

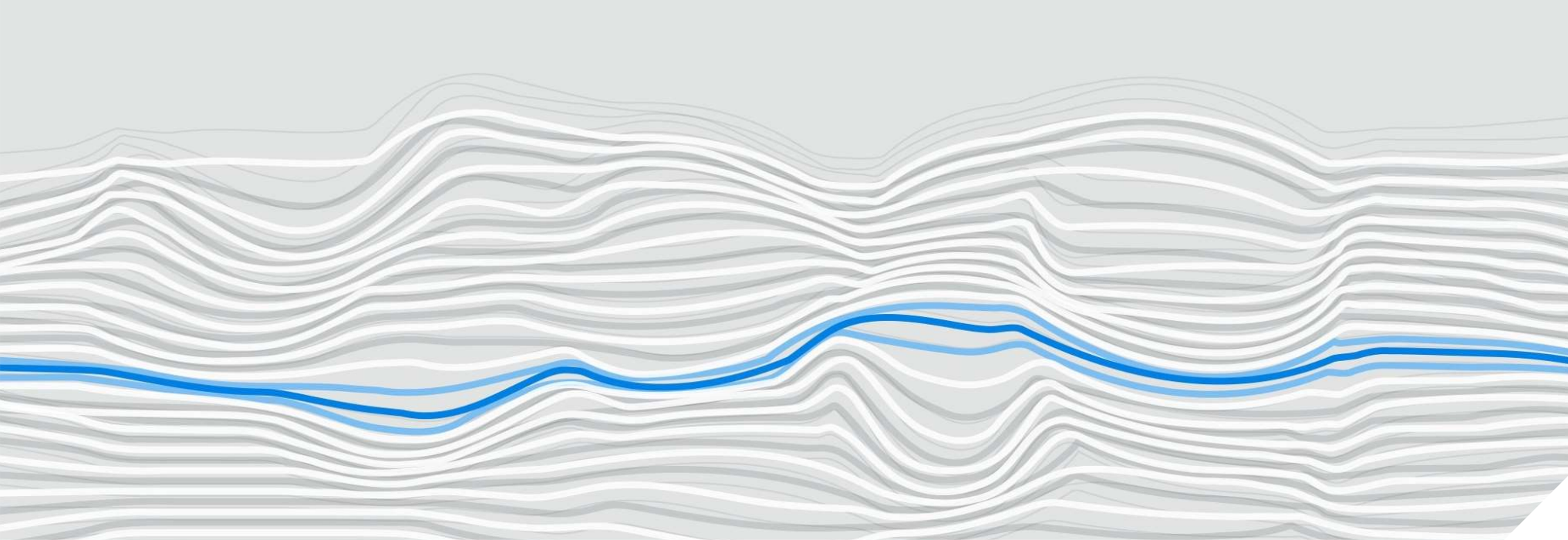


Basic Health Program Overview

Commonwealth of Kentucky, Department for Medicaid Services

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Agenda

Introduction/Background

- Overview and potential goals of the Basic Health Program
- Current market dynamics
- Premium subsidy value trends

Data Analysis

- BHP financial feasibility analysis
- Key considerations that could impact state cost
- American Rescue Plan impacts

Policy Discussion

- Churn considerations
- BHP policy decisions and Blueprint requirements

Open Discussion

Introduction / Background

BHP Overview

- Health benefits coverage program created by the ACA to cover low-income individuals through state-contracted plans (as an alternative to the Exchange)
- States can provide affordable coverage for individuals with income just above Medicaid limit
- States receive approximately 95% of what recipients would have received in Exchange subsidies to fund cost of premiums and benefits (administration cannot be funded with these dollars)

Eligibility

- Adults under age 65 with incomes 139-200% Federal Poverty Level (FPL)*
- Otherwise qualify for subsidies in the Marketplace
- Not eligible for “affordable” insurance through employer
- Must be citizens/lawfully present in U.S.

*Documented immigrants with incomes under 139% FPL are also eligible, provided they meet other conditions

Sources

1. <https://www.medicaid.gov/basic-health-program/index.html>
2. <https://www.kff.org/health-reform/report/the-acas-basic-health-program-option-federal-requirements-and-state-trade-offs/>

Where could the Basic Health Program fit?

