

Update to the Analysis of the Basic Health Program

2012 Joint Chairmen's Report (p. 22) – Report on Basic Health Plan

**Office of Planning, Office of Health Care Financing
Department of Health and Mental Hygiene**

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EXECUTIVE SUMMARY

Under the Affordable Care Act (**ACA**), states have been given wide latitude to design health coverage solutions that best fit their particular circumstances. For instance, states can expand Medicaid to cover parents and childless adults with incomes up to 138 percent of the Federal Poverty Level (**FPL**). States can also create their own health insurance exchanges in order to build marketplaces that best serve their populations. The legacy of the ACA will be a coverage tapestry that allows states to provide health insurance through multiple programs that take into account each state's unique characteristics. The Department of Health and Mental Hygiene (**Department**) is committed to working with its partners and stakeholders to deliver a health insurance system that is most beneficial to Maryland residents.

One of the opportunities available to states is the optional Basic Health Program (**BHP**). The BHP is a health coverage option found in Section 1331 of the ACA, which would allow Maryland to cover adults with incomes between 138 percent and 200 percent of the FPL through the Medicaid program instead of through the Maryland Health Benefit Exchange (**Exchange**). The program would be financed by the federal government, which would send the state 95 percent of the money it would have spent on the enrollee's advanced premium tax credits and cost sharing subsidies in the Exchange.

The Department cannot offer a full assessment of the BHP to the General Assembly at this point in time. The necessary federal guidance has not been released, leaving the Department unable to assess the State's financial liability for the program. Furthermore, even if the guidance were available, the Department's estimate would rely on a series of assumptions about the cost of coverage in the Exchange, as the financing of the program is dependent on those costs. Despite this hurdle, the Department can present a cost estimate and updated analysis to the General Assembly within 90 days after the release date of sufficient federal guidance.

While a full assessment is not possible at this time, the Department has revised its enrollment projections and found that the removal of the BHP-eligible population from the Exchange may threaten the viability of the Exchange itself. The Department has consulted with The Hilltop Institute (**Hilltop**) on enrollment projections for the BHP and the Exchange and has found that a significant proportion of the Exchange's core subsidy-receiving population would be redirected into a BHP. This redirection could have negative ramifications for the Exchange, most notably by reducing Qualified Health Plan (**QHP**) participation in the market, compromising financial self-sustainability, and increasing plan premiums.

It is important to note that if the BHP population was covered in the Exchange, the State would not incur any additional financial liability and any negative effects on the Exchange would be avoided. Since there is no deadline for the creation of a BHP, the Department recommends delaying any decision on implementation until federal guidance has been released and analyzed. Ultimately, it may be in the State's best interests to delay any decision until the Exchange is established and the full impact of the BHP on the Exchange is clear to policy-makers.

INTRODUCTION

The 2012 Joint Chairmen's Report (p. 22) requires the Maryland Health Benefit Exchange and the Department to submit a report to the Senate Budget and Taxation Committee, the Senate Finance Committee, the House Appropriations Committee, and the House Health and Government Operations Committee updating the "Analysis of the Basic Health Program" white paper and cost estimate.¹ The committees requested that if the Department was unable to provide a cost estimate, it should provide a timeline on when it would be able to complete an estimate. This paper provides an update to the white paper and informs the General Assembly that only a limited cost estimate is possible to complete at the present time. This is due to the absence of federal guidance on the basic health plan (BHP) that would address potential state financial liabilities. Once sufficient federal guidance is released, the Department will be able to conduct an updated cost estimate within 90 days.

This paper provides a limited analysis encompassing:

- A review of the basics of the BHP and the issues of churn and continuity of care, including a short discussion on Department efforts and the "Bridge Option";
- A discussion on the most pertinent issues on which the Department needs federal guidance; and
- An abbreviated update of enrollment and cost estimates completed by Hilltop in light of updates to their enrollment estimates for the BHP and Exchange.

While the Department is unable to definitively assess the costs to the State in this analysis, it has found that new enrollment projections indicate that the creation of a BHP could have a negative impact on the Exchange. This development and other policy issues will be assessed in greater detail when the Department submits an updated cost estimate after the release of federal guidance.

The delay in developing a cost estimate will not jeopardize BHP implementation. The ACA does not have a deadline for the creation of a BHP. The State could implement a BHP at any point in the future. Given that there is no timeline, the Department recommends that the General Assembly postpone a decision on the implementation of a BHP until the release of an updated cost estimate and analysis. However, since an updated analysis will still rely on assumptions about the Exchange that will not be known until the Exchange is fully operational, the State's most prudent course of action may be to postpone any decision on the BHP until the Exchange is established.

