To: Vermont Health Benefit Exchange Advisory Board
From: Bailit Health Purchasing (Amy Lischko, Joshua Slen, Beth Waldman, Brendan Hogan)
RE: Overview of Basic Health Program
Date: March 31, 2011

This memo presents some background information on the Basic Health Program and discusses the advantages and disadvantages to implementing this program in Vermont. It also discusses what additional information may be required before Vermont policymakers can make a decision about whether to proceed with a establishing a Basic Health Program.

Background

The Patient Protection and Affordable Care Act (PPACA) offers states the option to implement a Basic Health Program (BHP) to adults with incomes 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 Medicaid (federally matched). The federal government will give a state 95 percent of what they would have spent on tax credits and cost-sharing subsidies had these individuals enrolled in an Exchange plan.

The BHP must include at least the essential benefits under PPACA and consumers may not be charged more than what they would have paid in the exchange. Under this scenario, Vermont would contract with a "managed care system" or a "system that offer(s) as many of the attributes of managed care as are feasible in its local health care market."[i] Plans must report on selected performance measures and must also maintain medical loss ratios of 85 percent or higher. Vermont is not precluded from running its own managed care arrangement using a FFS payment system with primary care case managers, as it does today. However, the plan must also include case coordination and case management, incentives for preventive services, maximize patient involvement in health care decision-making and provide incentives for appropriate utilization.[ii]

If Vermont chooses to implement a BHP, eligible individuals cannot receive tax credits through Vermont's Health Benefit Exchange. HHS will make a single payment to the state at the start of the fiscal year based on best available estimates and will make corrections (if the amount was too high or low) in the next year's payment.

Because Vermont has already extended coverage through its Medicaid program to many of the adults who would be eligible for the Basic Health Program, and because it is simultaneously planning for a single-payer system, the decision about whether or not to implement the Basic Health Program option is understandably more complex.

Vermont's choices can be summarized as follows, and in Table One below:

1) Do not establish a Basic Health Program and instead move all eligible adults above 133% FPL to the Health Benefit Exchange for subsidized coverage under PPACA.
2) Transition VHAP, Catamount Health and Dr. Dynasaur coverage for adults between 133% - 200% FPL to a new Basic Health Program and allow only those adults between 200-400% FPL to receive subsidies in the Health Benefit Exchange.
3) Transition Catamount Health to serve as the Basic Health Program.
4) Do not establish a Basic Health Program but maintain coverage under VHAP and Dr. Dynasaur coverage for eligible adults (assuming ability to consider this coverage under an 1115 Waiver). Adults 200-400% FPL to receive subsidies in the Health Benefit Exchange.

Table One

Eligibility Group	Current Eligibility	PPACA Eligibility
Citizen adults no children	VHAP <150%FPL Catamount Health < 300% FPL	<134%FPL – Medicaid 134-200% - Basic Health or Exchange 200-400%FPL- Exchange
Citizen adults with children	VHAP < 185%FPL Catamount Health <300% FPL	<134%FPL – Medicaid 134-200% - Basic Health or Exchange 200-400%FPL- Exchange
Pregnant Women	Dr. Dynasaur < 200%FPL	<134%FPL – Medicaid 134-200% - Basic Health or Exchange 200-400%FPL Exchange
Children	Dr Dynasaur < 300%FPL	<300%FPL – Dr. Dynasaur (over cap enroll in Exchange)

Advantages and Disadvantages to establishing a Basic Health Program in Vermont

Advantages

1**) Additional revenue for Vermont:** If Vermont decides to move (from VHAP and Catamount Health) all eligible adults between 133 and 200% FPL into a Basic Health Program, the state will receive 95% of what it would have cost to subsidize these individuals in the Exchange in private insurance from the federal government. This is compared to approximately 60% federal funds in Medicaid or 100% federal funds directed to the individual through tax credits if this group moves into the Exchange. Some new analysis suggests it may be in a state's financial interest to operate a Basic Health Program.[iii]

A quick, preliminary analysis here provides some evidence that establishing a Basic Health Program may generate additional federal revenue for Vermont over what the state current receives in Medicaid. The federal government will tie subsidies to the second lowest cost silver plan (actuarial value = 70%). In 2009, private insurance premiums in Vermont ranged from $4670 to $5368 according to a recent report by Hsiao.[iv] However, the actuarial value of this insurance averages about 87%. Premiums for a silver plan are therefore likely to be less than what is noted above, because there is greater cost-sharing for the consumer. A comparison using the plans available through the Massachusetts Connector finds the difference in premium costs between the second lowest cost silver plan (actuarial value between 70-80%) and gold plan (actuarial value about 93%) to be about $1000 or 22% lower. If we decrease the average premium in Vermont by 22% we get a range of $3642 - $4187. Vermont would receive 95% of this premium from the federal government for people between 134-200% FPL or $3460 - $3978 if covering them under a Basic Health program.

