

# RESEARCH BRIEF

January 2012



## Evaluating the State Basic Health Program in Connecticut

The federal Patient Protection and Affordable Care Act (ACA) offers states many options and alternatives for tailoring national health reform to best meet their specific needs. The ACA's State Basic Health Program (SBHP) option affords states an opportunity to design a program for low-income individuals that offers better continuity of care at a lower cost, while providing a financial benefit to the state. This issue brief examines the factors that Connecticut should take into account in assessing the potential benefits of a SBHP. This analysis relies on the parameters of a SBHP as described in the ACA. The federal government has not yet issued key regulations – delineating, for example, what is the minimum benefits package that must be covered in a SBHP, or exactly how funds will flow to states – that will affect the potential cost and coverage of the SBHP option. The analysis presented here is based on existing information, acknowledging that the federal guidance may narrow the range of options available to the state.

### MAJOR CONCLUSIONS

- The State Basic Health Program (SBHP) option gives states an opportunity to provide rich health benefits to low income individuals at a cost that is both affordable to these individuals and cost neutral to the state.
- Connecticut policy makers must decide whether a SBHP will be part of the state's health insurance structure, and should consider this decision in conjunction with and in the same timeframe as design decisions about the state Exchange.
- The Legislature should make these decisions during the 2012 legislative session, to allow enough time to plan and implement the Exchange and SBHP by January 2014.




## What is the State Basic Health Program?

Under the ACA, low income individuals will receive federal tax credits to help them purchase health insurance through a Health Insurance Exchange. The SBHP option allows states to choose to establish a state program, similar to Medicaid, for certain low-income, uninsured individuals. If the state opts to establish a SBHP, the federal government will send the funds it would have used to subsidize individual premiums and out-of-pocket expenses directly to the state, and the state will use these funds to pay for health benefits.

Eligibility to participate in the SBHP is limited to state residents under age 65, with household incomes between 133 and 200 percent of the federal poverty level (FPL)<sup>1</sup>, who are not eligible for Medicaid or for affordable employer-sponsored insurance. Legal immigrants with household incomes below 133 percent FPL are also eligible for the SBHP, if they are also under age 65 and are not eligible for Medicaid or for affordable employer-sponsored insurance.

If a state chooses to implement a SBHP, individuals eligible to participate in the SBHP could not receive federal health insurance subsidies directly; eligible individuals would receive subsidized care only through the SBHP. SBHPs are required to provide at least the federal “essential health benefits” and to keep individuals’ premium contributions and out-of-pocket costs low.<sup>2</sup> State SBHPs must also include components such as “care coordination and care management for enrollees, especially for those with chronic health conditions,” incentives for use of preventive services and patient-involvement in health care decision-making, and performance measures for quality of care and improved health outcomes.

The SBHP option offers a number of potential benefits to eligible individuals and provides states enough flexibility to implement a SBHP that is cost-neutral to the state.



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## Benefits to individuals

### The state could design a SBHP to provide more coordinated care at a lower cost to eligible individuals:

- Compared with coverage purchased through an Exchange, a SBHP can require lower out-of-pocket contributions or forgo such contributions altogether and can provide access to a richer benefit package with patient-centered features.
- A SBHP can offer a provider network and benefits that are more consistent with Medicaid than private plans purchased through the Exchange. A recent study estimated that within one year, 50 percent of adults with family incomes below 200 percent of FPL will shift between eligibility for Medicaid and eligibility for subsidized insurance.<sup>3</sup> A SBHP could offer continuity of care for these individuals.
- Many adults who are eligible for the SBHP will have children enrolled in HUSKY A or B; a SBHP could offer these families access to the same network of providers.
- A SBHP could align Medicaid and SBHP eligibility screening and enrollment to help individuals avoid periods with no coverage.
- An individual who purchases insurance through the Exchange may receive a monthly advance of the premium tax credit, but the final credit is calculated when the person files an annual tax return. If advances exceed the total credit, for example because of fluctuations in household income, the person will owe the overpayment to the IRS. The SBHP would avoid this scenario.

## Benefits to the state

### Implementing a SBHP could also benefit the state of Connecticut:

- Some populations eligible for the SBHP, such as HUSKY parents with family incomes 133-185 percent FPL, currently are enrolled in the state Medicaid program; the state pays 50 percent of the cost of this care and the federal government pays the remaining 50 percent. If the state moves these individuals into a SBHP, the enrollees could receive the same or very similar benefits, with the federal subsidy replacing much or all of the state's contribution. This change would produce substantial savings to the state budget.
- If the state uses the same eligibility and enrollment systems for Medicaid and SBHP, it could spread administrative costs over more enrollees and potentially realize economies of scale. The state could also provide for seamless transitions between Medicaid and the SBHP, thus saving the administrative costs associated with reopening recently closed cases.

