MERCER

CONSULTING. OUTSOURCING. INVESTMENTS.

MANATT HEALTH SOLUTIONS

ANALYSIS OF THE BASIC HEALTH PROGRAM OPTIONS FOR NEW HAMPSHIRE

ENDOWMENT FOR HEALTH / HEALTH STRATEGIES OF NEW HAMPSHIRE

FEBRUARY 9, 2012

Government Human Services Consulting

Mercer Government Human Services Consulting
Gerry Smedinghoff, ASA, MAAA
Jared Nason

Manatt Health Solutions
Melinda J. Dutton J.D.
Deborah Bachrach J.D.

MARSH & McLENNAN COMPANIES

CONTENTS

1

Executive Summary

The Basic Health Program (BHP), as defined in the Patient Protection and Affordable Care Act (ACA), gives states the option to provide health insurance coverage to consumers with incomes between 138% (133% plus the 5% income disregard) and 200% FPL through a state administered program, supported with federal funds. The BHP creates a separate State operated health program in lieu of the Health Benefits Exchange[1] (Exchange) for this low income population. Those eligible for the BHP will not be eligible for the Exchange. States opting for the BHP receive 95% of the federal funding that would have been expended on federal tax subsidies had the individual participated in the Exchange. In turn, the state must use the federal dollars to provide coverage at least as comprehensive and affordable as that provided through the Exchange.

The BHP is often described as providing an affordability bridge between public and private coverage. The BHP allows states to offer eligible individuals lower premium and cost sharing than what would be required in the Exchange. This has the potential to increase participation and reduce the number of uninsured residents.

The Endowment for Health / Health Strategies of New Hampshire (Endowment), with the assistance of the Robert Wood Johnson Foundation, contracted with Mercer Government Human Services Consulting and Manatt Health Solutions (hereinafter refereed to Mercer/Manatt) to assess New Hampshire's policy options under the BHP and the financial feasibility of the BHP option in New Hampshire. The purpose of this report is not intended to advocate for or against the BHP option, but to provide an overview of the feasibility of the BHP and address policy options for New Hampshire policymakers, stakeholders and the public.

The process of assessing the financial feasibility of the BHP option included the following steps:

- Estimate the size and demographic characteristics of the population eligible for the Exchange in New Hampshire and the subsets likely to enroll in the BHP and the Exchange
- Estimate the Silver Level benefits and premiums likely to be offered in the Exchange
- Calculate the federal premium and cost sharing subsidies that would be made available to fund the BHP based on the estimated second lowest cost Silver Level[2] plan, (as outlined in the ACA), offered in the Exchange

[1] The Exchange referred to in this report could be either a State operated or Federally Facilitated Exchange.

[2] The Silver Level plan in this report refers to the levels of coverage described in the ACA (Bronze, Silver, Gold and Platinum, sometimes referred to as "precious metals") and not the New Hampshire Health Kids Silver program.

- Estimate the premiums that would be required to fund health care benefits to the BHP population, up to 200% of the federal poverty level (FPL) at Medicaid provider payment rates
- Calculate the difference between the estimated federal BHP subsidies available and the estimated BHP premiums
- Identify the risk factors that could significantly alter the results, present the conclusions about financial feasibility and policy options for the State

The financial feasibility analysis indicates that the BHP is a viable option for New Hampshire and could be implemented at no cost to the State. This is based on the assumptions that the BHP covers the same benefits expected to be offered in the Exchange and that provider reimbursements under the BHP are equivalent to current Medicaid reimbursements.

Mercer estimates the weighted average Calendar Year (CY) 2014 Federal subsidy to be $495 per member per month (PMPM). The modeling of the BHP incorporated conservative assumptions related to health status and costs, where possible. We estimate the weighted average monthly BHP premium cost in 2014 to be $385 PMPM. This estimate is based on premiums of $10 / $20 and cost sharing of 3.0% / 6.0% for individuals between 138% – 150% and 150% – 200% of the FPL respectively, using the same set of benefits offered in the Exchange.

Based on these estimates there is a projected excess of BHP subsidies over BHP costs of $110 PMPM, or approximately 29% of the BHP premium. Excess subsidies may be used to reduce BHP premiums and cost sharing, enhance the benefit package and/or increases to provider reimbursement.

Feasibility Caveats

Although the BHP appears to be financially feasible, implementation of a BHP comes with some element of risk to the State. The estimates provided are speculative at this early stage with so many provisions of the ACA undefined and specifics of the BHP undetermined. However, the gap between the estimated premium subsidy and projected health care cost to cover the BHP population, driven largely by the estimated differential in Medicaid versus commercial provider reimbursement rates, provides a level of confidence in the observed results. If the State increases Medicaid reimbursement rates from the levels used in this analysis, it would alter the final conclusions and recommendations made in this report. Similarly, any variation or modification of payment methodology, including the transition from the fee-for-service (FFS) rates under the State's newly implemented Medicaid managed care initiative could impact the estimates modeled in this report.

An additional caveat to the BHP modeling, calculations and conclusions contained in this report is the unknown variation of the Silver Level premiums offered in the Exchange. Our modeling estimates that the premium for the second lowest Silver Level plan offered in the Exchange will be $493 PMPM, or that the Silver Level premiums offered in the Exchange will be tightly clustered around this value. This weighted average premium value was developed by Mercer based on our analysis of the New Hampshire All Payer Claims Database (APCD) and our own

uninsured expansion modeling. Variation from this estimate for New Hampshire may be impacted by how the Exchange is established and the number of health plans offering Silver Level plans in the Exchange. Such variation would impact the estimates modeled in this report.

Policy Options / Considerations

The purpose of this report is to present a suite of options for State policymakers and stakeholders to consider as New Hampshire contemplates whether to implement the BHP. Specifically, the report examines policy options for the use of any excess Federal subsidies above the cost of the BHP, issues related to provider availability and implications and influences of the health care Exchange. We close our policy options discussion by identifying risks of implementing the BHP.

Options to Utilize Excess Subsidies

States opting for the BHP receive 95% of the federal funding that would have been expended on federal tax subsidies had the individual participated in the Exchange. These BHP subsidies must be set aside in a separate BHP fund. The State is restricted in the use of the excess Exchange subsidies to do one or more of the following:

- Reduce member premiums and cost sharing
- Expand covered services or benefits
- Increase provider reimbursement rates to potentially attract more providers to the BHP network

Each option impacts the cost of the BHP and ultimately the surplus available. These options can be implemented individually, or in a variety of combinations. Instead of presenting multiple scenarios on the BHP cost and subsidy surplus; where possible we present the estimated impact associated with each option individually. These impacts can be used to better understand the relationship of these policy options to the overall BHP cost and gauge the likelihood for implementing them.

