and some have already done so by passing exchange legislation. Several states have made key policy decisions and allowed the exchange to begin implementing them. Others have decided to set up the exchange's governance, while leaving the definition of a specific business plan to the exchange board—or simply set up a study, which would be brought back to the legislature for further action next year.[19] While these latter approaches may allow for more informed policy decisions, they may also threaten the state's ability to meet the January 2014 deadline.

There is a last set of states that so far, have chosen to do nothing. Such a decision ill-serves consumers; in the absence of state action, the federal government will be obliged to create an exchange for the state, and a federally run exchange will likely not be as strong as one that is set up within the state, and is accountable to the public and consumers.

If a state wants to provide better coverage options to individuals and small businesses and begin lowering the cost of care, it must take quick action to create a pro-consumer exchange that lives up to the promise of a better marketplace for consumers. This report provides a blueprint for how to do exactly that, addressing key implementation issues with section-by-section recommendations.

I: Accountability and Transparency

The opportunity to create an exchange will allow the state to increase competition and improve choices in its insurance market. However, to fully realize this opportunity, the exchange must be accountable to the public, and the individual and small business consumers who will buy their coverage through it. In creating the exchange's structure and governance, the state must ensure that this important new entity is transparent in its operations, and fundamentally accountable to the public interest. By following the recommendations below, the states can ensure that their health insurance exchange reflects these principles.

A Clear Pro-Consumer Mission

The exchange should be operated for the benefit of individuals, businesses and their employees, not insurance companies and providers. This charge should be included in the exchange's legislative mandate and mission, which could read as follows:

The exchange is established in the public interest, for the benefit of the people and businesses who obtain health insurance coverage for themselves, their families and their employees through the exchange now and in the future. It will empower consumers by giving them the information and tools they need to make sound insurance choices. The exchange works to improve health care quality and population health, control costs, and ensure access to affordable, quality, accountable care across the state.

Ensuring Accountability to the Public, Not the Special Interests

The exchange must have an organizational structure that makes it accountable to the public. That accountability can best be insured by creating the exchange as a strong, independent public agency, with a governing board. Allowing the exchange to be governed by a private non-profit organization runs the danger of making it unaccountable to the public or its representatives. At the same time, the exchange will

need to have some degree of independence from the state's government; it must have the ability to set its operating rules, recommend needed legislation, and negotiate on behalf of enrollees. Otherwise it will not have the agility and power it will need to be an effective advocate for consumers. Housing the exchange in an existing government agency could deny it this needed independence.

The governing body for the exchange should consist of representatives drawn from across the state's consumer and business communities. Persons who are or will become enrollees should be selected for service on the board, as well as organizations that represent them. Policy experts and those with detailed knowledge of insurance markets can also render important service. It may be appropriate for government officials, such as the state's Health and Human Services Secretary, to serve in an *ex officio* capacity, but such *ex officio* members should not be allowed to dominate the exchange board.

The people's elected representatives in the state legislature and statewide elected offices should have the responsibility of selecting members of the exchange board through gubernatorial and/or legislative appointment. But to prevent undue political influence, the removal of members should only be possible in cases of misconduct or malfeasance. Direct election of exchange board members should be avoided, because the impact of special-interest spending could be determinative, privileging industry interests over those of the public in board member selection.

Strong Protections Against Conflicts of Interest

While the exchange will serve many functions, in large measure the most important is its role as a purchaser of insurance. For it to be effective at this task, it must be a zealous advocate for the interests of consumers, which means that it must be free of influence from the insurance industry, brokers, and providers. Consumers need the exchange to deliver high quality, affordable coverage—when it comes to negotiating for a better deal, their interests are at odds with those of the insurers. Because brokers are usually paid by insurers on commission for the policies they sell, they face a similar conflict of interest. So do providers, because pressure on insurers to lower costs might translate to cost pressure on providers. As a result, representatives of these industry interests should not serve on the exchange board.

Spotlight on Small Business

Small business owners, and their employees, should have a voice in the exchange's decisions. They should be consulted in any stakeholder committees or hearings, and representatives of small business should be included on the exchange's governing board, so that they can lend their expertise about what will work for them. Because small business owners and workers will sometimes have different perspectives, both voices should be represented.

Industry stakeholder groups, including insurers, providers, brokers, and others, should have opportunities for meaningful input into the exchange's decisions, especially those touching on technical or workability matters, and should be allowed to share their expertise. When industry representatives serve in an advisory capacity, strong conflict of interest requirements should be in place to ensure that they themselves—and other members of their industry—do not influence decisions that might financially benefit them. An exception to these provisions should, of course, be made for consumers who will financially benefit if the exchange is able to deliver lower costs and higher quality.

Robust Public Participation

Broad public input should be solicited and considered, both in the process of forming the exchange and in its ongoing operation, to ensure that the exchange is meeting the needs of consumers and accomplishing its mission. When setting rules and procedures, the exchange should provide opportunities for public comment, including open hearings and calls for written comments. Stakeholder groups should also be engaged throughout the exchange's decision-making process, including through formal advisory committees.

A similar process should be followed as a state's legislature considers how to create and structure its exchange. Efforts should be made to solicit feedback from consumers, including individual and small business enrollees, and the consumer advocates who represent them. In addition, because in many states the exchange will serve populations with special health, cultural, and language needs, the exchange should take particular care to make sure that their decisions are informed by these perspectives as well.

Transparency of Budgets and Records

The public—and most importantly, enrollees—need to know that the exchange is working efficiently to promote their interests. The legislature and governor will also need to know the details of its operations, to inform their oversight and deliberations about possible further reforms. As result, transparency and public reporting are critical to allowing the exchange to build the trust it needs to do its job.

The exchange's yearly budget and details of its spending and revenue, including any contract agreements it reaches with insurers or outside vendors, should be made available to the public. Transcripts of hearings and other public proceedings should also be public and easily accessible. Transparency should be the rule across the exchange's activities and records. With that said, the exchange will also engage in negotiations with insurers, which will sometimes require some information to be kept confidential in order to protect the exchange's ability to drive a good bargain on behalf of consumers. Materials related to such negotiations should ordinarily not be open to public disclosure, except where the exchange board determines that disclosure would be in the interest of the public and of enrollees.

II: The Power of Negotiation

A well-made state exchange can help deliver lower costs for individuals and small businesses. Just as big businesses negotiate with insurers, using the bargaining power of their employees to push for lower premiums, so too can exchange enrollees benefit from a muscular exchange that negotiates on their behalf for better choices and lower costs.

But to live up to this potential, the exchange will need to do more than simply take all insurers who want to sell their products to its enrollees. It will have to take a close look at the benefits being offered, and the premiums and cost-sharing being charged, to assess whether they provide a good value.