## How Should Connecticut Assess the SBHP Option?

This section presents the factors the state should consider in evaluating the potential benefits and costs of a SBHP. We do not present rigorous estimates of the benefits and costs, because our main finding is that the state has a number of policy options it can exercise to affect those very estimates. It is our conclusion that the state has sufficient latitude within these options to implement a SBHP model that is budget neutral or requires a sustainable level of state funds.

The size and attendant costs, and therefore the attractiveness, of a SBHP are a function of three major factors: enrollment, cost per enrollee, and federal revenue per enrollee. The following three tables present a framework for considering these factors and suggest a likely range of values based on a variety of sources.



### Enrollment

Probable enrollees in a SBHP include currently uninsured adults in the income eligibility range who do not have access to affordable employer-sponsored coverage, adults who now purchase coverage in the individual market for whom the SBHP might provide better benefits at lower cost, and legal immigrants who would otherwise be eligible for Medicaid but have been in the United States for less than five years. Not every individual who is eligible for the SBHP will enroll. The figures presented in Table 1 provide a rough estimate of the numbers of individuals who may be eligible to enroll in a SBHP in Connecticut.

The state might also choose to change its Medicaid eligibility rules in order to move all or part of its adult Medicaid population with incomes above 133 percent of FPL to the SBHP, which would increase the enrollment estimate in Table 1.<sup>4</sup> For example, the state could restrict Medicaid eligibility for parents of children in HUSKY to 133 percent of FPL, while continuing eligibility at higher incomes for pregnant women and Medicaid for Employed People with Disabilities.<sup>5</sup> This is one policy lever the state has at its disposal.

**Table 1. Individuals Potentially Eligible to Enroll in SBHP**

| Eligible to Enroll in SBHP   | Source of Estimate  | Estimate*     |
|--|---|---------------|
| Uninsured adults, 133-200% FPL   | Kaiser Family Foundation, <a href="http://www.statehealthfacts.org">www.statehealthfacts.org</a> : 61,000 uninsured adults, 139-200% FPL, 2008-09                                       | 61,000        |
| LESS uninsured adults with access to affordable employer-sponsored insurance (ESI), 133-200% FPL | 61,000 uninsured (Kaiser Family Foundation) x 14% of uninsured with access to ESI (CT Office of Health Care Access 2006 Household Survey)   | (9,000)       |
| Adults who currently purchase individual coverage, 133-200% FPL                                  | Kaiser Family Foundation, <a href="http://www.statehealthfacts.org">www.statehealthfacts.org</a> : 13,000 adults with individual insurance coverage, 139-200% FPL, 2008-09              | 13,000        |
| Legal immigrants ineligible for Medicaid, 0-133% FPL   | 26,000 legal immigrants enrolled in Massachusetts CommonwealthCare Plan (similar to SBHP); x estimated 60% with incomes 0-133% FPL; x 53% (3.4 m. CT population / 6.5 m. MA population) | 9,000         |
| <b>Total potentially eligible</b>  |   | <b>74,000</b> |

\*Likely to be higher in 2014.

## Cost

A state’s decision about whether to adopt a SBHP might center on the extent to which the federal subsidies that are available will cover the expected costs of delivering care to the SBHP population. Because the SBHP is a public program, if federal subsidies and other revenue do not cover costs, the state will have to modify the program or provide state funds to make up the difference.

Cost per enrollee is the first part of this equation. Table 2 shows a range of plausible estimates for the costs of care that Connecticut might expect for enrollees in a SBHP.

As with enrollment, the state has a number of policy levers available to manage the cost of a SBHP. It can

continue Medicaid eligibility for HUSKY parents up to 185 percent of FPL, rather than moving them to a SBHP. It can continue the Medicaid for Employed People with Disabilities program, which would reduce the number of people with disabilities in the SBHP, and thus the average cost, while allowing people with disabilities continued access to the long-term services and supports available under Medicaid. The state can also adjust the optional benefits included in the SBHP (beyond the federally mandated “essential health benefits”), the rates paid by the SBHP, and the providers included in the SBHP provider network or the health plans with which the SBHP contracts.

