



Basic Health Program Report

In Accordance with Act 254 (SLH 2012)

Prepared by the

INSURANCE DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

February 2013

Foreword

Act 254 (SLH 2012) requires the Insurance Commissioner to submit to the Legislature a report that provides findings and recommendations related to a study of a basic health program for Hawai'i. Such a program is a state option identified in the federal Patient Protection and Affordable Care Act (PPACA).

This is the final report on the basic health program. The preliminary report was submitted in December 2012.

GORDON I. ITO
Insurance Commissioner

Final Basic Health Program Report (2013)

Introduction

Act 254 (SLH 2012) requires the Insurance Division of the Department of Commerce and Consumer Affairs to prepare a comprehensive study on the feasibility of establishing a Basic Health Program in Hawai'i. The feasibility study must include an analysis of the:

- a. Short-term and long-term financial costs and benefits to the State;
- b. Immediate and ongoing availability of federal funds to support the program and requirements for long term sustainability;
- c. Options for selecting providers for the program;
- d. Effect of the program on relevant existing health care providers and health care organizations, programs, and agencies, including the Hawai'i Health Connector;
- e. Potential benefits to enrollees of the program compared to the potential drawbacks to these same individuals if a Basic Health Program is not offered; and
- f. Other considerations that may impact the overall delivery of healthcare in Hawai'i:

Act 254 further requires the Insurance Division to submit a report of its findings and recommendations including any proposed legislation to the 2013 Legislature.

The Insurance Division contracted with the actuarial firm of Oliver Wyman Actuarial Consulting, Inc., to perform a feasibility study on the Basic Health Program. This study is attached as Appendix A to this report. We note that while the study is based on the best information currently available, the data is not perfect and federal regulations pertinent to the Basic Health Program have not yet been promulgated. In addition, because the report forecasts the future, there is a speculative aspect to it.

Overview of the Basic Health Program

A Basic Health Program would occupy the space between Medicaid and the Hawai'i Health Connector and serve people who are between 138% of the Federal Poverty Level ("FPL") and 200% of the FPL. Advocates for the Basic Health Program believe that it can reduce "churn" of membership that occurs as people transition between eligibility for the Medicaid program and the Hawai'i Health Connector. The evidence for this is unclear, and a study published in the NEJM suggest that the Basic Health Program could actually increase overall churning (see <http://www.nejm.org/doi/full/10.1056/NEJMp1111863>).

The Basic Health Program is authorized under Section 1331 of the Patient Protection and Affordable Care Act of 2010 ("PPACA"). The Basic Health Program may be run by a State government to provide health insurance to its population that meets the following criteria:

- a. Resident of the state who is a U.S. Citizen or a lawfully present immigrant;
- b. At least 19 years old;
- c. Under 65 years old at the beginning of the plan year;

-
- d. Not eligible for Medicaid, CHIP, Medicare, TRICARE, or Veteran's Health Care, or other public minimum essential coverage;
 - e. Their incomes fall between 138%¹ and 200% FPL for US citizens and at or below 200% FPL for legal aliens; and
 - f. Have no access to employer-sponsored coverage that meets the PPACA's minimum standards for affordability and comprehensiveness.

Within the Basic Health Program, states contract with health plans to provide essential health benefits for these non-Medicaid-eligible low-income individuals. However, there are numerous requirements for participating plans, including the following:

- a. Health plans must maintain a minimum medical loss ratio of 85%;
- b. Contracts must be awarded through a competitive bidding process;
- c. Coverage must be coordinated with Medicaid and CHIP;
- d. Health plans must provide essential health benefits;
- e. Premiums charged to members cannot exceed the premiums charged for the second lowest Silver level plan offered through the Hawai'i Health Connector;
- f. For individuals with incomes up to 150% FPL, cost sharing cannot exceed Platinum Level cost sharing requirements of 10%;
- g. For individuals with incomes between 150% and 200% FPL, cost sharing cannot exceed Gold Level cost sharing requirements of 20%;
- h. Health plans must operate as either a managed care system or offer similar benefits of case management;
- i. To the extent feasible, consumers should be offered a choice of plan options; and
- j. Health plans must coordinate administration with Medicaid and CHIP.