BASIC BACKGROUND ON THE BHP, CHURN & CONTINUITY OF CARE

BHP Background & Churn

As described in depth in the original white paper, the BHP is a way for the State to offer an insurance product to Marylanders between the ages of 19 and 64 with a household income between 138 percent and 200 percent of the FPL (and immigrants below 138 percent of the FPL who are ineligible for Medicaid).² Individuals must not have access to employer-sponsored insurance or be eligible for Medicaid.

The benefit package must meet the Essential Health Benefits (EHB) requirements for the Exchange and enrollee premiums cannot exceed the premium of the second-lowest cost Silver Tier plan in the Exchange. For enrollees

¹ Department of Health and Mental Hygiene, Medicaid Office of Planning & The Hilltop Institute. *Analysis of the Basic Health Program*. (January 2012).

² The ACA nominally raises the income eligibility limit to 133 percent of the FPL for parents and childless adults. However, Medicaid programs must disregard the first five-percentage points of income, effectively raising the income threshold to 138 percent of the FPL.

with incomes up to 150 percent of the FPL, cost sharing cannot exceed 10 percent of health care costs. For enrollees with incomes between 150 and 200 percent, cost sharing cannot exceed 20 percent of health care costs.

This population's default option for coverage is a QHP in the Exchange with enrollee access to premium tax credits and cost sharing subsidies. Maryland would receive 95 percent of these tax credits and cost sharing subsidies if it were to create a BHP in order to finance coverage. Enrollees would only have access to coverage in a BHP and their eligibility for the Exchange would be eliminated. The presumed goal of the provision is to allow Medicaid managed care organizations (MCOs) to continue to serve the Medicaid population when their incomes rise above the 138 percent of the FPL threshold.

National research shows that 50 percent of adults with incomes up to 200 percent of the FPL may experience a change in eligibility status at 138 percent of the FPL over the course of one year.³ Proponents of the BHP suggest that the transition from Medicaid to the Exchange will negatively impact individuals, as they will face premiums and co-pays that they did not face in Medicaid, and they could lose access to existing provider networks and services. Proponents also point out that there are parents who would be covered in the Exchange while their children were covered in the Maryland Children's Health Program (MCHP) because of MCHP's higher income eligibility level. Dividing parents and children into separate plans may create burdens on families navigating the system.

The case for the BHP is that the program can enhance coverage by effectively shifting the churn point from 138 percent of the FPL to 200 percent of the FPL. In theory, the State would be able to lower the costs of coverage relative to the Exchange by leveraging economies of scale and lower Medicaid provider reimbursement levels. The State would then take the savings and put them towards minimizing the premium and cost sharing obligations of enrollees, or expanding the benefit package. If the cost of the program were to exceed the federal payment, however, then presumably the State would have to pay the remainder of BHP costs entirely with state dollars.

The Department notes that the BHP may not solve all of the issues related to churn. First, implementing a BHP would shift the point of churn from 138 percent of the FPL to 200 percent of the FPL, where much evidence suggests that there is comparable amount of churn.⁴ Individuals would still be introduced to the same issues, such as premiums and co-pays, just at a different eligibility level. The Department discussed Maryland-specific churn at 200 percent of the FPL in the original white paper and will be able to further its analysis in the next updated paper when it can discuss churn in the context of the new cost estimate.

Second, the BHP will not be able to align all parents and children in a health plan within a single coverage system. The BHP may be able to join parents and children with incomes up to 200 percent of the FPL, but parents and children between 200 percent and 300 percent of the FPL will still be divided between systems since children will be eligible for MCHP Premium and adults will be eligible for Exchange coverage.

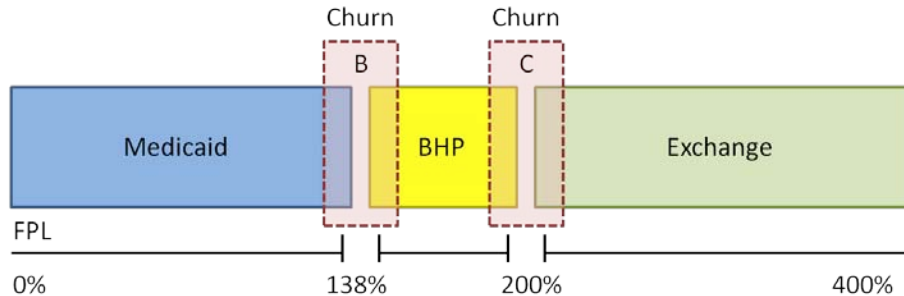
Third, the ability to limit premiums and co-pays and to expand benefits is premised on the idea of program savings. These savings are not guaranteed. If the Department were only able to offer the same premium, co-pays and services as a QHP, then the utility of the program would be in doubt because the enrollee could receive comparable coverage in the Exchange. Furthermore, a BHP with the same cost sharing and benefit features as a