**Table 2. Range of Cost Estimates per Enrollee in 2014**

| Dollar Estimate   | \$4100  | \$3500 - \$4900  | \$4700   | \$5300  | \$7400   |
|---|---|--|--|---|--|
| <b>Basis of Estimate</b>  | National average Medicaid expenditures for PPACA expansion population, 0-133% FPL   | Mercer SBHP estimate for Connecticut Exchange Board  | HUSKY parents, 133-185% FPL  | Massachusetts Commonwealth Care, Adults, 100-200% FPL   | Massachusetts Medicaid, Adults, 133-200% FPL (includes disabled and long-term unemployed individuals, does not include individuals enrolled in a private managed care plan)  |
| <b>Calculation of Estimate</b><br><i>Mathematical method used to derive the estimate</i>                          | Projected cost of new Medicaid enrollees under PPACA in 2014 (CMS) x 103% (CT Medicaid spending per non-disabled enrollee / US average Medicaid spending per non-disabled enrollee)                     | Mercer estimate based on provider reimbursement relativities:<br><ul style="list-style-type: none"> <li>■ DPH hospital reports</li> <li>■ Mercer Medicaid physician encounter studies</li> <li>■ CT commercial carrier survey</li> </ul> Mercer assumed higher morbidity below 200% FPL. | OFA based its estimate on actual DSS cost and caseload data for the adult 133-185% population, inflated at a 5% annual rate to 2014.   | Weighted average cost incurred (including costs incurred but not yet received) by 4 Managed Care Organizations, Plan Type 2, in FY2010. Inflated to 2014 using projected increases in national health expenditures per capita x 98% (CT Medicaid spending per enrollee / MA Medicaid spending per enrollee) | Weighted average cost per Medicaid recipient, FY 2010. Inflated to 2014 using projected increases in national health expenditures per capita x 98% (CT Medicaid spending per enrollee / MA Medicaid spending per enrollee)               |
| <b>Comparability of Estimate</b><br><i>Explanations of how estimates differ and may not be exactly comparable</i> | National average, not Connecticut specific. Lower income enrollees tend to be more expensive than higher income. Disabled enrollees are not included in this projection, but may be included in a SBHP. | CT specific estimate. Range reflects a range of enrollee cost sharing requirements.<br><br>Cost estimate depends on SBHP covered benefits and on enrollees’ health status.   | CT could change Medicaid eligibility rules so that these individuals would be eligible to participate in the SBHP, presumably at an equivalent cost. OFA estimated that other SBHP enrollees’ costs would be approximately 25% higher than HUSKY parents’ costs. | Commonwealth Care is a MA subsidized health insurance program, in which eligible individuals enroll in a managed care plan through a state Exchange.  | Because individuals with disabilities can qualify for MA Medicaid, this program likely includes a higher proportion of individuals with disabilities – and high health care costs – than a Basic Health Plan would.                      |
| <b>Data Sources</b>   | CMS Actuarial Report 2010; Kaiser Family Foundation statehealthfacts.org  | Mercer presentation to Connecticut Health Insurance Exchange Board Meeting, December 15, 2011  | CT Office of Fiscal Affairs (OFA), citing DSS  | Massachusetts Medicaid Managed Care Organization 4B reports, FY2010 year end Inflated using projected growth in National Health Expenditures per capita, 2010-2014, CMS. Kaiser Family Foundation statehealthfacts.org  | Massachusetts Medicaid claims data; expenditures by plan type, aid category and member income. Inflated using projected growth in National Health Expenditures per capita, 2010-2014, CMS. Kaiser Family Foundation statehealthfacts.org |



## Revenue

Revenues must compare favorably with costs for the state to proceed with implementing a SBHP. The state will receive federal revenues equivalent to 95 percent of the premium tax credits and cost sharing subsidies enrollees would receive if purchasing coverage through the Exchange. The federal subsidies will be calculated based on the age, income, health status, and geographic location of the enrolled population.