Basic Health Program (BHP) as potential “bridge insurance program”

MEDICAID
Adults 0-138% FPL
(children and pregnant women eligible up to higher FPLs)
No-cost or low-cost coverage (copays may apply)

EXCHANGE
Individual plans for the uninsured who cannot get Medicaid/Medicare
Enrollee pays premiums, copays, and coinsurance
Subsidies available from 139-400% FPL (higher incomes pay full price)

Note: persons with access to “affordable” employer-sponsored insurance are not eligible for exchange subsidies or BHP coverage

BASIC HEALTH PROGRAM

Individual plans for uninsured adults who cannot get Medicaid/Medicare
139-200% FPL

Goal is lower cost for enrollees than they could get with Exchange plans

Possible Policy Goals

Why choose to offer a BHP?

Cost

- More affordable coverage for consumers
- Low funding commitment required by state
- Ability to leverage existing state infrastructure for administrative efficiency

Quality

- Increased coverage levels
- Increased access to and competition among plans
- Concerns about churn between Exchange and Medicaid

State design

- Flexibility to design benefit package, cost-sharing, and other program requirements to best suit a state's goals

Some of these benefits could also be obtained through alternate coverage expansion options. This analysis focuses on potential impacts of a BHP rather than all possible policy choices.

Sources

1. <http://www.statecoverage.org/files/TheBasicHealthProgramOptionUnderHealthReform.pdf>

2. <https://www.macpac.gov/wp-content/uploads/2020/04/Medicaid-Buy-In-Program-Options-and-Considerations.pdf>

Other States' Experience with BHP

- Today only two states, New York and Minnesota, offer a BHP

Minnesota

- Sliding scale premiums based on income
 - Single benefit package
- Richer benefits than some Exchange plans, including dental and vision
- Joint procurement for Medicaid and BHP (same carriers must offer both)

Operating since 2015

New York

- Four benefit plans/cost sharing levels based on income (no cost if below 150% FPL)
- Enrollees can pay full cost to add dental/vision
 - Most participating carriers choose to offer Medicaid, BHP, and Exchange plans

Operating since 2016

Both states were able to leverage existing state-funded programs for BHP implementation

Data Sources

- <http://www.communityplans.net/wp-content/uploads/2017/01/The-Basic-Health-Program-New-York-and-Minnesota.pdf>
- <http://files.kff.org/attachment/Issue-Brief-Improving-the-Affordability-of-Coverage-through-the-Basic-Health-Program-in-Minnesota-and-New-York>

Market Dynamics Impacting BHP

Why has BHP not been adopted by other states?



Timing

Many states had already established their Exchange policies



Individual market impact

Decrease in individual market coverage could result in material shift in cost and premiums



Balancing funding with cost

BHP funding is tied to Exchange subsidies; Individual market premiums were below cost from 2014 through 2016