The federal law requires the exchange to offer a health plan only if offering it is "in the interest of [enrollees]."[20] States should flesh out this vague injunction and require the exchange to negotiate with insurers to offer lower cost, higher quality coverage options for consumers. Similarly, the exchange should monitor year over year premium increases to ensure enrollees continue to get a good deal. And because negotiating power and economies of scale depend on having a large pool of enrollees, the exchange should be made as large as possible.

States should have realistic expectations for what the exchange will be able to accomplish. In particular, its marketing leverage will likely vary from state to state, depending on the number of enrollees and the competitiveness of the market. In some states, the potential benefits of negotiation will be obvious, but they may seem more remote in others. Still, after 2014, the state's insurance market will see substantial change, and the exchange will likely grow larger and larger over time. Thus, even if state policymakers believe that the exchange's bargaining power will be initially limited, it should still be created with the power to negotiate so that it can use that power when circumstances change.

A Better Deal for Consumers

A strong exchange is a negotiating exchange. Empowering the exchange in this way will provide consumers and small businesses with an exchange that is not only a transparent and fair marketplace, but also a much-needed advocate standing up for their interests. With insurers competing with each other for access to enrollees, quality will increase and premiums will come down. A negotiating exchange will deliver concrete value for enrollees, with the potential to save consumers millions of dollars.

Some policymakers, as well as the insurance industry, have argued that the exchange should not negotiate for a better deal. Instead, they argue, plans should be allowed to set rates however they like, and be excluded from the exchange only for flagrant misconduct. This "all willing sellers" model, however, while potentially increasing the number of choices consumers have, would also lead to higher premiums. A negotiating exchange, on the other hand, will need to consider both the affordability of premiums and the number of insurance options available to consumers, so it will be able to balance these concerns effectively.

A further reason to insist on a negotiating exchange is to safeguard taxpayer dollars. The new health reform law provides federal tax credits for Americans whose income could make it difficult to afford health insurance. These tax credits will be delivered through the exchange, and their cost will be pegged to prices on the exchange. As a result, an exchange that successfully negotiates for lower premiums will not only deliver savings to enrollees, but also create savings for all taxpayers.

Spotlight on Small Business

The experience of small businesses illustrates the importance of a negotiating exchange. While large businesses are currently able to leverage the bargaining power of a sizable number of employees, their smaller cousins find that they have little ability to negotiate. With less expertise and fewer potential customers, small businesses often face a market where insurers don't need to compete for their business.

At the same time, small businesses lack the economies of scale enjoyed by large businesses—when they buy coverage, it may only be for a dozen employees. As a result, the administrative cost of securing coverage is proportionately higher for small businesses. Added together, these two factors mean that small businesses pay on average 18% more than large businesses do for comparable coverage.[22]

To solve these problems through a strong exchange, the state must ensure that it is empowered to negotiate on behalf of its enrollees, and take advantage of economies of scale. To best leverage these benefits, states should strive to maximize the number of exchange enrollees. As discussed in the main text, states have the option of immediately allowing small businesses with up to 100 employees onto the exchange and eventually opening it to large employers as well. More enrollees mean greater economies of scale, and greater bargaining power.

The experience of Massachusetts confirms the importance of this feature of an exchange. Through its competitive bidding process, the state's exchange has kept the growth of premiums below 5%, which is half of the level experienced by all commercial health plans in Massachusetts. Because Massachusetts subsidizes the purchase of insurance through its exchange for low income residents, these steps are expected to save the state $21 million in 2011.[21]

To give the exchange authority to negotiate, it must have the power to exclude low-value plans. The ability to say "no" is a prerequisite for any successful negotiation, and if the exchange is to deliver the maximum value for consumers and businesses, the state must explicitly give it the authority to exclude plans that fail to deliver robust consumer protections, quality care, and reasonable costs.

Stopping Excessive Premium Hikes

The exchange also has an important role to play in policing unreasonable rate increases. By pushing back against insurers with a history of significant rate hikes, the exchange can use its negotiating power to make premium increases more predictable and stable for consumers.

In many states, regulators review insurers' proposed rate increases to ensure that they are justified. The new law sets up a similar procedure at the federal level for states that do not currently review rates. In determining whether a premium increase is justified, regulators weigh some considerations that are similar to those the exchange should use in its negotiations, including whether the benefits offered are reasonable given the premium being charged. However, rate review also looks to broader issues, including the impact of the rate increase on insurers' solvency and ability to pay future claims.

Because the exchange, unlike a regulator, is concerned first and foremost with the interests of consumers, rate review is no substitute for an exchange with the power to negotiate. But states should take steps to harmonize the exchange's negotiations with their regulatory rate review processes, increasing the exchange's effectiveness and efficiency.

First, the exchange should have the power to act on information from federal and state regulators, and exclude plans with a track record of unreasonable premium increases and no clear plan for bringing them under control. It should also take this information into account as it negotiates with plans. Second, the exchange should participate in the review of products sold in the exchange by providing comments on the reasonableness of the increase and its likely impact on consumers. The same standards should apply to insurance plans whether they are offered on or off the exchange, but the expertise of the exchange should be brought to bear on the plans sold in its marketplace.

Expanding Bargaining Power

The bigger the exchange, the greater its negotiating power. As more people get their coverage through the exchange, it will gain leverage with insurers eager for the business of those enrollees. And the larger it is, the greater its ability to achieve economies of scale to reduce administrative costs. As a result, a large exchange is a strong exchange.

Per the federal law, individuals without group coverage will be able to use the exchange, as will small businesses of up to 100 employees, once the law's full provisions go into effect in 2014. The law allows states that currently define a small business as one with 50 or fewer employees to first open the exchange to these smaller businesses and then expand to businesses with up to 100 workers by 2016. Further, states are explicitly authorized to open the exchanges to larger employers starting in 2017.

Because the potential savings for consumers increase with the size of the exchange, the state should aim to maximize both eligibility and enrollment. The state should create a single, state-wide exchange, rather than splinter off its residents into separate regional exchanges depending on where they live, and it should operate a single exchange serving both individuals and small businesses.

It should also plan to open the exchange to employees of large businesses as soon as possible. However, expanding eligibility could create a risk of adverse selection and drive up premiums, for example if large employers with an older workforce flocked to the exchange, while those with younger, healthier workers stayed away (adverse selection is discussed in more detail in Section IV, below). The exchange should be charged with reporting to the legislature its recommendations on how to minimize these risks, so that it can adopt appropriate safeguards as it brings larger businesses onto the exchange.

In addition to opening eligibility to as many people as possible, the exchange should actively reach out to enroll people, because it will need to turn potential enrollees into actual ones, in order to increase its bargaining power.

The Basic Health Program Option

Under the new law, states have the option of creating a Basic Health Program. Under this arrangement, which is similar to existing Medicaid managed care plans, the state offers residents between 133% and 200% of the Federal Poverty Level access to a set of private plans, instead of offering them coverage through the exchange. The state negotiates with the insurers to secure the best possible rates for these enrollees, potentially reducing their cost sharing and providing coverage at a lower cost. States that choose this option may dedicate the federal dollars that this population would have received as tax credits in the exchanges to funding the program.