In FY09, VHAP members cost $3949 in total. Vermont receives a 60% match from the federal government, thus VHAP cost Vermont approximately $1580 per member. This analysis is clearly preliminary and will need a more in depth look once additional information is available. It is also unclear, however, what the requirements of the Basic Health Program are regarding actuarial value. Moreover, the Basic Health Program would likely incur more administrative costs than VHAP does due to additional requirements around case management and reporting. This quick analysis suggests that it may be cost-effective for Vermont to establish a Basic Health program as the State would receive almost the full costs of coverage for this population compared to only 60% under the Medicaid waiver.[v]

2) **Better continuity of care for low income Vermonters**: If Vermont implements a Basic Health Program it could continue to streamline benefits for all people under 200% FPL as it has done with its VHAP plan in the past and therefore maintain continuity in coverage. If Vermont moves people above 133%FPL to the Exchange, these individuals will experience increased premiums, cost sharing and benefit changes (depending on definition of essential health benefits) from VHAP, which may be confusing and have negative effects on continuity. Of course there would be ways to mitigate these negative effects. If a waiver continuance is permitted, maintaining coverage for these people under VHAP would also ensure continuity.

3) **Greater safety net viability:** PPACA includes a provision that mandates full participation by safety-net health care providers in Exchange plans, requiring Exchange plans to contract with all safety net providers, such as federally-qualified health centers. Moreover, the PPACA ensures that beginning in 2014 health center reimbursement is no less than their Medicaid Prospective Payment System rate from private insurers offering insurance plans through the new exchange. The health reform package aligns health center payment within private insurance plans with reimbursement under the Medicaid program to ensure that FQHCs do not lose revenue when they treat patients insured

under the new Exchange-based plans. Even with these provisions, there is no guarantee that eligible individuals insured by private plans will continue to seek care at safety net providers. There are currently 8 FQHCs in Vermont that serve low-income, medically underserved individuals. Creating a BHP that encourages people to seek care at safety net providers through tighter networks or lower cost sharing could help to ensure viability for the safety net as Vermont moves towards its single-payer system. The Exchange could also require this of Qualified Health Plans offering coverage through the Exchange.

4) **Greater financial protection for consumers** – The PPACA requires that individuals between 133-150% FPL contribute between 3 – 4% of income and those between 150-200% FPL: 4 – 6.3% of income towards premiums. Under a Basic Health Program Vermont could offer greater subsidies to individuals at these lower income levels ensuring greater enrollment and affordability. Vermont may be able to maintain the subsidy levels it currently has in its VHAP program for people under 200% FPL of between 2.4% and 2.9% of income. Moreover, the federal government requires some reconciliation at year's end that could endanger tax refunds or require payment to the IRS. This may deter some low-income individuals from enrolling in the Exchange. The Basic Health Program would not require individuals to undergo such reconciliation.

Disadvantages

1) **Less access to providers:** Because Vermont would receive 95% of the second lowest cost silver plan if it establishes a Basic Health Program, it is likely the state would need to pay providers less than what they would receive from a private plan operating in the Exchange. This could decrease choice of providers for people in the BHP and could continue the current cost-shift.

2) **Fewer people in the Exchange**: Implementing a BHP would reduce the number of people purchasing insurance in the Exchange. As Vermont moves to its single-payer system it would like to use the Exchange as a platform and encourage as many people as possible into the exchange. If the state continues to operate an expanded Medicaid program, either through VHAP or the BHP, fewer individuals will be purchasing via the Exchange. This may also present challenges for the financial viability of the Exchange because of Vermont's small market size, although as Vermont moves towards single-payer, this issue will be resolved.

3) **Risk selection**: Are people enrolled in VHAP between 133 and 200% FPL better or worse risk than those purchasing insurance through Catamount, those in the non-group market, and newly eligible uninsured between 200 and 400% FPL? It is unclear whether the federal government will allow the Basic Health Program risk pool to be merged with the non-group pool. It is important to know the differences in risk profiles if the federal government does not allow the pools to be merged. People currently enrolled in VHAP

and Catamount are likely higher risk than those who remain uninsured at similar incomes so the exact premium costs are difficult to estimate.

Next Steps

Vermont will need some additional information and analysis before it can make a decision about whether to establish a Basic Health Program. First, it will need information from the federal government regarding the make-up of the essential benefit plan as well as whether the Basic Health Program's risk pool can be merged with the overall non-group risk pool. Clarification from the federal government regarding the expected actuarial value of the Basic Health Program is also necessary. A more comprehensive analysis of the costs of each of these options is a recommended next step. Although this memo provided a quick analysis of the revenue trade-offs to Vermont in establishing a Basic Health Program, a more comprehensive analysis including the risk of the underlying populations and estimated premium costs in addition to the estimated additional administrative costs of establishing a new program is necessary. Specifically, as part of that analysis, the state should consider the potential advantages and disadvantages of the Basic Health Program from the perspective of consumers, providers and the state. Further the analysis should include the financial impact to the state modeled with different scenarios for the ongoing cost of VHAP or Catamount Health and the value of the federal subsidy.

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[i] ACA S1331(c)(2)(C)

[ii] ACA S1331(b)(2)(A)

[iii] Dorn, Stan; The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States. March 2011, AcademyHealth, SCI.

[iv] Hsiao, William et al. Act 128 Health System Reform Design, Achieving Affordable Universal Health Care in Vermont, January 2011.

[v] 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%FPL, BHP consumers may not receive coverage below the platinum level and, above 150% FPL, BHP AV may not fall below the gold level. S1331 (a)(2)(A)(ii) and S1331(a)unnumbered language.