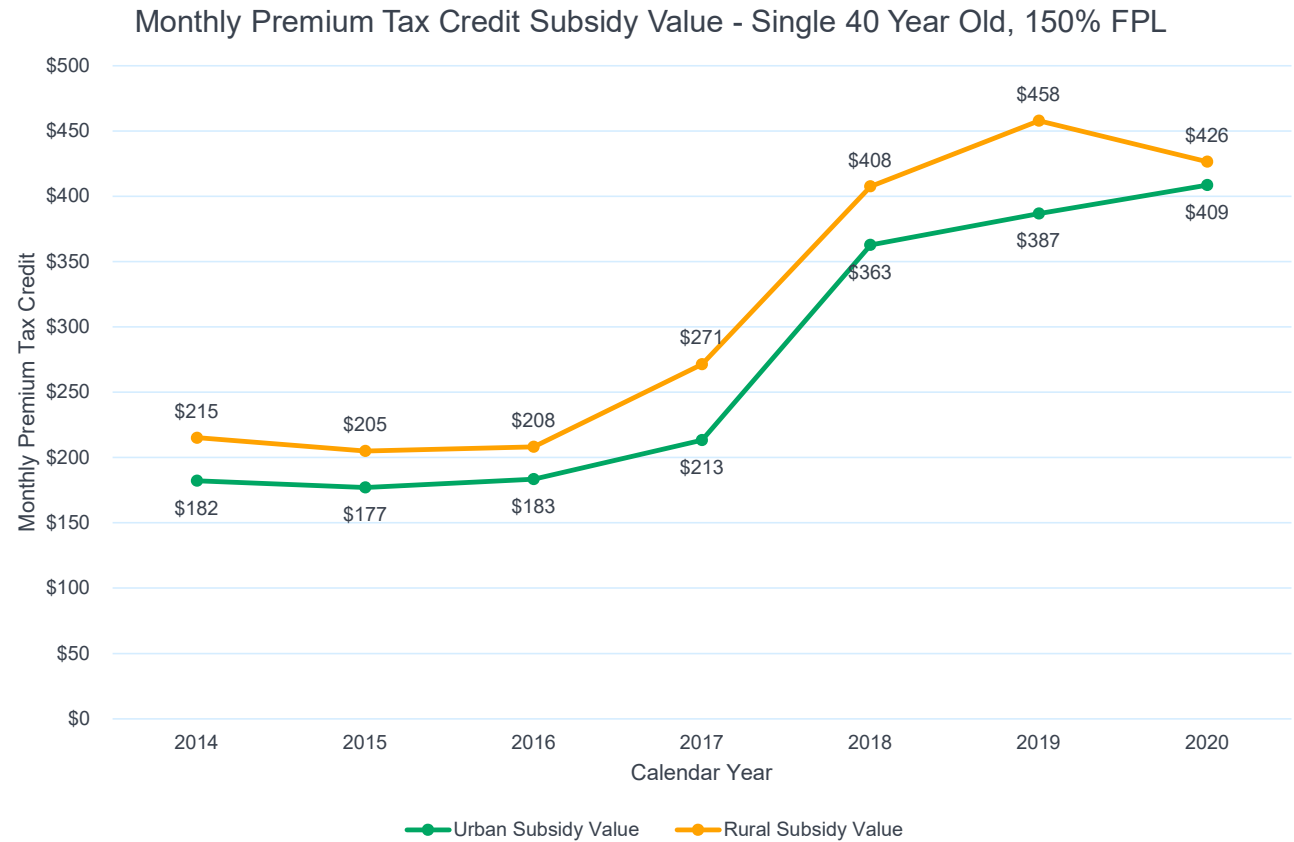
Long-term BHP uncertainty

Concern about ACA market changes 2017 through 2020 driven by changes in federal administration

BHP (and other options, like Medicaid buy-in) have been discussed more recently in several states

Kentucky Exchange Premium Subsidy Value Trends

- As Exchange premiums increased significantly beginning in 2017, premium subsidy values more than doubled for many BHP-eligible enrollees
- Premium subsidy increase partially attributable to CSR loading that began in 2018



Data Sources:

1. <https://www.soa.org/globalassets/assets/files/resources/research-report/2020/50-states-50-stories-dataset.xlsx>
2. <https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references>

AUGUST 3, 2021

BHP Data Analysis

Key Themes from Discussions with DMS

DMS outlined the Commonwealth's desired policy goals to be used as guardrails for this analysis

All citizens can obtain affordable coverage to best suit their needs

- Income-based premiums and low cost-sharing
- Easy to enroll and simple to understand benefits
- Minimize the impact of churn and gaps in coverage

Consider coverage options as a spectrum

- BHP as a “stepped” option between Medicaid and Exchange or private coverage

State-led program design and management

- Ability to customize program to fit needs of Kentuckians
- Align with other program management where possible