While this option may be attractive for many states, policymakers must be careful to consider the implications for the exchange if this population gets their coverage through a Basic Health Program instead. Because they would otherwise receive substantial subsidies, these are the potential enrollees most likely to purchase coverage through the exchange—without them, the exchange's bargaining power may be noticeably reduced.

III: Promoting Innovations in Cost and Quality

A health care exchange that pools its enrollees' bargaining power will help give consumers a better deal on their coverage, but it will need to do more to get the unsustainable rise in health care costs under control. That is because while consumers and businesses pay plenty in premiums and out-of-pocket costs, much of our health care spending does not yield the results that we really want—healthier people. Instead, as much as a third of all health care spending goes to treatments that at best are ineffective, and at worst can pose a danger to patient health.[23]

The payment systems used by major insurers, both public and private, are one root of this problem. The widely used fee-for-service payment approach rewards providers for the number and complexity of tests and procedures that can be billed, not the quality of care provided or whether the patient gets healthy.

Fortunately, research and the experience of innovative providers across the country have charted a path toward medical care which can better rein in costs and improve patient's health. Primary care physicians need to be able to work as a part of a team coordinating with a patient's other health professionals so that patients get all the care they need while avoiding unnecessary, duplicative, or harmful tests and procedures. And providers need easy access to updated medical records.

But providers will never achieve these wholesale changes in the delivery of care until payers change the way they pay for care. Insurers will need to move towards paying for quality and results, not volume. And the exchange, in its negotiations with insurers, can drive them to adopt these proven strategies, which will improve enrollees' health and lower overall health care costs.

Strategies to Achieve System Change

Medical Homes: This approach improves the quality of care and brings down costs by encouraging primary care physicians to work closely as a team with other specialists

and health professionals. A team of professionals, led by a doctor or nurse practitioner, is compensated for coordinating all of a patient's care, not just for the number of visits they have or tests they order. That team would have the time and resources needed to deliver the best care. By using electronic medical records, they would also help reduce medical errors and unnecessarily duplicative tests that can happen when one of a patient's doctors is unaware of what the others are doing. The burden of keeping track of tests, prescriptions and treatments will no longer fall solely on a sick patient. A nationwide system of medical homes could improve patient care and save up to $194 billion over ten years.[24]

Chronic Disease Management: Chronic disease management is a systematic approach that focuses on promoting a combination of behavior changes and clinical treatments to prevent chronic conditions from causing expensive health emergencies. For example, programs serving diabetes patients can closely monitor diet and other health indicators, to help the patient live a stable life rather than having to be rushed to the hospital for costly emergency surgery. While studies continue to evaluate these programs, research suggests that properly designed disease management programs can successfully reduce costs. Investments in chronic care management could lower costs by up to $418 billion over the next decade.[25]

Accountable Care Organizations: Best exemplified by high quality, low-cost providers like the Mayo Clinic, Intermountain Health in Utah, or Geisinger Health in Pennsylvania, Accountable Care Organizations (ACOs) integrate the care patients receive across the medical system. Rather than hospitals, physicians and other providers each being paid separately for individual treatments, under this model all three entities are all part of a single system which shares the payment for the patient's entire course of treatment and is accountable for the health and outcomes of the patient. In many cases, this allows doctors to be paid by salary, rather than through piecework fee-for-service rates, and creates additional rewards for improving patient health and reducing unnecessary costs.

Bundled Payments: This innovation replaces itemized fee-for-service payments with a single, bundled payment for all treatments, tests, and procedures a patient receives for a given condition. Hospitals, physicians, and other providers who have treated a patient are together reimbursed by a set amount for every patient admitted with a particular diagnosis (which can be adjusted upwards if the patient is especially high-risk and likely to require more extensive treatments). The providers share the payment, so that they are rewarded for delivering high-quality, effective care that ensures the patient will not be quickly readmitted for the same complaint. Properly structured bundled payments can generate enormous savings of up to $182 billion over ten years.[26]

The Path to Lower Costs and Higher Quality

These innovative approaches to delivery system reform can result in improved patient care and lower costs. In Medicare, the Affordable Care Act phases in these reforms over the next several years.[27] But if these changes are to extend beyond that single program, so that all consumers can receive their benefit, state policymakers should use their exchanges to drive insurers to adopt these reforms.

As discussed in Section II, above, states must act to ensure that the exchange have

the authority to negotiate with plans and set high standards that insurers will need to meet in order to participate in the exchange. While these tools can simply serve as a device to bargain down premium costs over the short term, the possibilities are much broader. Exchanges can also use that authority to accelerate system change that will bring down costs over the medium- to long-term.

The exchange should have a variety of mechanisms at its disposal in accomplishing these goals. If the exchange requires plans to submit competitive bids to participate, the extent and quality of cost-saving reforms should be a required element of every insurer's bid. For example, insurers participating in the exchange could be required to pay providers via bundled payments where appropriate, or reimburse primary care doctors for leading a medical home team.

In the same way that exchanges can negotiate lower premiums as a condition of entry onto the exchange, the exchange should use its bargaining power to push plans to aggressively implement these reforms. Indeed, if the exchange sets strong standards, it can help insurers who are already pursuing similar initiatives, by giving them more leverage with providers who might resist such reforms.

To give any real advantage to the exchange in these negotiations and help bring all health plans up to the level of the highest-performing ones, the exchange must have the ability to say no and to exclude those plans that refuse to take steps to lower costs and improve quality for consumers. It is for this reason that the "all-willing sellers" model for the exchange, often advocated by insurers and other industry interests, is simply inadequate. If a state exchange must accept all comers, it has given up the advantage it needs to insist that plans adopt these critically important system reforms.

Translating Policy into Results

The exchange's efforts cannot stop once plans have agreed to incorporate these reforms. The exchange must demand strong performance from insurers, and evaluate whether these new policies are accomplishing their goals.

State exchanges should have the authority and resources to monitor plans' compliance with their commitments. Insurers should be required to disclose information on the impact of the reforms they have adopted on quality of care and coverage, cost, outcomes, adherence to best practices and other appropriate information, to allow the exchange to evaluate the effectiveness of their programs. And the exchange should consider this information when considering the plans' participation in the exchange in the future.

Empowering the Consumer

The last ingredient needed for an exchange that delivers lower costs and higher quality is a strong role for the individual consumer. The Affordable Care Act requires exchanges to provide a website where consumers can compare and shop for the plan that is right for them, and requires that it provide some level of price and quality information. But states should go further.

Exchanges should provide easily understandable information about what delivery reforms like medical homes, accountable care organizations, and chronic disease

management mean and how consumers can best make use of them. States should also consider providing a special "seal of approval" that would be visible on the exchange website for those plans that do the best job of promoting high-quality and low-cost care. Policymakers should insist that more detailed metrics evaluating the quality of care and coverage, outcomes, adherence to best practices and other appropriate information be available to consumers through the exchange website. Finally, consumers should be able to access this information easily and understandably as they choose their coverage.