If Hawai'i was to create a Basic Health Program, the Federal government would pay the State 95% of the premium tax credits and cost-sharing subsidies that would have been provided for those individuals had they been enrolled in individual coverage through the Hawai'i Health Connector. The State must spend all federal funding received for the Basic Health Program on that program. If the federal funding received exceeded the cost of the Basic Health Program, the balance could only be expended on enhancements to the Basic Health Program such as reducing premiums, reducing cost sharing, increasing provider reimbursement, or covering additional benefits. Conversely, if federal funding received was less than the costs of the Basic Health Program, the State would have to cover the difference with general funds. Whether or not or to what extent the federal funding received can be used by the State for administration of the Basic Health Program is currently unknown. Funding for the Basic Health Program may also come from premiums and cost-sharing paid by the enrollees of the program.

¹ Section 1331 of the PPACA states that an individual is eligible for the Basic Health Program if, among other things, that person's household income exceeds 133 percent but does not exceed 200 percent of the federal poverty line. However, Section 1004 of the Reconciliation Act includes a 5 percent income disregard on the upper income limit for those eligible for medical assistance (i.e., Medicaid). So in principle, the limit is 133% to 200% FPL, but in practice, the income limit is 138% to 200% FPL.

The Basic Health Program must comply with the Essential Health Benefit requirements as outlined in section 1302(b) of PPACA. Section 1331(a)(1) of PPACA addresses the Basic Health Program's coverage of the Essential Health Benefits and reads as follows:

The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

We emphasize that, as of the date of this report, the federal Department of Health and Human Services (DHHS) has not issued administrative rules on the Basic Health Program. The federal government issued a Frequently Asked Questions document dated February 2013 indicating final guidance on the Basic Health Program is expected in 2014 and the program will be operational beginning 2015 for states interested in pursuing a Basic Health Program option.

Findings

Contained in the report are the financial results of the feasibility of a Basic Health Plan under certain assumptions. The baseline assumption projection indicates a significant program deficit in the first year of the program, although the deficit is expected to reverse over time. The projections also indicate sensitivity to increases in provider reimbursement levels. When higher provider reimbursement levels are modeled, the program reflects a deficit in the initial year which does not reverse when projected outward to year 2018. The projections are based on data from the U.S. Census Bureau's American Community Survey (ACS) which surveys a sample of the population and performs calculations to extrapolate to the entire population. ACS reports are the standard for actuarial estimates but still resulted in Oliver Wyman's calculating a lower than actual Medicaid enrollment for Hawai'i. Adjustments were made for this report but the experience underscores the possibility of variation between estimates and actuality, including the magnitude of the number of people who would be eligible for the Basic Health Plan.

Some opportunities and risks should be considered with respect to the Basic Health Plan.

Opportunities:

- a. May be able to provide an option more affordable and familiar than subsidized coverage in the Hawai'i Health Connector to lower income individuals;
- b. May reduce disruptions in coverage and "churn" in transitions between Medicaid and the Hawai'i Health Connector, although this effect is disputable;
- c. Likely to result in lower premiums in the individual market as those with higher morbidity, who are believed to have lower income and to be disproportionately eligible for the Basic Health Program, are removed from the individual non-group risk pool;
- d. Could result in increased federal funding and allow the State to treat legal aliens under 133% of FPL who are ineligible for Medicaid the same as US citizens at the same income level. (We are awaiting confirmation from DHHS that migrants under the Compacts of Free Association are eligible for premium tax credits and cost-sharing reductions);