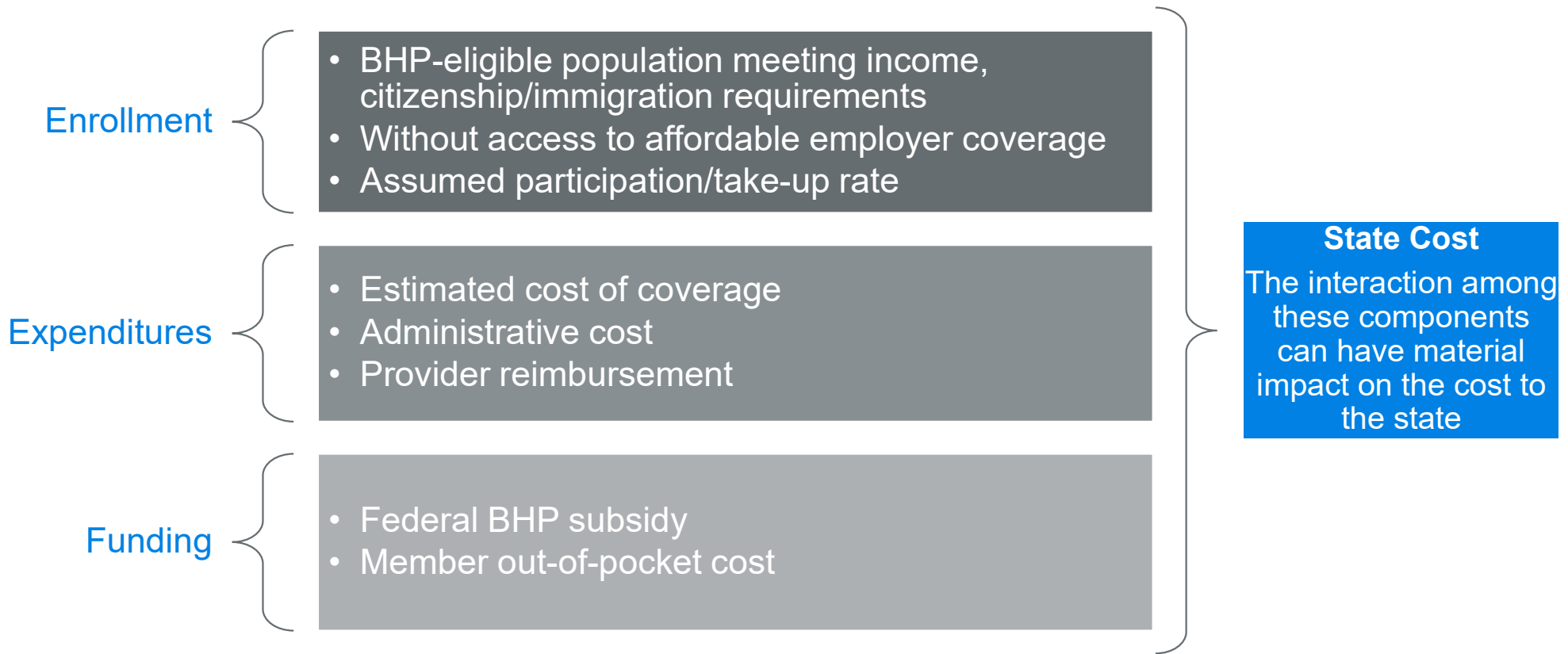
Ease participation burdens for providers

- Simple program design and sufficient payment rates
- Minimize need to collect copays

Low administration costs for state

- Leverage investments like the state-based Exchange
- Funding options other than state dollars

Key Components of Financial Feasibility Analysis



BHP Financial Feasibility Analysis

Overview of Best Estimate Results – without American Rescue Plan (ARP) provisions

Component	2022 Best Estimate	Key Assumptions/Notes
▶ Projected Enrollment	37,300	Approximately 75% enrollment of eligible population, 40% previously uninsured
▶ Projected Cost of Coverage (\$ millions)	\$238.9	Provider reimbursement at 110% of base Medicaid reimbursement levels for medical benefit expense component of estimated costs (excluding pharmacy)
▶ Projected BHP Funding (\$ millions)	\$232.2	Based on approximately 95% of exchange premium subsidies enrollees would receive in absence of BHP
▶ Projected Member Out-of-Pocket Cost (\$ millions)	\$33.0	Total enrollee out-of-pocket cost (premium and cost sharing) estimated at approximately 14% of total cost
▶ Available Additional Funds (\$ millions)	\$26.3	State margin estimated at 11% of total cost of coverage. Available additional funds may be used to increase provider reimbursement, reduce enrollee cost, or enhance other areas of the benefit plan

- Under our best estimate assumptions for the premium and cost-sharing designs modeled in the analysis, there appears to be sufficient funding from the federal government and member out-of-pocket contributions to cover the projected cost of healthcare coverage in the BHP.
- A range of potential outcomes could impact the key components of the feasibility analysis and have material impact on the estimated state margin.

BHP Financial Feasibility

Member Cost Sharing Assumptions – without ARP provisions

Cost Sharing Plan Designs		
Service Category	Enrollees < 150% FPL	Enrollees 150%-200% FPL
Emergency Room Services	\$ 75	\$ 75
All IP Hosp (inc. MH/SUD)	\$ 150	\$ 250
PCP (exc. Well Baby, Prev., X-rays)	\$ 10	\$ 25
Specialist Visit	\$ 20	\$ 25
MH/SA	\$ 20	\$ 0
Imaging (CT/PET Scans, MRIs)	\$ 50	\$ 40
Rehabilitative ST	\$ 20	\$ 25
PT/OT	\$ 20	\$ 25
Lab OP and Prof Services	\$ 0	\$ 25
X-rays and Diagnostic Imaging	\$ 0	\$ 40
OP Facility (e.g., ASC)	\$ 75	\$ 100
OP Surg Phys/Surg Services	\$ 0	\$ 0
Generics	\$ 10	\$ 7
Preferred Brand Drugs	\$ 20	\$ 25
No Deductible		
Benchmark Plan	94% Actuarial Value	Minnesota BHP Plan Design
Member Premium	\$10/month	\$25/month