Medicaid and BHP Provider Availability and Access

Although the BHP is a separate program from Medicaid, financial feasibility modeling assumes that the BHP would be administered at Medicaid provider reimbursement levels. One consideration for policymakers and stakeholders contemplating the BHP is the potential impact of Medicaid reimbursement levels on provider availability and access. The ACA creates a new federal standard for Medicaid which will extend eligibility to individuals and families below 138% of the FPL (133% plus the 5% income disregard) in 2014. This modification to eligibility will increase Medicaid/CHIP enrollment and, in turn increase demand on existing Medicaid provider networks. Implementing the BHP would further increase the patient base served by Medicaid providers (with Medicaid level) reimbursements by approximately 12,300 additional individuals.

Impact of the Exchange and Movement between the BHP and Exchange

The design of the Exchange and the possible "churn" of individuals between Medicaid, the BHP, and the Exchange are important to address. Individuals between 138% – 200% FPL are likely to experience fluctuations in income over the year, causing them to migrate among these three benefit plans. On the one hand, a BHP program can serve as a bridge between Medicaid and the Exchange, offering a mix of plans and products and a more gradual phasing in of member premium and cost sharing requirements to consumers as they transition between programs. On the other hand, the BHP creates an additional transition point across the spectrum, requiring the coordination of three programs instead of two.

Risks of Implementing a BHP Associated with Federal Subsidies

Two additional identifiable categories of BHP risks that cannot be quantified at this stage deal with retrospective adjustments to the federal subsidies provided to fund the BHP. Section 1331 of the ACA specifies that the Secretary of Health and Human Services (HHS) will make retrospective adjustments to the amounts of federal BHP premium and cost sharing subsidies to the states to account for the actual income and health status of each individual enrollee during the calendar year they are enrolled.

The retrospective income adjustment presumably would increase the BHP subsidies, if an enrollee's actual income was less than the income determined at enrollment. The BHP subsidies would decrease, if an enrollee's actual income was greater than the income determined at enrollment. In the Exchange, each enrollee bears the risk of this variation in the retrospective premium and cost sharing; while in a BHP, the state bears this risk.

In addition to the fact that the process for this adjustment is undetermined at this stage, is the inevitability of further complications; presented in cases of those BHP enrollees whose incomes drops below the 138% Medicaid eligibility threshold, as well as, those BHP enrollees whose incomes rise above the 200% FPL threshold. The final HHS rules and process for this adjustment may have a significant impact on the financial feasibility of the BHP option.

Literature Review

Finally, to provide readers sources of additional information, analysis and research done related to the BHP, we present a literature review, which contains a survey of BHP related policy studies, a summary of State affairs through February 2012 and a bibliography of references.

Mercer/Manatt wish to acknowledge the assistance of the New Hampshire Department of Health and Human Services (DHHS) and the New Hampshire Insurance Department (NHID) in providing access to data and assistance in understanding existing state programs and the assistance of the Endowment for Health, New Hampshire Fiscal Policy Institute, and New Hampshire Voices for Health in providing background and input throughout the duration of the project.

2

Disclaimer

Mercer has prepared these projections exclusively for the Endowment for Health, to estimate the range of the impact of federal Health Care Reform as it pertains to the Basic Health Plan and its state health insurance exchange. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability from the estimates.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the Patient Protection and Affordable Care Act (PPACA) and Health Care Education and Reconciliation Act (HCERA), together referred to as the ACA, have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. The State is responsible for all financial and design decisions regarding ACA and HCERA. Such decisions should be made only after careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

For our analysis, we relied on data and information and other sources of data as described in this report. We have relied on these data without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data, and it should also be noted that our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

In addition, the projections we show in this report are dependent upon a number of assumptions regarding the future economic environment, medical trend rates, carrier behavior, the behavior of individuals and employers in light of incentives and penalties, and a number of other factors. These assumptions are disclosed in our report and have been discussed with the Endowment. While this analysis complies with applicable Actuarial Standards of Practice and Statements of Principles, users of this analysis should recognize that our projections involve estimates of future events, and are subject to economic, statistical and other unforeseen variations from projected values. To the extent that future conditions are at variance with the assumptions we have made in developing these projections, actual results will vary from our projections, and the variance may be substantial.

Lastly the Endowment understands that Mercer is not engaged in the practice of law. While this report may include commenting on legal issues or regulations it does not constitute and is not a substitute for legal advice. Mercer recommends that the State secure advice from its legal counsel with respect to any legal matters related to this report or otherwise. The information contained in this document and in any attachments is not intended by Mercer to be used, and it cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

3

Financial Feasibility of the BHP

Background

The ACA provides States the option to implement a BHP for adults with incomes between 138% and 200% of the Federal Poverty Limit (FPL) who, in the absence of a BHP, would be required to purchase health insurance coverage in the Exchange with the assistance of premium and cost sharing subsidies. The BHP is not a Medicaid program; the BHP creates a separate State operated health program, in lieu of the Exchange, for this low-income population. Those eligible for the BHP will not be eligible for the Exchange or tax subsidies. The BHP is often described as a program to provide an affordability bridge between public and private coverage options. Individuals eligible for coverage under the BHP must meet the following requirements:

- Adults between the ages of 19 to 64 with modified adjusted gross income (MAGI) between 138% and 200% of FPL
- Not eligible for any government provided health care program (Medicaid, Medicare, or TRICARE)
- Without access to affordable minimum essential coverage offered through their employer
- With modified adjusted gross income below 138% FPL, not eligible for New Hampshire Medicaid because of immigration status

Most aspects of the design of the BHP are left to the discretion of the states, subject to ACA requirements outlined below.

Summary of BHP ACA Requirements

Key Component	Requirement	
Covered Services	Minimum Essential Health Benefits (EHB), not yet defined	
Member Premiums	Not to exceed premiums charged for the second lowest cost Silver Level plan offered in the Exchange	
Cost Sharing	138% – 150% FPL	150% – 200% FPL
	Not to exceed Platinum Level (10%)	Not to Exceed Gold Level (20%)
Delivery System	Managed care system Or Similar benefits of care management (e.g. fee-for-service + enhanced primary care case management) may work	
Plan Medical Loss Ratio	Cannot be less than 85% of the rate	
Plan Selection	Competitive process	

Section 1331 of the ACA provides two funding streams for financing the BHP. The federal government will pay states 95% of what it would have paid for the premium subsidy for these individuals had they enrolled in the second lowest cost Silver Level plan in the Exchange. In addition, the federal government will pay states a cost sharing subsidy of either 95% or 100% of what it would have paid for these individuals had they enrolled in the second lowest cost Silver Level plan in the Exchange[3]. These subsidies vary by the member's income, as defined by the ACA in relation to the FPL.