Towards a Coordinated Strategy on Costs and Quality

The exchange will not be the only active purchaser of medical care in the state. Other payers, such as large employers, public employee plans, the state Medicaid plan and union trusts, will likely also be developing their own initiatives to reform how they pay for care. By working together and aligning these programs, states can drive positive change in the health care market even more effectively, so that providers are not subjected to a variety of uncoordinated reform initiatives. Exchanges can play a strong leadership role in convening these multi-payer initiatives and making them effective. States should consider building into their exchange mechanisms allowing it to coordinate with other large purchasers to drive positive change in the marketplace.

IV: Ensuring Stability

The idea of creating health insurance purchasing pools, like those called for in the Affordable Care Act, is not a new one. In the past, many states have experimented with creating such pools, and their experience has shown that mechanisms like the exchange can succeed at improving choice and holding down costs. But experience has also shown that success is not automatic. In some states, the pools have been failures, forced to close their doors by upwardly-spiraling premiums and downwardly-spiraling enrollment.[28] In designing their exchange, states must take care to avoid past mistakes and create a stable marketplace for individuals and small businesses.

The past failures can often be traced to a single dynamic. Sicker enrollees congregated within the purchasing pools, with healthier enrollees remaining outside. Because sicker enrollees cost more to insure, this drives up premiums, leading more healthy people to drop coverage and secure less expensive coverage on their own, which in turn sends premiums within the pool up again. This phenomenon, called adverse selection, can lead to a vicious cycle that only ends with the destruction of the purchasing pool.

If a state decides to allow insurers to sell their products to individuals and small groups without going through the exchange, as most appear to be planning, the fundamental challenge is to ensure that the exchange does not become a dumping-ground for less-healthy patients, with healthier enrollees purchasing coverage outside of it. This is critical both to protect consumers and to instill confidence in insurers—if they are worried that adverse selection might undermine the exchange, they will be significantly less likely to participate.

Fortunately, the ACA guards against the worst risks of adverse selection by preventing insurers both on and off the exchange from directly discriminating against the sick, and it also contains specific provisions aimed at balancing risk on and off the exchange. But to complement these ACA policies, states should adopt additional measures to ensure that adverse selection does not undermine the viability of their insurance market.

Baseline Protections in the ACA

The Affordable Care Act contains important provisions to avoid adverse selection on state exchanges. Per the federal law, enrollees who purchase a product that is sold both inside and outside the exchange must be in the same risk pool, and insurers must charge the same premium in both cases. The same minimum benefit standards will apply across the entire insurance market as well, limiting insurers' ability to scoop up the healthy by offering low-cost, low-benefit plans. Tax credits will be available to some consumers who purchase coverage on the exchange, making it an attractive option for both sick and healthy. Most importantly, whether an insurer is doing business on the exchange or off, they may not deny coverage to people based on pre-existing conditions, and the ACA's rating rules, which allow insurers to vary premiums based only on age, geography and tobacco use, must apply identically inside and outside the exchange.

Further, all insurers will participate in a series of programs aimed at reducing the impact of differences in enrollee health. These programs (variously labeled reinsurance, risk adjustment, and risk corridors) mean that insurers who cover more sick people face less of a financial disadvantage than they otherwise would. The programs will apply both on and off the exchange, but by increasing the overall stability of insurers' risk pools, they will help reduce the incentive for insurers to segregate healthy enrollees off the exchange.

However, these protections, as important as they are, will not by themselves fully prevent the risk of adverse selection. For example, while healthy and sick enrollees must be charged identical premiums, the same is not true for young and old enrollees—the ACA imposes some limits, but insurers can still set lower premiums for the young, who tend to be more profitable. As a result, insurers will still have the ability to structure and market their plans to attract younger, less expensive enrollees to their non-exchange offerings.

Further, risk adjustment programs will likely be most effective in equalizing risk across insurers within the exchange—reducing the impact of health differentials across the state's entire health care market will be more challenging. As a result, many insurers may push to keep their non-exchange risk pool as healthy as possible.

States should compensate by incorporating the ACA's protections into their own law. For example, states can create their own supplemental reinsurance programs if the federal one proves insufficient. Further, to the greatest possible extent, states should make sure that identical rating rules apply to their entire insurance market, both on and off the exchange—not only will this help protect against adverse selection, it will also minimize disruption for consumers who move in and out of the exchange. The remainder of this section outlines additional steps states should take to guard against adverse selection.

Eliminating Steering

One way that less-healthy people can wind up in the exchange is if insurers or brokers put them there. While the Affordable Care Act limits the ability of insurers to make greater profits from the healthy than the sick, as discussed above many insurers might still wish to keep their non-exchange risk-pool as healthy as possible.

To guard against this possibility, states should protect the exchange by prohibiting

insurers or brokers from steering people either onto or off of the exchange, through setting different broker commissions, adopting targeted marketing strategies, or by any other method. This prohibition should be policed via the state insurance regulator, as well as the licensing authority for brokers.

Products Available On and Off the Exchange

If certain kinds of products are primarily available either on the exchange or, conversely, off of it, consumers who want those kinds of products will be drawn to that marketplace. That means that if products that appeal most to healthy consumers are primarily available outside the exchange, or if products that sicker consumers will want to buy are primarily available on the exchange, this could create a risk of adverse selection.

A state can reduce this risk by requiring insurers to offer "mirror" versions of all their products, such that they sell identical exchange and non-exchange versions. That way, consumers will have access to a broad array of benefit choices in both marketplaces, preventing the restriction of options that can lead to adverse selection. Additionally, since, as discussed above, the federal law requires that identical products use the same risk pool and charge the same premium both inside and outside the exchange, this would greatly reduce the risk of undermining the exchange.

If that approach is not possible, states could ensure that at least some products are available both inside and outside the exchange. The federal law already requires that exchange-participating insurers offer both at least one silver and one gold product inside of the exchange, so one place to start would be requiring insurers to offer those products outside the exchange as well.

Spotlight on Small Business

The problems posed by a pool of enrollees that doesn't spread risk aren't confined just to the exchange—many small businesses have experienced these issues as well. In most states, insurers currently set their prices based on the average age or health of a small business' employees. This means that businesses with healthier or younger workforces pay lower premiums, while those with older or sicker employees pay more. It also means that for smaller businesses, if one employee gets unexpectedly sick or ages into a new bracket, premiums for the entire business can jump. With the cost of health care already prone to double-digit rises, these unexpected rate shocks make it hard for small businesses to maintain stable coverage.

The exchange and related reforms can help mitigate this problem in two ways. First, by bringing the small business into a much larger pool, comprised of individuals and other small businesses, changes in the age or health status of a few employees will no longer have as much of a proportional impact on overall costs. Further, because the new reform law will prevent insurers from varying their prices based on the health of enrollees starting in 2014, and limit variation based on age, the risk of premium spikes will be much reduced.