- Before the ARP, the 2021 silver plan monthly out-of-pocket premium for a 40-year old non-smoker single coverage ranges from \$52 to \$139 for an income range of 139% to 200% FPL
- Individuals within the 139% to 200% income range are eligible for silver coverage with either 94% actuarial value (AV) or 87% AV, depending on income level

Source: <https://www.kff.org/interactive/subsidy-calculator-2021-before-covid-relief/>

Notes:

- Estimated 94% Actuarial Value (AV) calculated using federal Actuarial Value (AV) Calculator.
- MN Plan: the state's consulting actuary used actual population experience to determine a 94% AV, as MN operated MinnesotaCare prior to BHP implementation.
- The 94% AV plan provides an illustrative plan design option.
- In general, we expect the member cost share to be around (100 minus AV)% of cost; however, the actual member cost share portion will vary to the extent actual utilization of services is different from the data underlying the AV calculator.

Key considerations that could impact state cost



BHP plan design

Key components include benefit coverage and member out-of-pocket cost (premiums and benefit cost sharing)



Individual market premiums

Greater level of BHP funding may exist in rating areas with higher premium rates, while the potential for increased market competition could drive down individual market premiums



Provider reimbursement

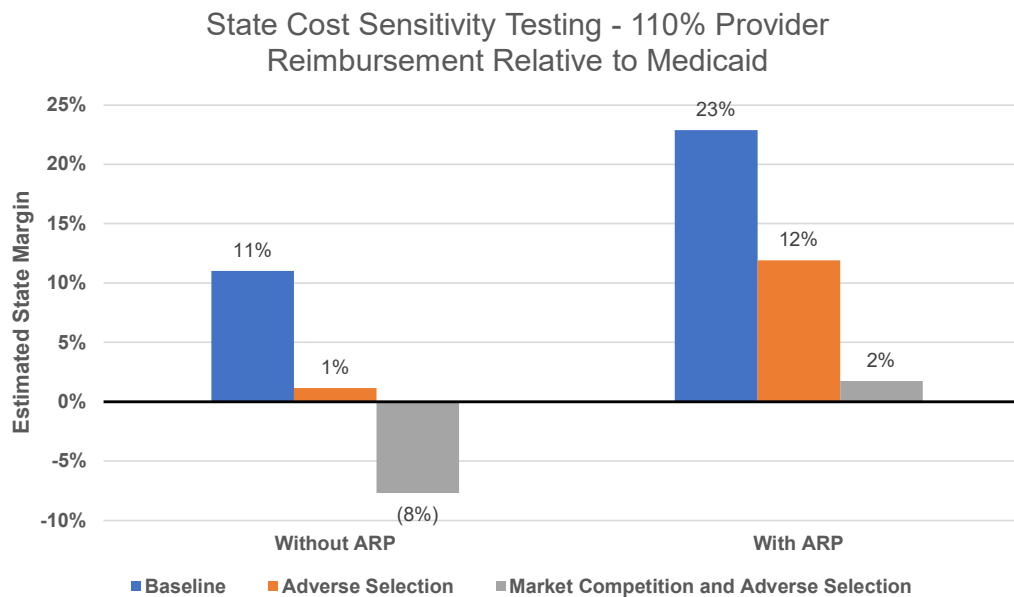
Based on review of CY 2019 experience, Medicaid reimbursement ranges from approximately 25-50% lower than estimated underlying Exchange reimbursement (approximately 40% statewide composite)



Health of enrolled population

The frequency and severity of healthcare services utilized by the covered population could impact the total cost of coverage. The BHP plan design can be a driver of member selection of BHP coverage.