The fact that BHP must provide the same benefits, services and cost sharing as the Exchange, but with less funding has led many states to look to their lower cost Medicaid plans and provider networks as the most viable vehicle for service delivery. Assuming the BHP will be operated by a state's Medicaid managed care organizations (MCO), the financial feasibility of a BHP is primarily determined by the differential between the state's Medicaid provider reimbursement rates in the BHP and its commercial provider reimbursement rates that would apply if this population were covered in the Exchange. The larger this provider reimbursement rate differential, the greater the likelihood that a BHP will be feasible from a state's financial perspective.

Analysis and Findings

Mercer used New Hampshire specific data to model of the financial viability as well as our own region specific information. The modeling incorporated multiple inputs, including population estimates, the projected cost of providing health insurance coverage to the BHP population and the estimated subsidizes that will be available to individuals purchasing care through the Exchange. In calculating the CY 2014 BHP premium subsidy and BHP cost estimates, Mercer employed conservative assumptions where possible. The analysis and findings are summarized here. The detailed description of the data sources, population estimates, BHP cost modeling, Sliver Level Exchange premium estimate and assumptions are detailed in Appendix 1.

The feasibility determination is based on whether the BHP option can be implemented at existing Medicaid provider payment rates at no, or little cost to the State (i.e., entirely funded by federal subsidies). Medicaid was selected as the benchmark because this program's provider reimbursement rates are typically lower than commercial health plans available in the Exchange. Building a BHP on a state's Medicaid health plans would allow states to cover low income parents and children together in the same, or similar plans and by the same provider networks.

The financial feasibility modeling assumes the BHP would be administered by the Medicaid agency and the cost of care actively managed in conjunction with the Medicaid managed care program, with the expected result of lower annual cost increases in the BHP (paid at Medicaid levels) than the Exchange (paid at commercial levels). The projected annual trend of 4.0% for the BHP is consistent with and compares well to surrounding State Medicaid trends. Although, recent New Hampshire Medicaid PMPM trends have been flat, we used 4.0% as a margin of conservatism; as these flat trends are unlikely to continue several years into the future. The

[3] The ACA is unclear whether the state will receive 100% or 95% of cost-sharing funds.

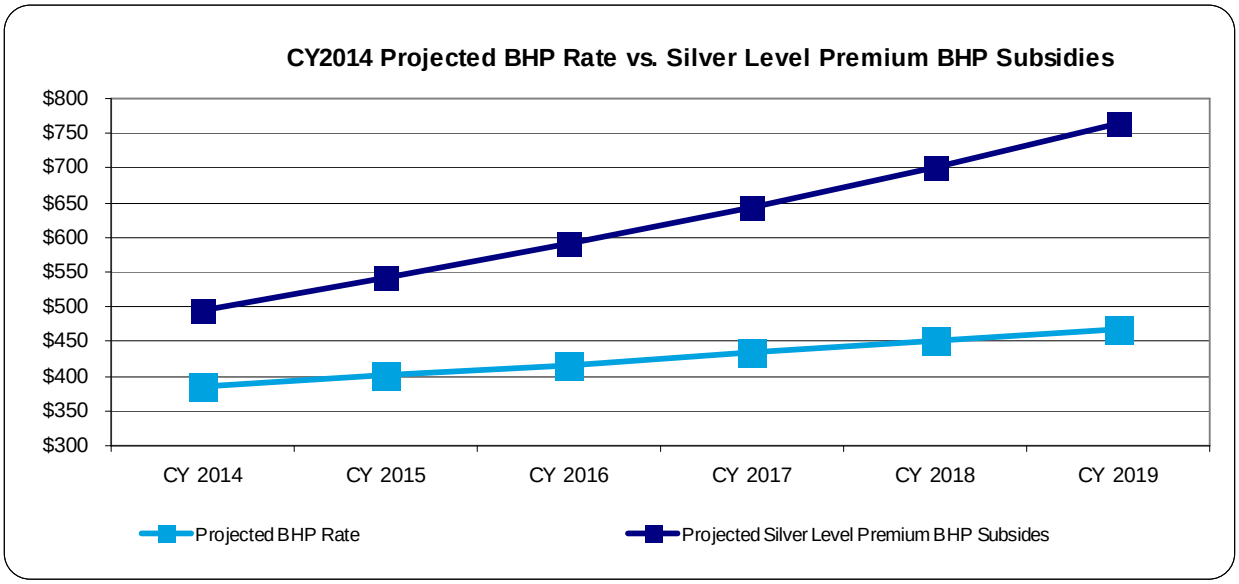
projected annual trend of 8.0% for the Exchange is consistent with current observed commercial trends, Mercer's annual health care cost survey and other national sources of information. The difference between BHP and Exchange trend factors has the impact of increasing the Exchange subsidy surplus in the later years of the projection.

CY2014 Projected BHP Rate, Federal Subsidy and Surplus / (Deficit)[1]

PMPM Estimates	Estimated Net BHP Premium[2]	Estimated Exchange Subsidies	Surplus/(Deficit)
2014	$385	$495	$110
2015	$401	$541	$140
2016	$417	$591	$174
2017	$433	$644	$211
2018	$451	$702	$251
2019	$469	$764	$295

1 – Figures presented in this table are rounded to the whole dollar.

2 – BHP estimated net premium is based on: $10 / $20 Premiums, 3.0% / 6.0% Cost Sharing, Medicaid Reimbursement. Note that premiums of $10 refer the population between 138% – 150% FPL and $20 between 150% – 200% FPL



1 – It is unclear if HHS has the authority to potentially adjust BHP payments in future periods.

Included as part of the estimated BHP rate are estimates for increased reimbursements to primary care providers (PCPs) to Medicare levels mandated by the ACA for CY2013 and CY2014. As the law currently stands, these PCP reimbursement rates will revert to their current levels starting in 2015; however, some states are contemplating leaving the PCP reimbursement rates intact after 2014.

The reader should note that Medicaid agencies are waiting for further clarification from HHS related to the specifics for implementing this provision of the ACA. The estimates used for this analysis were conservative; assuming a higher proportion of providers will receive the Medicare fee schedule reimbursement rates. Although the ACA allows for reductions to current levels in 2015, the assumed BHP rates for 2015 and beyond do not factor in this reduction.