States could go further and require insurers to offer more than one product at those silver and gold levels, or they may insist that plans also offer a product at the highest-benefit platinum tier. Further, states could require insurers who offer catastrophic coverage plans outside the exchange to offer identical plans on the exchange as well—since enrollees of these plans are most likely to be young and healthy, they pose the greatest adverse selection risks.

In developing the precise requirements, the state should closely examine the products currently being offered on its health insurance market, with a goal of ensuring that consumers both on and off the exchange have a robust set of choices between products with varying degrees of comprehensiveness.

Increasing Exchange Eligibility and Enrollment

The risk of adverse selection is closely tied to the total number of the exchange's enrollees—if the exchange is large, it will take a much greater imbalance in enrollees' health status to create an adverse selection problem. Put simply, a larger exchange has a greater "buffer" to protect against adverse selection. This means that outreach and enrollment efforts will themselves help the exchange's stability. Further, increased outreach may be needed to reach healthier consumers, since in many cases those with health problems are most alert and receptive to new information about coverage options.

There are, of course, many other benefits to having a large exchange—it increases the negotiating power of the exchange, as discussed above, and also helps more of a state's residents enjoy the benefits of the exchange. The fact that this approach also helps to better guard the exchange against adverse selection means that the state has a further reason to widen the eligibility rules for the exchange (for example, by including larger businesses, so long as the state is careful to open eligibility in a way that does not itself pose an adverse selection risk), and put a strong effort into outreach and enrollment programs.

The Basic Health Program Option

As discussed earlier in this report, the Basic Health Program provides an alternate way that states can choose to cover those between 133% and 200% of the Federal Poverty Limit. Taking these potential enrollees out the exchange's risk pool could potentially make it more difficult to ensure that the exchange is stable. One cause of this is the simple fact that the Basic Health Program will reduce the raw number of exchange enrollees. However, it is also the case that these consumers are likely to be among the healthiest of exchange's enrollees, because they receive the most generous subsidies, meaning that both healthy and sick will be likely to purchase coverage. To protect against the potential danger of adverse selection, state policymakers may wish to create reinsurance and risk adjustment mechanisms that link the respective risk pools of the Basic Health Program and the exchange.

Feedback and Monitoring

In addition to adopting the above policies, the state should closely monitor changes in the insurance market once the exchange is up and running, for imbalances in risk, premium spikes, or changes in the types of products available on and off the exchange. This task could be taken on by the exchange itself, the state insurance department, or some other entity. Regardless, whoever studies the market's stability should regularly make recommendations to the state on any action that is needed to maintain the viability of the exchange, and the appropriate body—whether the legislature, an agency, or the exchange itself—should take swift action to protect consumers by mitigating the problem.

V: Designing a Consumer-Friendly Exchange

Even if the state ensures that its exchange is fair and effective, if it is not easy to use and trusted by consumers, eligible enrollees won't materialize. And if consumers lack the ability to understand their options and make informed decisions, the power of the exchange to drive competition and quality will be undermined.

The exchange is a store where consumers can buy health insurance products—and anyone who's worked retail knows that the consumer experience is critical. For all the attention that must be paid to getting the behind-the-scenes aspects of the exchange to work, the front end is just as important. When a consumer goes to the exchange to buy coverage, will it be a simple, easy process, or will they get frustrated by needless red tape? Will they be able to entrust their personal financial information to the exchange? Will the exchange help them pick coverage that's right for their family? The answers to these questions cannot be taken for granted.

Simple, Streamlined, and Accessible

Many consumers will buy their coverage through the exchange's web portal. States have significant leeway to design that portal, but they must take care to ensure that it is as simple and consumer-friendly as possible. One necessary step will be to clearly label consumers' options, so that they can easily understand what they need to do to sign up for coverage. Another will be to ensure that the portal can analyze the information provided by the consumer and tailor the options it presents accordingly—for example, catastrophic plans should not be presented to those who are not eligible for them.

The exchange must be accessible to all potential enrollees, including those who lack broadband-speed internet connections. For some, the web portal will be the best way for them to buy coverage, but others will need different, equally clear pathways to enrollment, such as the toll-free hotline required by the ACA, or the Navigator program, which will allow the exchange to provide in-person community outreach.

The same amount of care, streamlining and simplification that go into the website should go into the materials and process used by the other access points—hotlines and Navigators. To the greatest possible extent, all three access points should use application processes and materials that are identical, so that consumers who sign up for coverage over the phone can then easily renew online, for example.

However consumers access the exchange, the information it provides must be designed with an eye towards the needs of those who will ultimately be using it. This means ensuring that the language used is straightforward and descriptive, avoiding jargon as much as possible. The state should audit the Flesch Reading Ease and Flesch-Kincaid scores of the various materials and web content being used, to ensure that they are comprehensible to ordinary enrollees—this is especially important because many exchange enrollees will be buying coverage for the first time, making them even less familiar with health coverage terms of art than the ordinary layperson.

Similarly, the state must assess the diverse language and cultural needs of potential enrollees and lay out a plan to meet them—simply offering a Spanish version of the web portal, for example, is a good start but will likely not be enough to guarantee that all consumers are able to use the exchange effectively. A good rule of thumb is that all materials should be translated into any language spoken by at least 5% of potential enrollees, and provision should be made for enrollees speaking other languages that fall below this threshold.

Getting all of these usability details right won't be easy. In addition to setting a strong plan, the exchange must also engage in testing and run focus groups, to make sure that consumers can easily navigate its various systems. Engaging a broad range of stakeholders in this testing process—including communities with specific language, cultural, and health needs—will help ensure that the exchange has a smooth start-up in 2014.

Empowering Consumer Choice

A well-designed exchange holds the promise of harnessing consumer choice to make the insurance marketplace more competitive. However, if consumers don't understand their options and aren't easily able to determine what coverage is right for them, this promise will be substantially weakened—and unfortunately, this is exactly what consumers currently face on the insurance market. To get past this confusing status quo and provide a consumer-friendly shopping experience, the exchange must do five things:

First, it must help consumers make apples to apples comparisons of plans. The five standardized tiers set out by the ACA will help with this, as consumers will be able to compare products that have roughly similar levels of coverage, but that will not be the extent of a state's power to improve the consumer experience. The exchange should also consider further standardizing its offerings, to reduce unnecessary variation and allow for better comparison-shopping. Finally, the exchange should make it easy for a consumer to compare the important aspects of two different coverage options at a glance, so they can focus in on important differences as they narrow down the list of options.

Second, the exchange should make it easy to find products that meet a consumer's

needs. The consumer should be able to prioritize different criteria, such as whether they care more about price, specific categories of benefits, location and breadth of provider networks, customer service, quality of care, history of premium increases, and so on—and then run a customized search to find plans that meet those particular needs.