-
- e. There is no risk of members owing money to the IRS at the end of the year due to differences and overestimates in advance premium tax credits (APTC) and final credits based on members' actual income;
 - f. Likely increased continuity of coverage for people transitioning from Medicaid to a Basic Health Program, assuming the Medicaid managed care delivery system is extended to the Basic Health Program;
 - g. The "cliff" or disparity between member premium and cost sharing in Medicaid and the Hawai'i Health Connector would be shifted from the 138% FPL threshold to the 200% FPL threshold;
 - h. May allow states to cover low-income parents and children together in similar plans and by the same provider networks (research shows greater retention of children covered in Medicaid and CHIP programs when a parent or sibling is also covered by public insurance);
 - i. Federal funds are based on premiums with underlying commercial reimbursement levels, which may lead to funds in excess of baseline costs (i.e. higher than Medicaid reimbursement levels) that could be used to increase provider reimbursement and/or cover additional services;
 - j. Potential for the states, as health coverage purchasers, to wield increased leverage with providers as the number of lives the states cover increases;
 - k. If CHIP authorization is not extended beyond 2015, the Basic Health Program provides states an opportunity to provide continued coverage to children in households up to 200% FPL (Hawaii currently covers children up to 300% FPL) with minimum service and care disruption;
 - l. The state has the flexibility to tailor the benefit plan of the Basic Health Program to meet the needs of the Basic Health Program population.
 - m. There is potential for the net cost of coverage in the Basic Health Program to decrease over time because of the differential between increases in Medicaid costs compared to those in the commercial market.

Risks:

- a. This analysis is based on estimates using the best available data but concerns of accuracy exist;
- b. Final regulations have not been released addressing items such as how payments to the State will be risk adjusted, settlement procedures, and other key details;
- c. Implementing a Basic Health Program would require the State to take on additional financial risk it otherwise would not be required to;
- d. There is the risk that federal subsidies for Basic Health Program will decrease;
- e. The Basic Health Program increases "churn", although this effect is disputable.
- f. If coverage via the Hawai'i Health Connector is viewed by the population who would be eligible for the Basic Health Program as being unaffordable, this population could remain uninsured despite the fiscal penalties;
- g. Establishing a Basic Health Program would decrease the number of people purchasing insurance through the Hawai'i Health Connector. This would result in the Hawaii Health

-
- Connector's fixed operating costs being spread over a smaller population, thus negatively affecting affordability for individuals and sustainability for the Connector;
- h. If the Hawai'i Health Connector were to consider selectively contracting with carriers to drive higher quality and lower costs, the Connector could lose some bargaining power if a Basic Health Program is established;
 - i. If commercial insurers effectively manage expenses in the individual market, this could lower the actuarial value of the benchmark benefits package and result in decreased revenue to the State for the Basic Health Program;
 - j. At least initially, commercial insurers could aggressively price their products in order to obtain a low cost Silver Level plan which would reduce the Federal subsidies to the Basic Health Program;
 - k. The State may be required to fund program start-up costs and lags in subsidy payments from the Federal government;
 - l. Funds received from the Federal government for Basic Health Program enrollees may not be used to cover costs associated with ongoing administration of the program; and
 - m. It is unknown at this time if the costs of administering the program would require a new general fund appropriation.

Recommendations

We recommend that the decision on whether to implement the Basic Health Program be deferred to the future for the following reasons:

- a. Federal administrative rules on the Basic Health Program do not exist;
- b. The U.S. Department of Health and Human Services expects to issue proposed rules on the Basic Health Program for comment in 2013 and final guidance in 2014. The program will be operational in 2015 for states interesting in the Basic Health Program option;
- c. In the absence of a Basic Health Program, individuals who would have been eligible for the program can instead receive sliding-scale premium tax credits and cost-sharing reduction for individual health insurance policies purchased through the Hawai'i Health Connector;
- d. It is advisable to wait and see how the market develops as the Patient Protection and Affordable Care Act is implemented and do an assessment of conditions and data in the future before deciding to implement a Basic Health Program; and
- e. The feasibility analysis of Oliver Wyman suggests that there is significant financial risk to the State of Hawaii in setting up a Basic Health Program at this time.

Conclusion

We do not recommend any legislation at this time to implement the Basic Health Program. The Basic Health Program remains worthy of consideration, but more information is needed. The target population between 138% FPL and 200% FPL can purchase subsidized health insurance through the Hawai'i Health Connector starting on January 1, 2014 and there is nothing that prohibits the State of Hawaii from establishing a Basic Health Program in the future. We should

await final federal regulations on the Basic Health Program and assess market developments as PPACA implementation proceeds.

APPENDIX A

“Analysis of the Basic Health Program Option”, Oliver Wyman Study