Conclusions for Policymakers/Stakeholders

Policymakers and stakeholders should consider what entity would be the most experienced and best positioned to provide coverage to these lower income clients and serve as the best steward of the program. It could be argued that the policies implemented by the Medicaid agency for its Medicaid managed care programs could be used to manage the same plans providing the BHP.

Based on the assumptions listed above, it appears that it is financially feasible to offer a BHP at Medicaid provider reimbursement levels, at no cost to the State. These results are driven by the estimated differential in Medicaid versus commercial provider rates of reimbursement. These estimates are speculative at this early stage, with so many provisions of the ACA undefined and specifics of the BHP undetermined. As outlined in the literature review (Summary Table of State BHP Analyses Published as of December 2011: Methodological / Modeling Results) the gap between the estimated BHP subsidy and projected health care cost to cover the BHP population is consistent with many findings from other studies on this topic.

Perhaps the most significant caveat to the BHP modeling, calculations and conclusions contained in this report is the potential variation in the value of the Silver Level premiums offered in the Exchange. Variation in Silver Level premiums would impact the premium and cost sharing subsidies available. These calculations and conclusions are based on the $493 PMPM weighted average estimate of Silver Level premiums. Implicit in the use of this $493 PMPM estimate is that this will represent the second lowest Silver Level plan offered in the Exchange, or that the Silver Level premiums offered in the Exchange will be tightly clustered around this value.

It is assumed that health plans may not have adequate information to accurately price health policies in the Exchange. The result may be rates that vary widely which could reduce BHP subsidy. If this were to occur, it might not be possible to implement the no cost scenario (described in Section 4) without additional State funding. However, plans that under price the market in 2014 (the first year of the Exchange) may very quickly increase their premiums in subsequent years (assuming the increases would be approved) and this BHP subsidy deficit may not last for more than a couple of plan years.

In contrast, the results in this analysis are largely immunized from the unknown assumption of the definition of the essential health benefits (EHB). If the EHB are greater, or less than, those priced in this analysis, then the Exchange Silver Level premiums, along with the federal BHP subsidies; would increase at approximately the same rate as the BHP costs, with the resulting BHP subsidy excess or (deficit) relatively unaffected.

Similarly, the results in this analysis are largely immunized from the unknown assumption of the medical inflation and utilization trends from now until 2014. If the medical trends are greater, or

less than, those priced in this analysis, then the Exchange Silver Level premiums, along with the federal BHP subsidies, would increase more or less at the same rate as the resulting BHP costs, with the resulting BHP subsidy excess or deficit relatively unaffected; assuming commercial trends exceed Medicaid trends. A more detailed discussion of the EHB and recent guidance is explored further in Appendix 1.

Additional Risks of Variation in Federal BHP Subsidies

Two additional identifiable categories of BHP risks that cannot be quantified at this stage deal with retrospective adjustments to the federal subsidies provided to fund the BHP. Section 1331 specifies, that the Secretary of HHS will make retrospective adjustments to the amounts of federal BHP premium and cost sharing subsidies to the states to account for the actual income and health status of each individual enrollee. The retrospective income adjustment presumably would increase the BHP subsidies if an enrollee's actual income was less than the income determined at enrollment (e.g., if actual income was 140% FPL instead of 180%), and would decrease the BHP subsidies if an enrollee's actual income was greater than the income determined at enrollment (e.g., if actual income was 180% FPL instead of 140%). In the Exchange, each enrollee bears the risk of this variation in the retrospective premium and cost sharing, while in a BHP, the state bears this risk.

The process for this adjustment remains undetermined at this stage. Further complications are presented in cases of those BHP enrollees whose incomes drops below the 138% Medicaid eligibility threshold; as well as, those BHP enrollees whose incomes rise above the 200% FPL threshold. The final HHS rules and process for this adjustment may have a significant impact on the financial feasibility of the BHP option.

The retrospective risk sharing adjustment presumably would increase the BHP subsidies if an enrollee's health status was calculated as higher than the average Exchange risk and would decrease the BHP subsidies if an enrollee's health status was calculated as lower than the average Exchange risk. Assuming the final HHS rules and process for this adjustment follow this logic, the BHP retrospective risk adjustment would reduce the unknown morbidity risk a state would be taking by implementing a BHP and would not have a significant impact on the financial feasibility of the BHP option.

Federally Qualified Health Centers / Rural Health Clinics

The ACA currently requires Exchange participating health plans to offer Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as part of their provider networks. As it stands today the payment requirements to these providers is unclear. Mercer did not make any adjustment to the estimated BHP or Exchange health care costs to account for this requirement. If material changes to this assumption are anticipated, this analysis should be further refined to reflect the assumed delivery system for the BHP.

Impact of Premium Payment Grace Period and Lapses in Coverage

While there are monetary penalties (which increase with income) for failing to pay premiums and continue coverage once an immediate health need passes; the ACA allows for a generous 90

day grace period of continued coverage once a member ceases to pay monthly premiums and there is no waiting period, or underwriting when re-enrolling after a gap in coverage. The result will be that healthier lives will tend to lapse, while those with acute and chronic health care needs will tend to remain covered, increasing the average per capita cost.

The State of Washington BHP began in 1989 and has more than two decades of experience. While it covers a similar population as the ACA BHP, those earning less than 200% FPL; it also covers those below 138% FPL, down to the Washington State Medicaid income limits of 74% for parents and 0% for childless adults. The monthly premiums for a 42 year old in the plan range from $100.00 for those earning 140% FPL and $180.00 for those earning 180% FPL, which are higher than the projected member premiums in the Exchange.

In 2008 and the first part of 2009, approximately 4% of the Washington BHP membership lapsed each month. Once an enrollment cap was enforced in 2009 and a waiting list was created for those who wanted to enroll but could not, the monthly lapse rate dropped to about 3% in 2010. This decrease in the lapse rate is consistent with the adverse selection assumption, which holds that the remaining population will be less healthy and more diligent in paying their monthly premiums to avoid losing their valued coverage for any period of time.

While some of the Washington BHP lapses are due to (a) changes in income, (b) replacement by other coverage – ESI, Medicaid or Medicare, (c) movement out of state and (d) death; the level of adverse selection present is significant and measurable. The adverse selection present among the New Hampshire BHP population is assumed to be similar and could have a significant impact on BHP costs in New Hampshire.