³ Sommers B. D. and Rosenbaum S. *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*. Health Affairs, 30, no. 2 (2011): 228-236

⁴ See the *Analysis of the Basic Health Program* for the Maryland-specific churn analysis. See the following for other analyses on churn at 138 percent and 200 percent of the FPL: Buettgens M, Nichols A, Dorn S. *Churning Under the ACA and State Policy Options for Mitigation*. (June 2012); Hwang A., Rosenbaum S., and Sommers B. D. *Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges*. Health Affairs, 31, no. 6 (2012): 1314-1320; and Graves, John A., Ph.D., Rick Curtis, M.P.P., and Jonathan Gruber, Ph.D. *Balancing Coverage Affordability and Continuity under a Basic Health Program Option*. N Engl J Med 2011; 365:e44.

QHP would create another layer of churn between Medicaid and the BHP because BHP enrollees would confront the same economic decisions as Exchange enrollees would while navigating an additional system between Medicaid and the Exchange.

Figure 1: Churn at 138 percent and 200 percent of the FPL



Continuity of Care Efforts

The BHP is only one of several approaches to address churn and continuity of care issues between Medicaid and the Exchange. The Department released a white paper on continuity of care issues in September 2012 that addressed possible strategies to provide protections to individuals who churn while in the middle of a course of treatment.⁵

The white paper was intended to assist discussion in a larger initiative currently headed by the Exchange. In the Maryland Health Benefit Exchange Act of 2012, the General Assembly instructed the Exchange to address continuity of care between health insurance markets and to form recommendations for legislative action.⁶ The Exchange has formed an advisory committee with the Maryland Insurance Administration, the Department and other stakeholders to develop strategies and legislative recommendations to fulfill this mandate. The results of that workgroup will be reviewed by the Exchange and will likely result in recommendations for the 2013 legislative session.

Bridge Option

Stakeholders have raised the issue that churn and family alignment in one plan could be accomplished by the Tennessee Insurance Exchange Planning Initiative’s “One Family, One Card” or the “Bridge Option” proposal. The Bridge Option – as conceived by Tennessee – works as follows: Medicaid MCOs could offer a Silver Tier plan in an exchange that would be limited in enrollment to individuals who had been in that Medicaid MCO within the last 6 to 12 months and/or to individuals who had a dependent in that Medicaid MCO. The QHP would have the same provider network as the Medicaid MCO plan. The goal of the Bridge Option is to keep families in a single plan and to allow individuals to remain in their existing provider network after they experience an eligibility change.

Enrollees would not be mandatorily or auto-enrolled in the plan and would still be able to choose other QHPs in an exchange. Proponents expect that enrollees would want to enroll in a MCO Bridge product because they would be able to stay in the same provider network and, if they have dependents enrolled in a CHIP program, would be able to remain in a plan with their children. There is no FPL limit at which enrollment would stop for a Bridge

⁵ Department of Health and Mental Hygiene. *Continuity of Care Issues Between Maryland Health Benefit Exchange and Maryland Medicaid: Recommendations for Further Study by the Continuity of Care Committee* (September 2012).

⁶ Maryland Health Benefit Exchange Act. HB 443 (Chapter 152 of the Acts of 2012) §8.

product. Thus, if an individual experienced an income fluctuation that resulted in an income higher than 200 percent of the FPL, they would still have access to the Bridge product.

CMS has approved the Bridge Option and it did issue initial guidance on the proposal on December 10, 2012. In the guidance, CMS announced that Bridge Option QHPs could limit enrollment in the plans to only Bridge Option eligible individuals, as requested by Tennessee.⁷ Tennessee had also asked whether a Bridge Option QHP could be recognized as the second lowest cost Silver Tier plan in an exchange, but CMS did not definitively answer this question.⁸ This issue is crucial, as Bridge Option QHPs could possibly limit federal financial assistance for all enrollees in an exchange by lowering the cost of the Silver Tier plan that serves as the reference premium for advanced premium tax credits and cost sharing subsidies. Presumably, CMS will address this issue in later guidance.

The Department has concerns on whether the Bridge Option is best suited for Maryland. First, the Department notes that nothing precludes Medicaid MCOs from simply entering the Exchange as a QHP and selling products targeted at low income families that could enroll together. The normal course of business in the Exchange should allow Medicaid MCOs to offer coverage that would accomplish the goals the Bridge Option seeks to achieve.

Second, in order to accomplish the Bridge Option in Maryland, the Exchange would need to operate a complicated plan selection and plan management model, whereby: (a) adults who did not qualify for the Bridge would be offered all the normal QHPs (but not Medicaid MCOs); and (b) adults who would qualify for the Bridge would be offered both Bridge and QHP products. This set of rules would need to be folded into the determination of plan selection for the Exchange. The rate reviews and pricing would also have to track these populations and their risk status.