Third, the exchange should develop ratings and rankings to allow consumers to understand the strengths and weaknesses of their coverage options. These could include one to five star ratings for particular aspects of coverage, such as those discussed above, as well as a "seal of approval" for high-performing plans. These ratings should be incorporated into the comparison and search tools discussed above.

Fourth, one of the most important pieces of information a consumer must have when choosing their coverage is whether their current doctor or other provider is included in the insurer's network. There should be easy-to-use search tools integrated into the exchange web portal to allow consumers to know whether changing their coverage will also mean changing their doctor.

Fifth, the exchange must clearly explain the cost of each product, beyond just the monthly premium. Products with high deductibles and coinsurance may lead to consumers paying significant amounts through cost-sharing, and those impacts could be less visible. As a result, the exchange should list, in addition to the monthly premium, the expected yearly cost-sharing under the

Spotlight on Small Business

Currently, small businesses wishing to purchase coverage for their employees face a dizzying array of choices, with insurers offering benefit packages that appear only slightly different from each other, but whose surface similarities can mask substantial variation in covered benefits. Untangling these subtleties, and determining which plans are a good fit for the particular health needs of a business' employees, can be a full time job by itself. But most small businesses can't afford a dedicated health benefits manager to perform these tasks.

The steps outlined in the main text will make this task much easier for small business owners. Further, a small business will be able to allow its employees to choose whatever plan they like, rather than the current system, where the business is often forced to rely on a one-size-fits-all approach. And because the exchange will employ Navigators to perform outreach and help enrollees understand their choices, small businesses will have built-in support and advice.

It will be important that the exchange offer a single application for employees to use, regardless of what plan they choose; that it allow the business to make a single premium payment, without forcing it to engage in complicated allocations; and for businesses that qualify for the ACA's new small business tax credits, they should be able to easily see how those credits will reduce the premiums they will pay.

product for a patient with low, average, and high health needs, to allow for a more informed evaluation of consumer options. Similarly, because some exchange enrollees will receive tax credits to offset the cost of their premiums, a calculator including these savings should be incorporated into the buying process, so that consumers will know what they will actually have to pay. Only by detailing all these aspects of the plan can consumers get an accurate picture of their costs, and choose the plan that is right for their budget and health needs.

Privacy Protections

The exchange will have access to sensitive consumer information, including financial and medical information. If consumers are not confident that the exchange will keep their personal data safe, they will be hesitant to enter the exchange or give it the information needed to make accurate eligibility and enrollment decisions. Building consumer confidence in the privacy and security of their personal information therefore must be a priority for the exchange.

The exchange must develop and implement a plan to ensure that identifiable personal information is not shared, internally or externally, with those who do not have an immediate, legitimate need for it, for example in order to make eligibility determinations or process payments. Under no circumstances should the exchange sell personal data, or share it with others for commercial use. Consumers should be able to easily access all of the data the exchange has about them, and make corrections to erroneous information. Protections must be adopted to prevent data breaches or unauthorized access. And in the event that such breaches do occur, the exchange must speedily inform consumers and take strong action to minimize the harm.

The exchange should clearly disclose these protections, so that consumers know that the exchange takes its responsibility to their personal data seriously. Similarly, in order to build trust, whenever the exchange asks for personal information, it should make clear exactly why that information is needed.

Consumer Assistance

Even the best designed exchange will not function perfectly in all cases. Individual consumers will need help in determining their eligibility and picking coverage. They also should have a place to register complaints and suggestions. Consumer assistance programs should be developed in tandem with outreach and Navigator programs, with coordination to ensure that they are all consumer-friendly and give the same information. Language access and cultural competency will be a critical component of successful programs.

Some states already have a state insurance ombudsperson or insurance consumer protection section within an agency, or may partner with separate nonprofit groups to serve this function. The ACA provides funding and technical assistance to such programs, and states may want to use these funds to integrate these existing programs into the exchange as it is developed.

Feedback from these avenues of consumer assistance should be gathered, analyzed, and fed back to the exchange's policymakers, so operations can be analyzed and improved to eliminate common problems. Consumer satisfaction is the ultimate test of the exchange's success; their experiences will be the best barometer for determining what needs to be done to meet the goal of providing affordable, quality, accessible coverage.

VI: Coordinating with Public Programs

While the exchange represents a significant new opportunity to improve the quality and affordability of health insurance, it is only one piece of the state's larger health care landscape. Public programs, including Medicaid and the Children's Health Insurance Program (CHIP), will continue to play a significant role, and the way they interact with the exchange will be important to the success of both.

Medicaid, in particular, will see its eligibility significantly increased in 2014, the same year the state exchange will open its doors. Many of those who apply for Medicaid will not be eligible for that program, but could qualify for tax credits to buy coverage on the exchange—and vice versa, as some of those who enter the exchange might also be eligible for a public program. Further, over time consumers might move from one to the other as their income fluctuates. States that carefully address these eligibility, enrollment, and transition challenges will save money due to increased efficiency, and consumers will have an easier experience getting their coverage. Those that do not will run the risk of burying the promise of health reform in confusion and red tape.

Beyond these coverage issues, the state can also take action to integrate its public programs with the exchange to achieve greater effectiveness. Some of the consumer tools that the exchange will develop could be used in public programs as well to improve the consumer experience, and aligning the quality-improving, cost-lowering policies pursued by the exchange and public programs will similarly increase the effectiveness of both.

Eligibility and Enrollment

One of the most important functions that the exchange will serve is to help qualifying consumers get access to affordability tax credits to help them pay for their coverage. However, some of those who try to buy coverage through the exchange will inevitably be eligible instead for a public program, such as Medicaid or CHIP. Then, when families actually apply, the

picture could be even more complex, as different family members might be eligible for different sources of coverage.

In order to meet these challenges, the exchange must make it simple for consumers to enroll in the program that is appropriate for them. This means it must coordinate its eligibility systems with those of the state's public programs, to catch whether an applicant for coverage is eligible for one of them instead. If so, the exchange should forward the application to the relevant agency, which can then process the paperwork and enroll the applicant, without requiring the applicant to submit duplicate forms or visit another office.

Similarly, states should make sure that if a consumer applies for a public program such as Medicaid, but does not qualify, he or she is immediately connected to the exchange. Whatever door a consumer enters through, they should quickly and easily receive the appropriate coverage, and to the extent possible, the state should employ a single eligibility and enrollment system.

At every step, as the state develops its eligibility and enrollment system, it must strive to create a simplified, streamlined process that avoids red tape and efficiently gathers the information it needs, both from applicants and from existing data sources—for example, a state could allow applicants to enter their social security numbers to allow the application system to access their age, income information contained in their tax returns, participation in other public programs, or other needed information.