Modeling Constraints

Because of numerous uncertainties about the health care marketplace in 2014, the analyses and findings contained in this report are preliminary and subject to change for many reasons, including, but not limited to:

- Key terms and provisions in the law remain undefined, or not yet fully defined, such as the definition of the “Essential Health Benefits” that will be required for all products offered in the Exchange and which will drive the BHP premium and cost sharing subsidies
- Key terms and provisions of the law conflict. For example, Section 1331(a)(2)(A)(ii) defines the BHP cost sharing subsidies to be a minimum of Platinum Level benefits (90% actuarial value) for individuals between 100% and 150% FPL and Gold Level benefits (80% actuarial value) to individuals between 150% and 200% FPL, while Section 1402(c)(2) defines the additional cost sharing subsidies to be a minimum of 94% actuarial value for individuals between 100% and 150% FPL and 87% actuarial value to individuals between 150% and 200% FPL
- Key terms and provisions of the law are unclear, such as the precise definition of “actuarial value” and the formula for the BHP cost sharing subsidy (100% or 95%)

Uncertainties regarding consumer behavior under the ACA, for example:

- What will be the level of compliance with the federal insurance mandate?
- Will those above 400% FPL, not eligible for premium subsidies purchase health care in the Exchange, or migrate to other products, leaving the Exchange with a potentially lower income and less healthy risk pool?
- How will the 90 day grace period for non payment of premiums and the lack of a penalty for re-enrollment affect coverage persistency and premium payments in a BHP and/or in the Exchange?

Decisions about how the State would structure a BHP, such as the premiums and cost sharing levels will impact the risk profile of those who enroll.

4

Policy Options

Analysis of Savings and Opportunities Created by a BHP

In the previous section we established that the BHP appears to be financially feasible with a surplus in federal funding exceeding program costs. In this section, we discuss the impact of provider availability and access, and present policy options for the use of the excess BHP subsidies, including benefit package design, consumer affordability, and provider reimbursement increases. In addition, this section examines:

- Covering existing Medicaid populations
- Management of the BHP and Exchange implications that impact the BHP.

Impact on Provider Availability and Access

Changes in the financial eligibility requirements for Medicaid under the ACA will extend eligibility to individuals and families below 138% FPL. In New Hampshire, this change will increase the number of Medicaid/CHIP enrollees by almost 20,000 in 2014. The increased Medicaid enrollment could place additional strain on Medicaid provider networks and potentially increase cost shifting to commercial carriers while reducing access and availability to providers for Medicaid clients.

Although the BHP population is not a Medicaid/CHIP program, its financial viability is linked to utilizing Medicaid reimbursement rates. Therefore it is likely that the same health care providers that serve the Medicaid/CHIP population would also serve the 12,300 estimated BHP clients. It is recommended, if the BHP is implemented in New Hampshire, an analysis of the provider infrastructure should be undertaken to assess the impact of expanding the Medicaid eligible population as required by the ACA, as well as the additional impact of potentially adding the BHP population to this patient base.

Options and Opportunities to Utilize Excess Subsidies

The State is restricted to the use of any excess BHP subsidies to the following purposes:

- Reduce BHP client monthly premiums and out-of-pocket cost sharing
- Expand BHP client benefits
- Increase BHP provider reimbursement rates to potentially attract more providers to the Medicaid/BHP network

Assuming the BHP would be administered by the Medicaid agency and actively managed in conjunction with the Medicaid managed care program, resulting in lower annual rate changes in the BHP than the Exchange; the difference between BHP and Exchange trend factors would

increase the BHP trust fund surplus in the later years. This increase in the trust fund, (illustrated on page 9), over several years will create the opportunity to policy makers to revisit and refine the program features over time. It is unclear if HHS has authority to modify or adjust BHP payments over time in reaction to the growing excess between the cost of the BHP and the Exchange subsidies.

Reduce Premiums and Out-of-Pocket Cost Sharing

One option for the BHP trust fund surplus is to reduce cost sharing for low income individuals participating in the BHP, to levels lower than those that would have been required in the Exchange. The modification of enrollee premium and out-of-pocket cost sharing influences the ultimate net cost to the state, (total BHP cost less member premium and cost sharing contributions), as well as, the number of enrollees participating in the BHP.

Higher member premiums and cost sharing have the effect of reducing enrollment and increasing the average acuity and cost, also referred to as morbidity, in the BHP. Although, it is expected that BHP subsidies will be risk adjusted, there is a likelihood that estimates might deviate from the assumptions. Lower member premiums and cost sharing have the effect of generating the highest level of enrollment and decreasing the average level of morbidity in the BHP. Three scenarios of premiums and out-of-pocket cost sharing are illustrated in the table below.

Scenarios of Premiums and Out-of-Pocket Cost Sharing[1]

PMPM Estimates	Zero Premiums No Cost Sharing Medicaid Reimbursement	$10 / $20 Premiums 3.0% / 6.0% Cost Sharing Medicaid Reimbursement	$20 / $60 Premiums 5.0% / 12.0% Cost Sharing Medicaid Reimbursement
Federal Subsidy	$495	$495	$495
Net State BHP Cost	$426	$385	$330
Excess / (Deficit)	$69	$110	$165

1 – Figures presented in this table are rounded to the whole dollar.

Considerations for Policymakers

The evaluation and choice between the premium and cost sharing scenarios presented is not necessarily obvious. The scenario resulting in a $165 PMPM subsidy surplus might appear to offer the best protection to the State. This scenario also has the highest premiums and cost sharing, likely generating the lowest participation (of the above three scenarios) and the highest level of morbidity in the BHP.

Conversely, the no cost Medicaid scenario might appear to present the greatest risk to the State's budget. However, this scenario will have the effect of generating the highest enrollment and the lowest level of morbidity in the risk pool; decreasing the likelihood that these unknown variables might deviate significantly far from the assumptions.

As member premium and out-of-pocket cost sharing levels are evaluated, it should be noted that the level of member out-of-pocket costs influences the number of individuals that will choose to purchase coverage versus paying annual penalties for opting out. With higher premiums, it can be expected that "healthy" or less expensive individuals, who have no immediate health care need, may opt to forego coverage; which will have the affect of increasing the overall BHP rate, because only more acute and more expensive clients will enroll in the BHP. This issue is explored further as part of the Affordability and Continuity of Coverage section contained in the Literature Review.

Higher member premium and cost sharing levels increase the level of adverse risk selection and leads to higher enrolled morbidity. Because higher premiums and cost sharing tend to entice those individual that have a chronic condition or immediate health care need, this has the effect of increasing the average cost.

With the assumption that a BHP would only be implemented with reduced premiums and cost sharing (as compared to what would be available under the Exchange for the same BHP eligible subgroup), it is reasonable to conclude that the risk of the enrolling population up to 200% FPL, would be better under a BHP, than the risk of the same population subgroup that would enroll in the Exchange. However, some studies have indicated the opposite (that the risk of the enrolling population up to 200% FPL may not be lower cost). Studies have shown that there is a relationship between income and morbidity. Lower income individuals generally have higher morbidity which generates higher health care costs.