Finally, while the initial guidance tasks the Exchange with certain responsibilities like certifying QHPs, the division of regulatory duties between state agencies is still unclear. These implementation issues make the Bridge Option a very complex endeavor given the possible volume of churn and the division of families between MCHP and the Exchange. Implementation may be especially burdensome in light of the reality that Medicaid MCOs should be able to accomplish all of the goals of a Bridge Option plan by just offering coverage as a QHP.

Since significant issues remain unresolved, it is premature for Maryland to consider the Bridge Option until some of the larger questions concerning implementation are addressed.

NEED FOR FEDERAL GUIDANCE

As of December 10, 2012, CMS has not released sufficient federal guidance on the BHP.⁹ Thus, the Department is only able to submit this abbreviated update because the underlying issues that prevented a full analysis in January 2012 remain extant today. The Department remains interested in guidance on a number of issues, chief among them being:

⁷ Centers for Medicare and Medicaid Services. "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid." (December 2012). See Tennessee Insurance Exchange Planning Initiative. *FAQs about the "One Family, One Card" or Bridge Option*. (August 2012) for a synopsis of Tennessee's questions to the federal government.

⁸ Id. CMS states that "the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits." The statement does not clearly answer whether Bridge Option plans will be considered as second lowest cost Silver Tier plans.

⁹ In the Department's research, a short passage in a piece of guidance on state exchanges did address BHP issues. It was focused on the use of Planning and Establishment Grant dollars for BHP activities. See Centers for Medicare and Medicaid Services. "State Exchange Implementation Questions and Answers." (November 2011). The more recent Centers for Medicare and Medicaid Services. "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid." (December 2012) only reiterated that BHP guidance is forthcoming.

- How the federal payment will be calculated;
- Whether states will have to provide a three-month coverage grace period for enrollees that do not pay their premiums;
- How under- and over-payments to the states will be managed by CMS;
- Whether states can use the federal payment to pay for state administrative costs; and
- How the federal government will oversee the program.

Once federal guidance is released, the Department should be able to offer the General Assembly an updated analysis and cost estimate within 90 days.

Payment Methodology

A major roadblock to an accurate estimate is the lack of guidance on how the federal government will determine federal payments for the program. It is unclear exactly how the federal government will calculate the annual prospective payment. The ACA states that CMS should consider a series of detailed data points in making the payment determination on a per enrollee basis. These points include age, geography and health status.¹⁰ The Department must understand the methodology to be able to model the payment and therefore form an estimate for a BHP in Maryland.

There are also two issues surrounding the cost sharing subsidy portion of the payment that must be addressed. First, the law is unclear whether states will receive 100 percent or 95 percent of the cost sharing subsidies in the federal payment for the BHP.¹¹ This is not an inconsequential amount of funding, and it could have an impact on whether the BHP is a viable option for Maryland.

Second, the cost sharing subsidies – unlike Exchange premiums or Medicaid matching funds – are not treated as mandatory spending under federal law, thus making them subject to the sequester under the Budget Control Act of 2011.¹² If the federal payment was reduced due to cuts in cost sharing subsidies, then the Department may need to expend state dollars to make up the difference in BHP costs. This would also be true if cost sharing subsidies were cut in some other future deficit reduction measure.

Three Month Coverage Grace Period

The ACA requires QHPs to observe a three-month grace period whereby they will provide coverage for individuals that do not pay their premium.¹³ The statute does not contain similar language for the BHP. However, the Department would need clarification on whether this provision or a similar policy would be applicable to a BHP because of the potential impact on costs.

¹⁰ Patient Protection and Affordable Care Act. Public Law 111–148 (hereafter “ACA”) § 1331(d)(3)(A)(ii) instructs CMS to consider “the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled.”

¹¹ ACA § 1331(d)(3)(A)(i).

¹² Redhead, C. Stephen. *Budget Control Act: Potential Impact of Automatic Spending Reduction Procedures on Health Reform Spending*. Congressional Research Service. (November 2011).

¹³ ACA § 1412(c)(2)(B)(iv)(II).

Reconciliation

The federal government funds the BHP each year prospectively based on what it estimates the costs of coverage to be. The ACA describes the process that would ensue when inaccurate payments are made to states. If CMS were to over- or under-estimate payments to a state, they must correct the over- or under-payment by adding or subtracting the money from the next fiscal year's payment.¹⁴ This would have financial implications for states because states would be responsible for paying for a portion of the BHP coverage if the federal government underestimated the cost. Additionally, if a state was unaware of an overpayment and used the excess funds in some manner to improve the program, it could be penalized the next year through reduced funds.

Thus, a state could be held financially responsible for the costs that arise if the payments are made in error. CMS could establish a safe harbor threshold that would allow states that receive an overpayment to avoid reductions in the next fiscal year's disbursement. However, the federal government would have to establish this as a rule. Regardless, the Department should know whether states could be held financially responsible for over- and under-payments.