BHP Financial Feasibility – Sensitivity Testing



American Rescue Plan

- Under the ARP provisions, the 2021 silver plan monthly out-of-pocket premium for a 40-year old non-smoker single coverage ranges from \$0 to \$43 for an income range of 139% to 200% FPL (previously \$52 to \$139)
- BHP funding increases with ARP subsidy increase
- Member premiums reduced to \$0 <175% FPL, \$15 >175% FPL

Source: <https://www.kff.org/interactive/subsidy-calculator/>

If “Best Estimate” assumptions materialize, there may be sufficient margin to consider increases to provider reimbursement or other benefit plan enhancements.

- Adverse Selection Scenario: 10% higher per capita BHP cost than baseline estimates
- Market Competition: the potential for increased market competition could drive down individual market premiums (and PTCs) and result in a decrease to federal BHP funding
- Note: Each 1% of margin is worth approximately \$2.5 million

Policy Discussion

Drivers and Consequences of Churn

- “Churn” is defined as a transition between different types of coverage and/or becoming uninsured
- Low-income individuals are more at risk of churn due to frequent or seasonal income fluctuations
- Churn can also be driven by administrative complications in enrollment and renewal processes and/or affordability issues
- Churn can result in disrupted care plans and increased costs

Sources

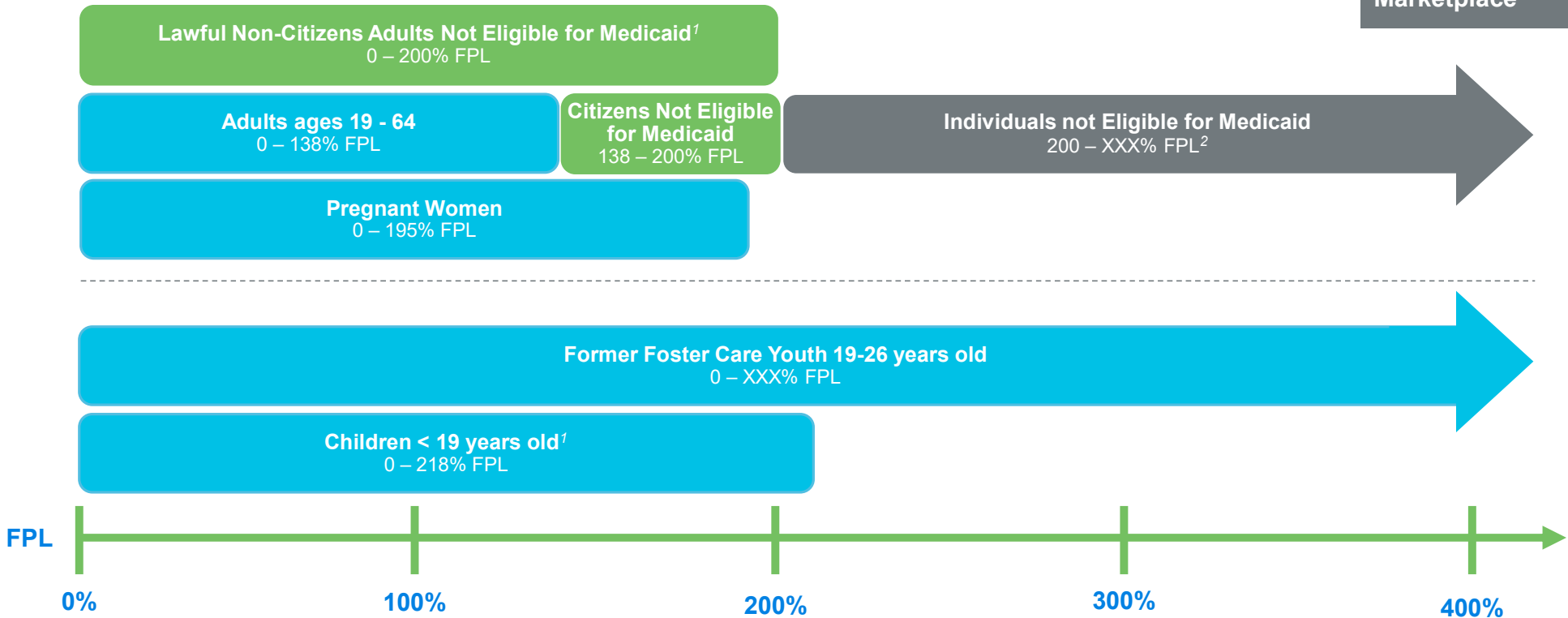
1. https://www.communitycatalyst.org/resources/publications/document/Health-Insurance-Churn-November-2016_FINAL.pdf
2. <https://www.commonwealthfund.org/publications/journal-article/2016/oct/insurance-churning-rates-low-income-adults-under-health>
3. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00378?journalCode=hlthaff>