Additional Health Care Benefits

Excess premium subsidies can also be directed to enhancing the medical benefits covered under the BHP. For example, services such as a comprehensive adult dental benefit that includes preventative and restorative services, or non-emergent transportation, are not included in the EHB benefit package for the BHP. Inclusion of new or additional benefits has the effect of reducing the difference between the cost of the BHP and the federal Exchange subsidies

Considerations for Policymakers

Determining whether additional benefits should be considered for the BHP includes the following considerations:

- Should benefits be permitted to vary among Medicaid, the BHP, and the Exchange? What kind of behaviors and actions would these policies influence?
- Should benefits be standardized among Medicaid, the BHP, and Exchange to ensure no disruption in the coverage experience, as clients migrate between programs?

Provider Reimbursement

As previously discussed in the financial feasibility section, the financial feasibility modeling assumes the BHP will operate using the same level of provider reimbursement that is currently in place in the Medicaid program today; including estimates for the impact of the PCP Medicaid fee schedule increase that will be effective for 2013 and 2014. Although, this provision expires in

2015, when reimbursement can return to pre-2013 levels, the BHP modeling does not rescind these PCP reimbursement increases.

Provided that adequate funds exist as modeled, the State could opt to increase the level of reimbursement to BHP providers. The impact of provider fee increases to broad definitions of service categories are estimated in the following table in increments of 5.0%.

Estimated Impact of 5.0% Provider Reimbursement Increases[1, 2]

General Service Category	BHP Rate Impact PMPM (Estimated)
Inpatient hospital	$3.00
Outpatient hospital	$6.00
Physician related services (non – PCP)	$5.00
Other services (Non Pharmacy)	$1.00
All Services (Non Pharmacy)	$15.00

1 – Figures presented in this table are rounded to the whole dollar.

2 – BHP estimated rate impact is based on: $10/$20 Premiums, 3.0%/6.0% Cost Sharing, Medicaid Reimbursement. Note that premiums of $10 refer the population between 138% and 150% FPL and $20 between 150% and 200% FPL.

To determine more detailed fee increase impacts on specific services, or sets of services, Mercer recommends a more extensive analysis based on service level data, rather than aggregate data as was done in this exercise.

Considerations for Policymakers

As policymakers consider provider reimbursement rates, it is important to understand implications they may have on the delivery system. On the one hand, increased reimbursement for BHP providers could help alleviate strain on the provider networks utilized by Medicaid and BHP. On the other, enhanced rates for BHP but not Medicaid could disadvantage Medicaid enrollees competing for limited provider services. Additional questions for consideration include:

- How would varied reimbursements between Medicaid and the BHP impact provider participation in the program(s)?
- How would varied reimbursements be administered, if the BHP were offered by the same managed care organizations that also serve Medicaid?
- Will MCOs be able to accurately communicate to providers the enrollment data as members migrate to and from Medicaid (where members have no cost sharing and cannot be denied services) and the BHP (where members will have cost sharing and can be denied services)?

Covering Existing Medicaid Populations

The Medicaid eligibility threshold increases to 133% in 2014 (effectively 138% with the 5% income disregard). New Hampshire can assess the populations currently covered under its Medicaid programs and possibly align them with the subsidies and incentives of the ACA. If the

State chooses to terminate coverage for individuals currently covered by Medicaid above 133% of the FPL, they can consider moving these populations into to the BHP in 2014. Common populations considered eligible to be shifted include:

- Breast and cervical cancer
- Pregnant Women
- Medicaid for Employed Adults with Disabilities (MEAD) program
- Other programs that provide Medicaid coverage in excess of 138% of the FPL

Moving these populations to the BHP would increase the average cost of the BHP and reduce excess Exchange subsidies available for other purposes, such as, increasing provider reimbursements. The shift of these clients would result in State general fund savings because the State share of Medicaid costs would be eliminated when these populations are transferred to the BHP. Here, it is important to note that moving these Medicaid populations to the BHP will result in requiring monthly premiums and cost sharing for these populations.

Considerations for Policymakers

As the State addresses the expanded population coverage question, policy makers should bear in mind the potential risks associated with making such determinations. As the excess subsidy is reduced closer to zero, the risk to the State increases, as there is less margin for the deviation, or variation, in the estimates modeled. In the event that BHP costs exceed the subsidy, the State could be at risk for covering the deficit with 100% state funds.

In the scenario of a BHP operated by Medicaid MCOs, this initial risk of a subsidy deficit would be borne by the MCOs. However, as rates rise to their natural levels, the state will then bear this risk. In the scenario of a BHP operated by the State (e.g., in a Primary Care Case Management (PCCM) model), the State will bear this entire risk from BHP inception.

Management and Operations of the BHP

Policymakers and stakeholders also must consider what state entity will be responsible for operation of the BHP. Many studies assume that the BHP will be operated by the State agency responsible for administering Medicaid. This reasoning is driven by the fact that the populations are similar enough to leverage existing processes and policies for benefit administration. In fact, many States have implemented Medicaid expansions designed to cover single adults and childless adults between the State's Medicaid FPL and 200% of the FPL.

One could assume that under management of the Medicaid agency, the annual rates of change in BHP costs could be minimized because data would be readily available in future years that could be analyzed to potentially modify the BHP program to address policy options presented here. The financial feasibility modeling estimates a lower rate of growth (annual rate increase) in the BHP than for Exchange premiums. The BHP could be administered as a managed program paid at Medicaid FFS rates. However, in this scenario, the State would bear the financial risk should actual health care costs exceed premium and cost sharing subsidies. Although other entities such as the Exchange could administer the BHP, as already discussed, the financial

feasibility is dependent on providers serving BHP clients at Medicaid fee structures. If other entities were to administer the BHP they would likely have to contract with Medicaid health plans in order to access Medicaid reimbursement levels.

Considerations for Policymakers

- Do the current Medicaid managed care plans have experience with expansion coverage in other State Medicaid programs?
- Is the BHP best served through the existing structure, oversight and management of a Medicaid agency more familiar with BHP like populations?
- Could the cost of administration loading in the BHP cost and Medicaid capitation payments benefit from additional economies of scale?
- Which agency is the best able to manage the health plans through enforcement of contractual terms, data collection, policies and annual rate determinations?
- How would the states cost of administering the BHP be funded? The ACA does not specify how BHP administration is to be funded, and statutory language defining the permissible use of BHP funds raises questions regarding whether they may be used for administrative purposes. If administration cannot be funded by the excess premium subsidies, administrative costs would need to be covered by other sources, such as the State general fund or other assessment.