Funding for Administrative Functions

The ACA's language is ambiguous on whether states can use a portion of the federal payment for state administrative expenses. The statute reads that BHP payments can only be used to pay for premiums, cost sharing, and/or to expand benefits.¹⁵ This language may preclude states from using BHP payments to fund the state administrative costs of the BHP. The federal government may interpret the relevant passage to include administrative costs as a means to pay for premiums and cost sharing, but until that guidance is released, it is an open question.

These administrative costs will be significant. The Department has determined that operating a BHP would require additional duties. At a minimum, the State would have to collect and disperse the BHP-enrollee premiums to MCOs, manage a trust fund for federal payments, and make changes to its claim and enrollment processing system called Medicaid Management Information System (**MMIS**). There would also be costs to manage the program and ensure program quality. Potentially more state functions would have to be included if federal regulations required certain activities. The present estimate determines the costs to be between \$201 million and \$334 million over the course of FY 2014 through FY 2020.

The federal government addressed the financing issue briefly in a short document on Exchange implementation in November 2011. In that document, CMS stated that establishment grant dollars could be used for Exchange establishment activities that would "coordinate or overlap with [BHP] activities" such as a call center. However, establishment grant funds could not be used to support BHP operations. CMS suggested that states "may opt to fund" BHP administrative activities through state dollars or user fees but did not address the premium or cost sharing subsidies financing issue.¹⁶

The prospect of using state general fund dollars to fund administrative costs is problematic because it would result in state costs that would not otherwise exist if coverage was provided in the Exchange. Furthermore, it is unclear how user fees would work in a BHP. Presumably, enrollees could not be subject to them because of strict rules limiting out-of-pocket expenditures of Exchange enrollees in the ACA.

¹⁴ ACA § 1331(d)(3)(B).

¹⁵ ACA § 1331(d)(2).

¹⁶ Centers for Medicare and Medicaid Services. "State Exchange Implementation Questions and Answers." (November 2011).

As for user fees placed on MCOs, similar costs, like assessments, are typically passed onto the State by including them as a rate component in the capitated payment. That may not be possible in the BHP for two reasons. First, the statute's ambiguity on whether state administrative costs could be paid for with federal dollars remains an issue until it is clarified, even in the user fee scenario. Second, the ACA requires that health insurance plans must have a medical loss ratio (**MLR**) of 85 percent in the BHP.¹⁷ This indicates that even if it is allowable to account for the user fee in the rate, it may not be possible to do so because it could violate MLR requirements. MCOs may be dissuaded from offering coverage in the BHP if they had to shoulder the cost of user fees outside of a capitated payment.

Role of Federal Oversight

Though not strictly a cost concern, the Department should know how the federal government intends to manage its role in a BHP. Under the ACA, the federal government will review state BHPs annually to ensure that states are meeting eligibility, financial and quality control requirements.¹⁸ The Department would need to know what metrics will be used to assess federal compliance in order to form a recommendation on the BHP.

UPDATED ENROLLMENT AND COST ESTIMATE

As noted above, the Department cannot present an updated cost estimate until 90 days after federal guidance is released. Nevertheless, the Department can present this short enrollment and cost estimate based on new enrollment projections done by Hilltop.

BHP & Exchange Enrollment

The Hilltop Institute recently made updates to its enrollment estimates for the Exchange.¹⁹ The new estimate shows that the number of individuals expected to enroll in the BHP is lower than previously estimated. In the original white paper, Hilltop had projected that 82,000 individuals would enroll in a BHP by FY 2016. In the present estimate, Hilltop projects that 45,000 individuals would participate in a Maryland BHP at that time.

The new estimates also address the Exchange's potential enrollment with and without the BHP. The original estimate projected that 130,000 individuals with incomes between 200 percent and 400 percent of the FPL and 58,000 with incomes above 400 percent of the FPL would enroll in the Exchange by FY 2016. The present estimate projects that only 85,000 individuals with incomes between 200 percent to 400 percent of the FPL and 54,000 individuals with incomes above 400 percent or in the Small Business Health Options Program (SHOP) would enroll.

This new enrollment estimate is significant because it appears that the reduction in the number of covered individuals would have a negative effect on the Exchange. First, the Exchange must be financially self-sufficient by January 2015. If the Exchange opts to pursue a financing strategy that relied on user fees, it would have a smaller base from which to draw funds. Second, a smaller market may dissuade commercial carriers from entering the Exchange as QHPs, therefore limiting choices for consumers and reducing competition. Third, the removal of the BHP-eligible population would reduce the number of covered lives in the risk pool, which could have the

¹⁷ ACA § 1331(b)(3).

¹⁸ ACA § 1331(f).