Creating this streamlined no-wrong-door enrollment system will be important to ensuring that consumers are able to easily sign up for coverage. Not only will this benefit those consumers, it will also be important for ensuring that the exchange has a stable risk pool—the larger the number of enrollees, the more stable the exchange will be, and the applicants most likely to be turned off by a complex application process will be those who are healthy and least in need of coverage. Further, states will need to both create new eligibility and enrollment systems for the exchange, and update their existing Medicaid systems to account for new eligibility changes in the federal reform law. They should take the opportunity to integrate these systems, rather than creating two parallel but separate systems.

Transitions and Renewals

Year after year, exchange enrollees will need to renew their coverage. If their income increases and they no longer are eligible for subsidies, they likely will continue to purchase coverage through the exchange—but if their income decreases, they will become eligible for Medicaid rather than subsidized exchange coverage, and if they go to work for an employer that offers job-based coverage, they will likely exit the exchange. Similarly, Medicaid enrollees whose incomes increase will become newly eligible for coverage through the exchange. And those who turn 65 will become eligible for Medicare. Managing these transitions will be critical to ensuring that the state's exchange remains stable over time.

Ideally, the state's system will obtain updated information from enrollees in both public programs and the exchange each year (either directly from enrollees, or via tax returns or other data sources). Based on this information, if the enrollee's eligibility has not changed, their coverage should be automatically renewed after giving the enrollee a chance to opt out. If the

enrollee instead becomes newly eligible for some other source of coverage, the exchange should present the enrollee with their new choices—however, even if the enrollee does not specifically take action, the exchange or Medicaid should automatically enroll them.

Only if the enrollee specifically opts out of coverage should they exit the system—otherwise consumers may fall through the cracks, leaving them without coverage and potentially in violation of the federal law's individual coverage requirement. Differences in the timing of eligibility determinations and the commencement of coverage mean that the state must pay careful attention to realize this goal of seamless coverage and renewal.

Navigators and Outreach

Experience with existing public programs has clearly shown that simply giving consumers new coverage options is not enough to guarantee that they will exercise them—if members of the public do not understand how they can access those options, they will not take advantage of them. As discussed above, broad enrollment will not only help the beneficiaries affected, but also increase the stability of the exchange's risk pool, giving the state another reason to prioritize enrolling eligible consumers in the exchange.

Simply posting information on a state website and running a few public service announcements will not be enough to drive the necessary enrollment. Specific outreach efforts will be needed. However, it will be difficult for the state to reliably target those who will be eligible for coverage through the exchange without also targeting those who will be eligible for coverage through an expanded Medicaid program or some other public program. In order to maximize its investment in outreach, then, the state should ensure that its efforts inform members of the public about the exchange as well as about other public programs.

One particular area where states should take into account the role of public programs is in deciding how to run its Navigator program, through which the exchange will contract with individuals and organizations to reach out to particular communities to provide information and help

The Basic Health Program Option

States that opt to create a Basic Health Program will have to make an additional effort to coordinate its enrollment with both Medicaid and the exchange. Enrollees below 133% of the Federal Poverty Limit would be in Medicaid, those between 133% and 200% would enroll in the Basic Health Program, with those above 200% purchasing coverage from the exchange; thus, most enrollees would either move from Medicaid to the Basic Health Program, or vice versa, or from the Basic Health Program to the exchange, or vice versa. However, there will certainly be cases where enrollees "skip" the Basic Health Program, due to large swings in their income. States must make sure that all three systems are prepared for all the possible transitions. Similarly, Navigators should be educated and provide information about the Basic Health Program in states where the option exists.

eligible consumers enroll in the exchange. In many states, insurance brokers or agents have pushed to be the primary or even the sole providers of Navigator services. But while many brokers possess significant expertise about private coverage, and have deep relationships with some small businesses, in many states they may not have the required knowledge about public programs, or the language or cultural skills needed to perform effective outreach to underserved communities.

As a result, in designing their outreach efforts, states should make sure that they have all their bases covered—in some communities, brokers can be an effective information source, but a strong Navigator program should also include a wider array of organizations, particularly those with longstanding ties to underserved communities and constituencies.

Leveraging Consumer Tools and Aligning Incentives for Quality and Lower Costs

As discussed above, the exchange has the opportunity to create ratings, comparison tools, standardized forms, and other services to allow consumers to easily understand their coverage options when purchasing coverage through the exchange's web portal. While most of these tools will be developed with an eye towards private individual and small group private coverage, some of them might also be helpful for allowing public program beneficiaries to understand their coverage. This will especially be the case in states that have a significant number of Medicaid managed care plans, since in those states, enrollees will similarly have to assess which of their options is the best choice for them. As a result, states may want to incorporate these aspects of the exchange's systems into those of their public programs, as well as pursuing the enrollment and eligibility integration discussed above.

Finally, as discussed above, one of the key policy innovations exchanges should pursue is encouraging private insurers to adopt payment reforms that would reward high-quality, lower-cost care. The impact of these reforms will be heightened if similar reforms are also instituted in the public programs administered by the state, so that providers don't face a confusing, contradictory array of different payment systems. State employee benefit plans could also be incorporated into this effort.

Endnotes

1 H.R. 3590, the Patient Protection and Affordable Care Act of 2010 (hereafter "ACA").

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3 Council of Economic Advisers, *The Economic Effects of Health Care Reform on Small Businesses and Their Employees*, July 25, 2009, at http://www.whitehouse.gov/administration/eop/cea/Health-Care-Reform-and-Small-Businesses.

4 Jonathan Gruber for Small Business Majority, *The Economic Impact of Healthcare Reform on Small Businesses*, June 2009, at http://www.smallbusinessmajority.org/small-business-research/economic-research.php.

5 ACA § 1311(b), § 1321(c).

6 ACA § 1311(a), (d)(5).

7 ACA § 1311(b)(2), § 1312(f)(2).

8 ACA § 1311(c)(5).

9 ACA § 1311(c)(5), (d)(4).

10 ACA § 1311(c)(3), (c)(4).

11 ACA § 1311(d)(4).

12 ACA § 1302(e).

13 ACA § 1311(d)(3).

14 ACA § 1401, § 1402.

15 ACA § 1311(c)(1), (d).

16 ACA § 1311(e).

17 ACA § 1341, § 1342, § 1343.

18 ACA § 1311(d)(6), (7).

19 For example, California passed legislation in 2010 creating its exchange, which has since begun conducting meetings and preparing its business plan (the California exchange's website, *at* http://www.healthexchange.ca.gov, contains information on its meetings and activities). By way of contrast, recently-passed bills in Maryland and Oregon will require state-created exchanges to bring their business plans back to their respective legislatures for approval. *See* Maryland SB 182, Oregon SB 99. Representing a third, even slower approach, the Illinois legislature has set up a study committee to make recommendations on creating an exchange. Illinois HB 1577.

20 ACA, § 1311(e).

21 Massachusetts Connector, *Report to Massachusetts Legislature on Implementation of Health Care Reform, FY 10*, November 2010, *at* https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/Connector%2520Annual%2520Report%25202010.pdf.