Exchange Implications that Impact the BHP

The BHP has several potential implications for a state Exchange including the issue of movement or “churn” between Medicaid, the BHP and the Exchange and how the Exchange can impact the Silver Level premium used to derive the subsidy.

Movement Between Programs

The possible “churn” of individuals between Medicaid, the BHP, and the Exchange, is an important consideration to address. The income band between 138% and 200% FPL is small, $7,600 per year. BHP eligible individuals may be more likely to experience fluctuations in income over the year that will result in migration between Medicaid, BHP and Exchange plans.

Sommers and Rosenbaum, in the February 2011 issue of *Health Affairs*, published a study that showed that over the course of a year approximately 50% of the people at this income level will experience earnings fluctuations which will move them above or below the 138% FPL BHP eligibility threshold, rendering them ineligible for the specific coverage they have and requiring them to re-enroll in the coverage for their higher income category.

A September 2011 Institute for Health Policy Studies report projects that the total number of individuals eligible for the BHP in a given year will be four times greater than the number eligible at the start of the year, due to income fluctuations among this segment of the population. Regardless of the actual percentage, which will vary with changing economic conditions, this churning of coverage will also likely exist above, or below the 200% BHP upper income eligibility threshold, requiring individuals to disenroll in the BHP and enroll in the Exchange (or vice

versa). We did not attempt to model this phenomenon and have not made any adjustment to our analysis to account for this.

Section 1411(b)(4) of the ACA places the responsibility for income redeterminations on the individual enrollees. It states "*If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer*."

The expected result is that individuals will be less likely to report increases in their income, reducing, or eliminating their premium and cost sharing subsidies; whereas, they will be more likely to report decreases in their income, increasing their premium and cost sharing subsidies, or even moving them from the Exchange to the BHP or from the BHP to Medicaid. This means that more of the increases in federal subsidies will be reported earlier, leaving the decreases in federal subsidies to be accounted for after the year has ended, in the retrospective reconciliation process.

The process for retrospective reconciliation remains undetermined at this stage. Further complications are presented in cases of those BHP enrollees whose incomes drop below the 138% Medicaid eligibility threshold; as well as, those BHP enrollees whose incomes rise above the 200% FPL threshold. The final HHS rules and process for this adjustment may have a significant impact on the financial feasibility of the BHP option.

The retrospective risk sharing adjustment presumably would increase the BHP subsidies, if an enrollee's health status was calculated as higher than the average Exchange risk and would decrease the BHP subsidies if an enrollee's health status was calculated as lower than the average Exchange risk. Assuming the final HHS rules and process for this adjustment follow this logic, the BHP retrospective risk adjustment would reduce the unknown morbidity risk a state would be taking by implementing a BHP and would not have a significant impact on the financial feasibility of the BHP option.

The BHP offers a bridge for individuals between the no cost Medicaid benefit and the cost of the Exchange plan. This lower cost alternative to the Exchange plan would result in a higher participation rate and could also reduce the overall morbidity of the enrolled BHP membership. Consideration should be made for the fact that the BHP provides a step between programs as participant's income fluctuates and they gain and lose Medicaid benefits.

Implications of the Design of the Exchange on the Silver Level Premium

The design of the Exchange can impact the Silver Level premium and the subsidies for the BHP derived from them. How the Exchange is organized and operated, including how it manages participation at the various metallic levels (Bronze, Silver, Gold and Platinum) could influence how many carriers offer Silver Level plans. Additionally, any provisions that actively influence annual premiums impact the viability of the BHP. Since subsidies for a BHP are based on the

second lowest Silver Level premium offered in the Exchange, the number of plans and variation of premiums will impact the subsidies available. Because Exchanges are complex, and the State's objectives could vary and are unknown, an exploration of how the various Exchange decisions impact on the BHP is not within the scope of this report.

The member premiums and cost sharing in a BHP and in an Exchange, (with or without a BHP), will have an impact on the risk profile of the population that enrolls. Generally, higher premium and cost sharing levels have the result of increasing the level of adverse risk selection among the enrolled population, (i.e., higher monthly premiums encourage healthier individuals to opt out of the Exchange to avoid purchasing benefits they are not likely to use). With the assumption that a BHP would only be implemented with reduced premiums and cost sharing (as compared to what would be available under the Exchange for the same BHP eligible subgroup), it is reasonable to conclude that the risk of the enrolling population up to 200% FPL would be better under a BHP, with lower member premiums, than the risk of the same population subgroup that would likely enroll under an Exchange, with higher member premiums.

5

Impact on the Exchange

This section of the report addresses some of the potential impacts adopting a BHP option could have on the Exchange in New Hampshire. Specifically, the following areas are discussed:

- Impact on Exchange risk
- Impact on Exchange self sustainability

Impact on Exchange Risk

The BHP population, with incomes of less than 200% FPL, should represent a less healthy (and more costly) risk profile than the remaining Exchange population above 200% FPL as discussed in previous section. The level of premiums and cost sharing in a BHP and in an Exchange (with or without a BHP) will have a direct impact on the risk of the population that enrolls.

Specifically, higher premium and cost sharing levels increase the level of enrolled adverse risk. With the assumption that a BHP would only be implemented with reduced member premiums and cost sharing (as compared to what would be available under the Exchange for the same BHP eligible subgroup), it is reasonable to conclude that the risk of the enrolling population up to 200% FPL would be better under a BHP than the risk of the same population that would enroll under an Exchange.

It is impossible to be sure how the risk of the remaining Exchange population above 200% FPL would compare to the group below 200% of the FPL under an Exchange. However, one could argue that with less disposable income at the lower income levels, the impact of adverse risk would be greater at the lower income levels. If that holds true, Exchange risk may actually improve with the implementation of a BHP.

On the other hand, for individuals at higher income levels, the Exchange premium subsidy is considerably lower than for those at lower income levels. Therefore the motivation to participate within the Exchange versus the outside market is much lower for the healthiest segment of the Exchange population. Plan participation, consumer choice and risk dynamics for the Exchange population are complex and beyond the scope of this analysis.

Impact on Exchange Self-Sustainability

All Exchanges must be self-sustaining by January 1, 2015. Therefore, it is reasonable to be concerned about removing some Exchange eligible members from the pool from which the Exchange may be funded. Because participation in the Exchange is driven by the premium and cost sharing it can assumed that higher premium and cost sharing would result in lower enrollment.