¹⁹ The enrollment estimate used in this paper is an updated, unpublished estimate taken from Hilltop's Maryland Health Care Reform Simulation Model. For the most recent published estimate, see Fakhraei, S. H. (2012). *Maryland health care reform simulation model: Detailed analysis and methodology*. Baltimore, MD: The Hilltop Institute, UMBC.

result of increasing the cost of insurance in the Exchange. This would mean that premiums for Exchange enrollees would be higher than they would have been had the BHP population received coverage in QHPs.

Table 1: Projection of Individual Enrollment in Medicaid, the BHP and the Exchange²⁰

Fiscal Years	2014	2015	2016	2017	2018	2019	2020
1. Medicaid Expansion	93,255	114,863	122,181	129,531	135,736	141,542	145,753
2. Medicaid "Woodwork" Effect	11,046	23,117	32,301	40,150	41,793	42,956	44,069
3. Basic Health Program (138-200% FPL)	37,427	42,308	45,143	50,023	56,105	61,728	67,761
3.1 BHP with Income between 138-149% FPL	7,112	8,039	8,578	9,505	10,661	11,729	12,876
3.2 BHP with Income between 150-200% FPL	30,315	34,269	36,565	40,518	45,444	49,999	54,885
Total New DHMH (1+2+3)	141,728	180,288	199,625	219,704	233,634	246,226	257,583
4. Exchange (200-400% FPL) with Subsidy	67,244	77,937	84,992	96,562	109,240	120,187	132,508
5. Exchange without Subsidy >400%FPL & SHOP	42,464	49,591	54,414	62,245	70,562	77,604	85,632
Total New Coverage	251,436	307,816	339,031	378,511	413,436	444,017	475,723
Current Medicaid (Excluding PAC)	986,347	993,275	1,004,559	1,018,234	1,032,784	1,045,455	1,056,676
New Medicaid (1+2)	104,301	137,980	154,482	169,681	177,529	184,498	189,822
Total Medicaid with Health Care Reform	1,090,648	1,131,255	1,159,041	1,187,915	1,210,313	1,229,953	1,246,498

Estimated Costs

Because enrollment is now estimated differently, the scale of estimated federal payments and program costs is different as well. The Department can present Hilltop’s original Base Cost and High Cost scenario analyses with the new enrollment information, but counsels that the cost estimate is not complete because it still makes assumptions that must be resolved by federal guidance. This guidance includes the exact methodology the federal government will use to calculate the payment and whether there are state financial liabilities that cannot be paid for with federal dollars. The Department and Hilltop will reassess the Base Cost and High Cost scenario assumptions once federal guidance is released. However, knowledge of costs in the Exchange may not be available until the Exchange itself is fully established.²¹

It is important to note that both the Base Cost and High Cost scenarios only estimate costs to cover the BHP requirements under the ACA. In other words, they estimate the cost of the BHP where the BHP offers comparable features and coverage as a plan in the Exchange. The estimates do not factor in what level of savings would need to occur in order to realize policy goals like expanding benefits or reducing premiums and cost sharing.

²⁰ As noted in Footnote 18, the enrollment estimate presented here is an updated, unpublished estimate taken from Hilltop’s Maryland Health Care Reform Simulation Model.

²¹ See Department of Health and Mental Hygiene, Medicaid Office of Planning & The Hilltop Institute. *Analysis of the Basic Health Program*. (January 2012) for a detailed explanation of the assumptions and methodology behind the Base Cost and High Cost scenarios.

Each table below shows estimates of the State’s gross costs of establishing a BHP and the State’s administrative costs of operating a BHP program. The third row of each table shows federal payments for the BHP based on 95 percent of the premium tax credits and cost-sharing subsidies that the federal government would have otherwise paid to the individuals in the Exchange.

The fourth row depicts enrollees’ maximum payments for premiums, as specified by the ACA, assuming that all enrollees would make their payments on time. Row 5 shows the State’s net costs of the BHP, with the same assumption.

Row 6 assumes that 10 percent of BHP enrollees will delay their premium payments by 90 days. Row 7 shows the State’s net total costs of BHP with the 90-day delay in payments. These rows were added to account for the potential that a three-month grace period for nonpayment of premiums could apply to the BHP.

Rows 8 and 9 show federal subsidies for coverage through the Exchange for individuals with incomes between 200 percent and 400 percent of the FPL, and total federal subsidies in the Exchange for individuals with incomes between 138 percent and 400 percent of the FPL.

At this stage, Hilltop estimates in the Base Cost Scenario described in Table 2.1 that the costs to implement a BHP exceed the federal payments by between \$296 million to \$493 million from FY 2014 to FY 2020. The state administrative costs are between \$201 million to \$334 million.