22 *Economic Effects of Health Care Reform.*

23 *See* Statement of Peter R. Orszag, Director, Congressional Budget Office, *Opportunities to Increase Efficiency in Health Care*, Health Reform Summit of the Committee on Finance, United States Senate, June 16, 2008, at http://www.cbo.gov/ftpdocs/93xx/doc9384/06-16-HealthSummit.pdf.

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26 The Commonwealth Fund, *Finding Resources for Health Reform and Bending the Health Care Cost Curve*, June 2009, at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jun/Finding-Resources-for-Health-Reform.aspx.

27 *See* ACA, Title III.

28 *See* Timothy Stoltzfus Jost for the Commonwealth Fund, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, July 2010, at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.

Building a Better Health Care Marketplace

Policy Brief #3: Spotlight on Small Business

While many Americans struggle with the rising costs and eroding quality of health care, the plight of small businesses stands out – lacking the advantages possessed by larger businesses, they face unique challenges. Without the bargaining power to negotiate with insurers for better rates, they often get less value for their health care dollars. And because smaller businesses often lack a human resources department, they are often left alone to negotiate an often-confusing insurance market.

In tandem with other reforms in the new federal health care law, states can design their exchange to help address all of these problems, giving small businesses and their employees access to meaningful choices and higher-value, more affordable coverage. Not only will this benefit the small businesses themselves, but lowering the cost they pay for their coverage can have a significant positive impact on the state's economic health and job creation rates.

Delivering Lower Premiums for Entrepreneurs

As discussed in the previous Policy Brief in this series, one of the key strengths of a well-designed exchange is its ability to negotiate for a better deal on cost and quality. While large businesses are currently able to leverage the bargaining power of a sizable number of employees, their smaller cousins find that they have little ability to negotiate. With less expertise and fewer potential customers, small businesses often face a market where insurers don't need to compete for their business.

About this Series:

The creation of a new health insurance exchange offers states an opportunity to improve health care and lower costs by pooling consumers' bargaining power, creating economies of scale, and pushing insurers to delivering lower costs and higher quality. Illinois PIRG's *Building a Better Health Care Marketplace* project provides recommendations to advocates and policymakers for how to create a strong, pro-consumer exchange. Support for the project is generously provided by the Robert Wood Johnson Foundation. For further information on this project, and other policy briefs in this series, please visit http://www.illinoispirg.org.

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At the same time, small businesses lack the economies of scale enjoyed by large businesses – when they buy coverage, it may only be for a dozen employees. As a result, the administrative cost of securing coverage is proportionately higher for small businesses. Added together, these two factors mean that small businesses pay on average 18% more than large businesses do for comparable coverage.

To solve these problems through a strong exchange, the state must ensure that the exchange is empowered to negotiate on behalf of its enrollees, and take advantage of economies of scale. To best leverage these benefits, states should strive to maximize the number of exchange enrollees. As discussed in the previous Policy Brief, states have the option of allowing small businesses with up to 100 employees onto the exchange and eventually opening it to large employers as well. More enrollees means greater economies of scale, and greater bargaining power.

Giving Businesses Better Choices

Currently, small businesses wishing to purchase coverage for their employees face a dizzying array of choices, with insurers offering benefit packages that appear only slightly different from each other, but whose surface similarities can mask substantial variation in covered benefits. Untangling these subtleties, and determining which plans are a good fit for the particular health needs of a business' employees, can be a full time job by itself. But most small businesses can't afford a dedicated health benefits manager to perform these tasks.

The exchange can help make this process much easier for business. By standardizing insurance products within tiers, and creating decision tools to allow for easy apples-to-apples comparisons, the exchange can allow even small businesses without much time or expertise to find the coverage choices that are right for them. Easier comparisons will also increase competition among insurers, lowering prices and increasing quality.

Further, a small business will be able to allow its employees to choose whatever plan they like, rather than the current system, where the business is forced to rely on a one-size-fits-all approach. And because the exchange will employ navigators to perform outreach and help enrollees understand their choices, small businesses will have built-in support and advice.

To ensure that the exchange delivers these results for consumers, states should ensure that their exchange has a mandate to increase the standardization of insurance products to reduce unnecessary complexity, and develop tools to make each plan's costs and

particular benefit design clear and understandable.

Increasing the Stability of Small Business Premiums

In most states, insurers currently set their prices based on the average age or health of a small business' employees. This means that businesses with healthier or younger workforces pay lower premiums, while those with older or sicker employees pay more. It also means that for smaller businesses, if one employee gets unexpectedly sick or ages into a new bracket, premiums for the entire business can jump. With the cost of health care already prone to double-digit rises, these unexpected rate shocks make it hard for small businesses to maintain stable coverage.

The exchange and related reforms can help mitigate this problem in two ways. First, by bringing the small business into a much larger pool, comprised of individuals and other small businesses, changes in the age or health status of a few employees will no longer have as much of a proportional impact on overall costs. Further, because the new reform law will prevent insurers from varying their prices based on the health of enrollees starting in 2014, and limit variation based on age, the risk of premium spikes will be much reduced.

Coverage Options for Entrepreneurs

Many small businesses are created by entrepreneurs who have left their previous, more stable job, to accomplish their dream of creating something new. Currently, however, that is a difficult step for many prospective small business owners to take, since it may mean the loss of their employer-based coverage. As discussed above, as a small business the new coverage they get will likely be more costly and lower-value than if they had been working for a larger employer. And if the new business starts with only the owner as an employee and cannot access the state's small group insurance market, the entrepreneur will face an even worse deal on the individual market. If he or she has a pre-existing health condition, they might not be offered coverage at any price.

The exchange's power to pool the bargaining power of all its enrollees, and the health reform law's related reforms to eliminate the ability of insurers to discriminate against the less healthy, can create an attractive, reliable option for entrepreneurs. The establishment of an exchange can enable these new small business owners to focus on starting their new business instead of worrying about their coverage.

Making the Exchange Friendly to Small Business

For the most part, the steps necessary to make the exchange meet the needs of small businesses are no different from those that will serve the needs of all consumers. However, there are a number of additional policies that states can adopt that will ensure that small businesses reap the maximum benefit from the exchange.

First, small business owners, and their employees, should have a voice in the exchange's decisions. They should be consulted in any stakeholder committees or hearings. The exchange should be run by an independent governing board, including representatives of small business who can lend their expertise about what will work for them. Because small business owners and workers will sometimes have different perspectives, both voices should be represented.

Next, because small businesses will generally want to focus on running their business, not on the minutiae of administering their employees' health benefits, every effort should be made to streamline the experience of choosing and purchasing coverage. Again, much of this work will benefit all consumers – and will be discussed in further detail in a future Policy Brief – but for small businesses, it will be important that the exchange offer a single application for employees to use, regardless of what plan they choose; that it allow the business to make a single premium payment, without forcing it to engage in complicated allocations; and for businesses that qualify for the ACA's new small business tax credits, they should be able to easily see how those credits will reduce the premiums they will pay.