The state can also require enrollees to pay a portion of the premiums and/or can include copayments and deductibles in the benefit design. The ACA allows states to set enrollee contributions as low as zero, and as high as reference amounts for coverage through the Exchange. For example, the state could require a single individual with income at 150 percent of FPL to contribute an amount between \$0 and \$1200 per year toward the cost of the SBHP.<sup>6</sup>

**Table 3. Estimates of Federal Revenue per Enrollee, 2014**

| Basis of Estimate  | Connecticut<br>average small employer group  | National Average  | Massachusetts<br>Commonwealth Choice Plan                                   |
|--|--|---|---|
| Reference Premium:<br>2nd lowest silver plan<br>premium in 2014* | \$5400   | \$4700  | \$6500  |
| Premium subsidy**  | \$4100   | \$3700  | \$5300  |
| Cost-sharing subsidy***  | \$1100   | \$ 700  | \$1600  |
| Total subsidy  | \$5200   | \$4400  | \$6900  |
| Adjust to Connecticut<br>spending levels                         | NA   | x 120% (CT health spending<br>per capita / US health spend-<br>ing per capita)  | x 95% (CT health spending<br>per capita / MA health<br>spending per capita) |
| Total estimated federal<br>revenue per enrollee                  | <b>\$5200****</b>  | <b>\$5300****</b>   | <b>\$6600****</b>   |
| Data sources   | Mercer presentation to<br>Connecticut Health Insurance<br>Exchange Board Meeting,<br>December 15, 2011 | Congressional Budget Office,<br>December, 2010<br>Kaiser Family Foundation<br>statehealthfacts.org<br>Deflated from 2016 estimates<br>using projected growth in<br>National Health Expenditures<br>per capita, 2014-2016, CMS | Milliman, April 2011<br>Kaiser Family Foundation<br>statehealthfacts.org    |

\*A silver plan must cover 70 percent of the average costs of "essential health benefits."

\*\*Premium subsidy is the difference between the reference premium and what someone would be expected to pay toward that premium in the Exchange (e.g. 2% of income at 133% of FPL, 4% of income at 150% of FPL, 6.3% of income at 200% FPL).

\*\*\*Cost-sharing subsidy serves to limit deductible and copayment expenses to what they would be in a platinum plan (6% of benefit costs for income up to 150% FPL) or a gold plan (13% of benefit costs for income between 151% and 200% FPL).

\*\*\*\*Rounded to nearest \$100

## Summary

The cost of a SBHP and the revenue received will vary based on a number of factors including the health care needs of the individuals enrolled, the covered benefits, and payments to providers, as well as revenues received from the federal government and enrollees. The state has a number of levers it can use to “slide” the actual program cost and revenue up and down along these axes, as illustrated by Figure 1.

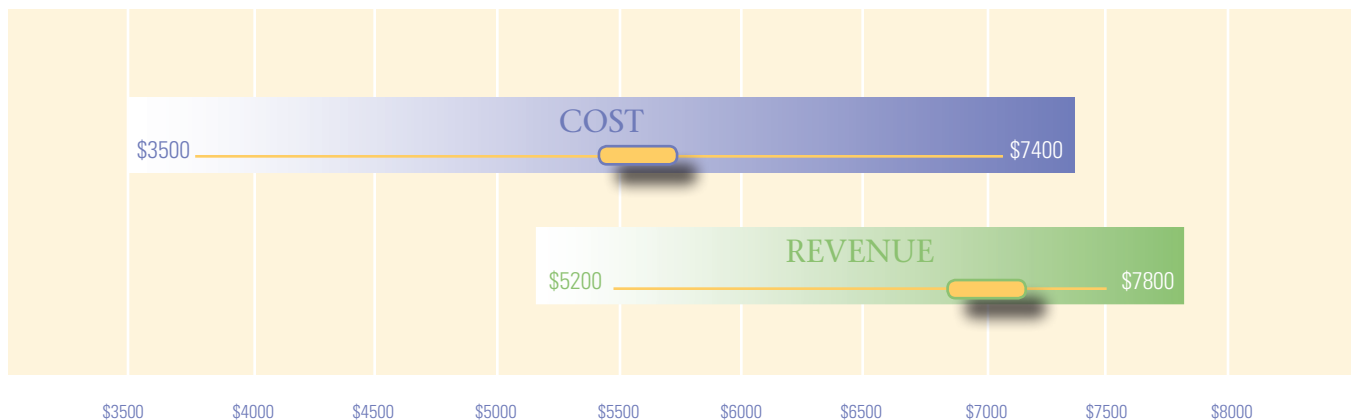
One important policy guideline should be that groups of people who currently have other sources of coverage should not be made worse off by the creation of a SBHP. This guideline would be most relevant in determining how to cover adults with family income over 133 percent of FPL who are now covered by HUSKY. In this case, the overriding policy goal could be to maintain the benefits

this population now has through HUSKY, but to determine how to achieve this in a way that is most beneficial to the individuals and the state. Options include:

- Maintaining this group in HUSKY with no changes;
- Designing the SBHP with the same or equivalent benefits and changing HUSKY rules to restrict eligibility for parents to 133 percent of FPL and below; or
- Providing additional state-funded subsidies for coverage purchased through the Exchange, calibrated so that parents in this income range could attain the same coverage at the same costs as they do in HUSKY.