- 2015 study: **1 out of 4** low-income survey respondents **changed health coverage at least once during the year**. Nearly 20% of those were uninsured and gained new coverage. Three most common reasons for churn (other than newly-insured):
 - Job-related insurance changes
 - Loss of eligibility for Medicaid or Exchange subsidies
 - Inability to afford a previous plan
- 2020 study: Medicaid coverage disruptions and coverage loss **declined by 4.3%** in states that expanded Medicaid

Future Churn Potential in Kentucky

Consider overlapping population groups to inform eligibility coordination policies

Medicaid*
BHP
Marketplace



¹Lawful non-citizen adults may apply for Medicaid after a 5-year waiting period. KY waives the waiting period for non-citizen children.

²Marketplace subsidy eligibility adjusted for Kentucky Medicaid Expansion & BHP eligibility.

Also note: Senior care and aged, blind, and disabled Medicaid coverage options not addressed.

Size of bars are not to scale as compared to each other – goal of chart is to show overlaps, not scale

BHP Policy options

Mitigating the impact of different churn types

Coverage Gaps

- Continuous enrollment (annual income recertification)
- Permit year-round enrollment
- Grace periods for non-payment

Transitions between coverage types

- Coordination of eligibility and enrollment systems
- Commonality of carriers across programs (Medicaid/BHP/Exchange)
- Simplicity of plan design

Solutions for Both

- Independent assisters
- Carrier outreach requirements
- Proactive outreach at 60/90 days prior to known transition points

Consider additional coordination strategies:

- Require Medicaid plans to become BHP carriers
- Permit (or require) Exchange carriers to offer BHP plans
- Promote parents selecting the same carrier where Medicaid-enrolled children are enrolled
- Default BHP enrollment for children < 200% FPL aging out of Medicaid
- “Easy Enrollment” where consumers are auto-enrolled based on tax return (Maryland model)

BHP Blueprint Process

Required form for states to operate a Basic Health Program

- The Blueprint addresses a variety of topics:

Program Design
Choices

Operations and
Management
Processes

Compliance with
Federal Rules

- States must solicit **public input** on the Blueprint before submitting to HHS for certification

While a detailed program implementation plan is not necessary at this stage, directional decision making is useful to:

- Assess impacts to the various financial scenarios
- Make realistic projections for member enrollment and provider reimbursement
- Understand the timeline for implementation
- Compare the proposal to other policy alternatives (e.g., 1332 or 1115 options)

Sources

1. <https://www.medicaid.gov/basic-health-program/index.html>
2. <https://www.medicaid.gov/sites/default/files/2019-11/basic-health-program-faqs-5-7-14.pdf>

DMS Preliminary Policy Discussions for the BHP Blueprint

- Each policy decision point, as required on the Blueprint, was reviewed by DMS
- Options were considered based upon how they might support the Commonwealth's policy goals
- Themes from the preliminary DMS decision set are as follows:

Coordinate largely with Medicaid program rules and health plan (MCO) delivery system, since most churn is likely to happen with Medicaid

Flexible program participation rules (like year-round enrollment and 90-day grace periods) and **assist to help members enroll**

Lower-cost plans than available on the Exchange (sliding scale premiums, low copays, no deductibles) with prices kept the same across carriers

Covered benefits are aligned with Medicaid, but with no vision/dental or transportation coverage (but vision/dental can be purchased on Exchange)

Provider reimbursement at Medicaid rates (or higher than Medicaid if funding permits) - also avoid deductibles and minimize copays for easier participation

State control of program design and **keep DMS administrative costs low** by leveraging state Exchange investments and (where possible) Medicaid funding

Limitations and Qualifications

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and the Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Medicaid Services (DMS) dated June 22, 2020 and amended as of April 7, 2021.

The information contained in this presentation will be used to guide a discussion with DMS and the HJR57 Workgroup on a potential BHP in Kentucky.

In performing this analysis, we relied on data and other information either provided by DMS or obtained through licensed or public sources. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. Milliman's data reliance includes information related to DMS' eligibility system and review of publicly available data sources.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

We have developed certain models to estimate the values included in this analysis. The intent of the models was to estimate the financial feasibility for a Basic Health Program. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by DMS or obtained through licensed or public sources for this purpose and accepted it without audit. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

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