Table 2.1: BHP Costs (Savings) in Million Dollars – Base Cost Scenario

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
1. State's Gross Total Costs of BHP	\$129	\$301	\$333	\$382	\$445	\$507	\$577	\$2,674	\$2,005	\$3,342
2. State Administration Costs of BHP	\$13	\$30	\$33	\$38	\$44	\$51	\$58	\$267	\$201	\$334
3. Federal Payments for BHP (Million \$)	-\$100	-\$234	-\$259	-\$298	-\$347	-\$398	-\$454	-\$2,090	-\$1,567	-\$2,612
4. BHP Enrollees' Max. Premium Payments without Delay	-\$23	-\$53	-\$58	-\$66	-\$76	-\$85	-\$96	-\$457	-\$343	-\$571
5. State's Net Costs of BHP (without Payment Delay)	\$19	\$44	\$49	\$56	\$66	\$75	\$85	\$394	\$296	\$493
6. BHP Enrollees' Premiums with 10% Delaying 90 Days	-\$22	-\$51	-\$57	-\$64	-\$74	-\$83	-\$93	-\$446	-\$334	-\$557
7. State's Net Total Costs of BHP with 90 Day Delay	\$20	\$46	\$51	\$58	\$67	\$77	\$88	\$406	\$304	\$507
8. Federal Subsidies for Coverage thru Exchange (200-400% FPL)	\$107	\$258	\$292	\$347	\$412	\$476	\$552	\$2,446	\$1,834	\$3,057
9. Total Subsidies in Exchange without BHP (138-400% FPL)	\$213	\$505	\$565	\$661	\$778	\$895	\$1,030	\$4,645	\$3,484	\$5,807

Under the Base Cost Break Even Point scenario described in Table 2.2, Hilltop continues to estimate that costs must rise by 16 percent over the base cost in order for Maryland to offer a BHP plan that would be comparable to a QHP.

Table 2.2: BHP Costs (Savings) in Million Dollars – Base Cost Scenario at Break Even Point

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
1. State's Gross Total Costs of BHP	\$129	\$301	\$333	\$382	\$445	\$507	\$577	\$2,674	\$2,005	\$3,342
2. State Administration Costs of BHP	\$13	\$30	\$33	\$38	\$44	\$51	\$58	\$267	\$201	\$334
3. Federal Payments for BHP (Million \$)	-\$119	-\$280	-\$310	-\$356	-\$415	-\$474	-\$542	-\$2,496	-\$1,872	-\$3,120
4. BHP Enrollees' Max. Premium Payments without Delay	-\$23	-\$53	-\$58	-\$66	-\$76	-\$85	-\$96	-\$457	-\$343	-\$571
5. State's Net Costs of BHP (without Payment Delay)	-\$1	-\$1	-\$1	-\$2	-\$2	-\$2	-\$2	-\$11	-\$9	-\$14
6. BHP Enrollees' Premiums with 10% Delaying 90 Days	-\$22	-\$51	-\$57	-\$64	-\$74	-\$83	-\$93	-\$446	-\$334	-\$557
7. State's Net Total Costs of BHP with 90 Day Delay	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8. Federal Subsidies for Coverage thru Exchange thru Exchange (200-400% FPL)	\$141	\$340	\$385	\$456	\$539	\$622	\$718	\$3,201	\$2,401	\$4,002
9. Total Subsidies in Exchange without BHP (138-400% FPL)	\$267	\$634	\$711	\$831	\$976	\$1,121	\$1,288	\$5,828	\$4,371	\$7,286

Table 3.1 shows the model output for the High-Cost Scenario, which assumes that the cost to provide coverage through the BHP will be impacted by changes in Medicaid costs. Specifically, the scenario estimates that physician fees will increase to 100 percent of Medicare fees and Federally Qualified Health Centers (FQHCs) will provide 15 percent of all physician services. Under this scenario, the State's net costs, including 10 percent administrative costs, are estimated to be between \$439 million and \$731 million from FY 2014 to FY 2020.