Policy makers and other stakeholders should weigh the relative costs and benefits of these options.

**Figure 1. Range of SBHP Cost and Revenue Estimates per Enrollee**



## Conclusion

The SBHP option gives states an opportunity to provide rich health care benefits to low-income individuals at a cost that is both affordable to these individuals and cost neutral to the state. Connecticut policy makers must decide whether a SBHP will be part of the state’s health insurance structure, and should consider this decision in conjunction with and in the same timeframe as design decisions about the state Exchange. The Legislature should strive to make these decisions during the 2012 session, to allow enough time to plan and implement the Exchange and SBHP by January 2014.

The SBHP legislation could require that the Department of Social Services (DSS) design the program so that enrollee benefits and cost-sharing requirements are as similar to Medicaid as possible, while making the program cost-neutral to the state. Establishing these parameters will require careful analysis and important decisions about who should be eligible for SBHP and HUSKY, the costs and revenues associated with different alignments, what benefits to include and how to provide them. The analysis should incorporate an evaluation of federal regulations as they are issued.

44 Capitol Avenue, Suite 301  
Hartford, CT 06106

860.278.5688  
www.larcc.org

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Researchers/Authors:

Katharine London  
Robert W. Seifert  
Principal Associates  
Center for Health Law and Economics  
University of Massachusetts Medical School



## References

Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, U.S. Department of Health and Human Services; 2010 Actuarial Report on the Financial Outlook for Medicaid; Figure 5: Past and Projected Medicaid Expenditures on Medical Assistance Payments per Enrollee, by Enrollment Category, FY200-FY2019; p. 26.

Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, U.S. Department of Health and Human Services; <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>; Table 1: National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2005-2020; data posted as of September 29, 2011.

Congressional Budget Office (CBO), "Selected Publications Related to Health Care Legislation, 2009-2010," December, 2010; Table 2: Analysis of Exchange Subsidies and Enrollee Payments in 2016 under the Patient Protection and Affordable Care Act, p. 221.

Connecticut Office of Fiscal Analysis (OFA), OFA Fiscal Note SB-1204: An Act Establishing the Connecticut Health Insurance Exchange. May 2011.

Dorn, Stan, "Serious Errors in the OFA Fiscal Note for HB 6305: Responding to the Office of Fiscal Analysis Conclusions," prepared for the Universal Health Care Foundation of Connecticut, April 5, 2011.

Enthoven, Alain, W. Kramer, D. Riemer, and J. Minarik, Making Exchanges Work in Health Reform (Washington, D.C.: Committee for

Economic Development 2009). Available at [http://www.ced.org/images/library/reports/health\\_care/exchangememohc09.pdf](http://www.ced.org/images/library/reports/health_care/exchangememohc09.pdf).

Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org). Data posted as of September 12, 2011.

Mercer, presentation to Connecticut Health Exchange Board Meeting, December 15, 2011, slides 53-70.

Palmer, Jeremy; Milliman Healthcare Reform Briefing Paper, "Healthcare Reform and the Basic Health Plan Option: Modeling Financial Feasibility," Milliman, April, 2011.

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

## Notes

1 Between \$24,645 and \$37,060 for a family of three in 2011.

2 The CMS Center for Consumer Information and Insurance Oversight (CCIIO) issued an Essential Health Benefits Bulletin on December 16, 2011 soliciting comments on a plan that would direct each state to select a "benchmark plan [that] would serve as a reference plan, reflecting both the scope of services and any limits" on essential health benefits. This benchmark will affect SBHP cost and revenues.

3 Sommers and Rosenbaum, 2011.

4 The ACA requires "maintenance of effort" on Medicaid eligibility rules for adults, but only until a state's Exchange is operational, which will most likely be in January 2014.

5 Analyses of the Basic Health Program opportunity in Connecticut have variously estimated the number of HUSKY parents in this income range as 15,000 (Dorn) and 31,000 (Connecticut Office of Fiscal Analysis)

6 2014 dollars. Premium contributions for an individual at 150% FPL can be up to 4 percent of income, or \$756 in 2014 (2011 amount inflated by 5 percent per year). Cost sharing may be the equivalent to the cost sharing required in a Platinum plan purchased in the Exchange, or 6 percent of benefit costs for someone at 150% FPL. Based on the cost estimates in Table 2, that is a range of \$256 to \$444 per year.