Table 3.1: BHP Costs (Savings) in Million Dollars – High-Cost Scenario

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
1. State's Gross Total Costs of BHP	\$137	\$321	\$354	\$407	\$473	\$540	\$615	\$2,847	\$2,135	\$3,559
2. State Administration Costs of BHP	\$14	\$32	\$35	\$41	\$47	\$54	\$61	\$285	\$214	\$356
3. Federal Payments for BHP (Million \$)	-\$100	-\$234	-\$259	-\$298	-\$347	-\$398	-\$454	-\$2,090	-\$1,567	-\$2,612
4. BHP Enrollees' Max. Premium Payments without Delay	-\$23	-\$53	-\$58	-\$66	-\$76	-\$85	-\$96	-\$457	-\$343	-\$571
5. State's Net Costs of BHP (without Payment Delay)	\$28	\$66	\$73	\$84	\$97	\$111	\$126	\$585	\$439	\$731
6. BHP Enrollees' Premiums with 10% Delaying 90 Days	-\$22	-\$51	-\$57	-\$64	-\$74	-\$83	-\$93	-\$446	-\$334	-\$557
7. State's Net Total Costs of BHP with 90 Day Delay	\$29	\$67	\$74	\$85	\$99	\$113	\$129	\$596	\$447	\$745
8. Federal Subsidies for Coverage thru Exchange (200-400% FPL)	\$107	\$258	\$292	\$347	\$412	\$476	\$552	\$2,446	\$1,834	\$3,057
9. Total Subsidies in Exchange without BHP (138-400% FPL)	\$213	\$505	\$565	\$661	\$778	\$895	\$1,030	\$4,645	\$3,484	\$5,807

Table 3.2 shows the High-Cost Scenario at the break-even point. It assumes that costs in the individual market would have risen by 24 percent above the projected market cost.

Table 3.2: BHP Costs (Savings) in Million Dollars – High-Cost Scenario at Break Even Point

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
1. State's Gross Total Costs of BHP	\$137	\$321	\$354	\$407	\$473	\$540	\$615	\$2,847	\$2,135	\$3,559
2. State Administration Costs of BHP	\$14	\$32	\$35	\$41	\$47	\$54	\$61	\$285	\$214	\$356
3. Federal Payments for BHP (Million \$)	-\$129	-\$301	-\$333	-\$383	-\$447	-\$511	-\$583	-\$2,686	-\$2,015	-\$3,358
4. BHP Enrollees' Max. Premium Payments without Delay	-\$23	-\$53	-\$58	-\$66	-\$76	-\$85	-\$96	-\$457	-\$343	-\$571
5. State's Net Costs of BHP (without Payment Delay)	-\$1	-\$1	-\$1	-\$2	-\$2	-\$2	-\$2	-\$11	-\$9	-\$14
6. BHP Enrollees' Premiums with 10% Delaying 90 Days	-\$22	-\$51	-\$57	-\$64	-\$74	-\$83	-\$93	-\$446	-\$334	-\$557
7. State's Net Total Costs of BHP with 90 Day Delay	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8. Federal Subsidies for Coverage thru Exchange (200-400% FPL)	\$157	\$378	\$428	\$507	\$599	\$690	\$796	\$3,556	\$2,667	\$4,445
9. Total Subsidies in Exchange without BHP (138-400% FPL)	\$293	\$695	\$779	\$910	\$1,069	\$1,227	\$1,410	\$6,384	\$4,788	\$7,980

The Base Cost and High Cost scenarios do not make any assumptions about the effects of health care reform developments like community rating rules, guaranteed issue of coverage to individuals with pre-existing conditions, and the impact that the Maryland's high-risk pool program, the Maryland Health Insurance Plan (MHIP), will have on the risk pool in the Exchange. However, ascertaining the true costs of those developments may not be possible until the Exchange is fully established and QHPs are certified.

This analysis does show that costs in the Exchange would have to be between 16 to 24 percent higher than the current trend of individual market costs for comparable coverage in order for Maryland to operate a BHP without using state dollars. This may be possible, as analysts have found that costs may increase between 4 and 40 percent depending on the effect of insurance reforms and the characteristics of the Exchange risk pool.²² However, the Department withholds greater analysis until it can conduct a cost estimate that takes into account federal guidance on payment methodology, the availability of premium and cost sharing dollars for state administrative costs, and other issues.

CONCLUSION

The Basic Health Program may be a valuable tool to provide coverage to Marylanders with incomes between 138 percent and 200 percent of the FPL. However, the Department is unable to offer the General Assembly an updated cost estimate at this time because necessary federal guidance has not been issued. The Department will be able to offer the General Assembly an updated cost estimate 90 days after guidance is issued. In the meantime, the Department recommends that the General Assembly delay legislative action on the BHP until federal guidance is released and fully analyzed.

Recent updates to the Department's enrollment projections do indicate that the BHP may have a negative impact on the Exchange. The creation of a BHP could reduce the number of Exchange enrollees to a significant degree, which could limit financing for self-sustainability, deter some carriers from offering QHPs, and raise the cost of insurance because of a reduced risk pool.

While the Department will be able to offer a cost estimate within 90 days after the issuance of federal guidance, there will still be unknown factors impacting costs and enrollment that could affect the viability of the program. The ACA does not have a deadline for the creation of the BHP, and states could implement a Basic Health Program after an Exchange is established. It may be in the State's best interest to consider a BHP after the Exchange is operational and the State has a better understanding of the Exchange market place.

²² Mercer. *Report of Market Rules and Risk Selection for the State of Maryland*. Report to the Maryland Health Benefit Exchange. (November 2011).

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