- In the scenario with a BHP which provides lower premium and cost sharing we estimate of those in the 138% – 200% FPL bands eligible for the BHP is approximately 18,000 individuals and that 12,300 or approximately 70% will enroll.
- In the absence of a BHP which provides reduced premium and cost sharing, we assume that only 9,000, or roughly half of those in the low income band (138% – 200%) would enroll in the Exchange because of the fact that premiums and cost sharing would likely be higher.

The implementation of a BHP would have the affect of reducing the number of individuals in the Exchange which could impact the financial viability of a State run Exchange as being self-sustaining. Mercer/Manatt recommends that if the State engages in any Exchange planning activities the impact or implications of a BHP option should be considered.

6

Literature Review

As discussed above, states considering the BHP option are faced with several interconnected policy considerations and design choices. This section surveys the available literature for the following:

- Affordability and continuity of coverage for consumers
- Ability to offer benefits, plans, and provider networks that meet consumer needs
- How, by whom, and at what cost the program will be administered
- Projected financial risks and benefits to states of covering BHP populations
- Implications of adopting a BHP for the state Health Insurance Exchange

States' evaluation of the BHP also will be informed by federal guidance, some key aspects of which are still emerging.

Since the passage of the ACA, a series of policy reports and state specific analyses have provided important insight to state policymakers as they consider whether and how to implement a BHP. This section summarizes these existing national and state analyses in an effort to inform New Hampshire policy makers and stakeholders as they explore the BHP option in their state.

BHP Program Costs and Financing

A threshold issue for states in weighing the BHP option is the potential financial risk and benefit to the state. Because federal funding for the program is capped, states bear the risk if the cost of coverage under the BHP exceeds federal funding. Virtually every published study of BHP indicates that the federal funding for the program is likely adequate to meet program costs.[i] While some analysts are cautious about BHP for other reasons, most find that BHP will yield net operating surpluses in the range of roughly 20% of program costs.

Some states have documented additional cost savings for states based on the assumption that populations currently receiving coverage through programs funded in whole, or in part with state funds could be transitioned into the fully federally funded BHP. The basic eligibility criteria for BHP are clear. Individuals below 200% FPL are eligible, including legal immigrants, as long as they do not have access to Medicaid or affordable job based coverage. Most BHP analyses focus on the core BHP population, (the uninsured from 138 – 200% FPL). However, some have noted that populations currently enrolled in State funded expansion and waiver programs (such as the Breast and Cervical Cancer program) with incomes above current Medicaid levels are likely to transition into BHP programs. To the extent those populations leave state funded programs for the fully federally funded BHP, states will experience savings

However, while many of the published analyses utilize conservative assumptions where there is lack of clarity about the details of federal implementation, some analysts have suggested that caution is warranted in producing such estimates, pending additional guidance required to accurately estimate federal financing.[ii]

Affordability and Continuity of Coverage

The most cited potential benefit of the BHP option is the opportunity to improve health insurance affordability for the population between 138% to 200% FPL. While some BHP state analyses have modeled the maximum enrollee cost sharing levels when determining the financial viability of the BHP, most states either assume lower than the required cost sharing levels in their modeling[iii] or suggest that reducing enrollee cost sharing could be a priority for states in allocating surplus federal BHP funding.[iv] In addition, there is consensus that implementing a BHP is likely to reduce uninsurance and improve take-up of health coverage as a result of offering lower cost coverage relative to subsidies in the Exchange.[v]

The BHP presents both opportunities and challenges relative to continuity of coverage. On the one hand, the BHP may improve continuity of coverage by smoothing the "affordability cliff" that would otherwise occur for low-income families transitioning between Medicaid coverage (with minimal cost sharing) and coverage in Exchanges (with relatively higher costs to the family). However, the creation of a third program under the ACA, alongside Medicaid and Exchanges, creates an additional break point where members would transition between programs.[vi] Alignment of administrative infrastructure and of health plan standards and procurement could help minimize disruptions and leverage the BHP to improve continuity of coverage for individuals, and families.[vii]

BHP Program Design, Benefit Package, Plans and Providers

States have wide latitude in designing their BHP programs within a set of broad constraints. However, significant consensus has emerged in the field about what program designs are most likely to yield successful BHP programs.

Perhaps the most fundamental question for states is whether a BHP would be built on the framework of existing public insurance health plans and provider networks, or whether the BHP would look more like a commercial health plan product and be more aligned with the state Exchange. While continuity concerns would dictate that participating plans and providers should be aligned across Medicaid, BHP, and the Exchange to the greatest extent possible, it is clear that to be financially viable, BHP coverage would need to utilize lower cost plans and lower provider reimbursement levels than would be available through the Exchange. States with a robust network of Medicaid plans or plans that provide both public and private coverage are well positioned to leverage these plans and their participating providers in implementing a BHP. Even so, enhancing provider reimbursement may be necessary to ensure adequate access to providers for BHP members; a number of studies suggest such increases as a priority for the allocation of surplus federal BHP financing.[viii]

Administration of the BHP

States must determine what entity should be responsible for designing, implementing, and administering the BHP program. Most states have looked to existing agencies or entities to administer the BHP, including the Exchange, the state Medicaid agency, the state Department of Insurance, or other entities such as high risk pools or state CHIP agencies. The source of funding to support the administration of the program is unclear. Federal law appears to prohibit use of federal BHP funds to support the administration of the program. Some states have observed that the BHP could be funded through the same or similar revenue generating models as the self-sustaining Exchange, such as assessments and fees. As yet, very few analyses have considered the size or scope of these administrative costs in any detail.[ix]

BHP Impact on State Health Insurance Exchanges

Virtually all studies of the BHP recognize that the implementation of a BHP would reduce the size of a state's Exchange and many discuss the implications of possible changes in the Exchange risk profile on premiums. However, the true impacts of a BHP on state Exchanges has yet to be fully explored in the literature and may vary significantly between states.

On the issue of exchange size and viability, while analysts have suggested that a smaller Exchange might have less purchasing power, or less capacity to attract the participation of insurers;[x] there is significant disagreement about the level below which the Exchange is likely to suffer these deleterious effects. Various strategies have been suggested to help remedy the problematic effects of BHP on Exchange size, most notably by integrating a BHP within the Exchange to maintain administrative scale and leverage with carriers, particularly those providing coverage to Exchange, BHP, and Medicaid populations. This strategy could also deliver significant administrative returns to scale.[xi]

While most analysts assume that creating a BHP will have some effect on Exchange risk, it is not clear what this effect will be. Some assume that BHP populations are healthier risk than higher income Exchange populations because they tend to be younger,[xii] (see CSS, Dorn); others believe that BHP populations are higher risk than Exchange populations, because they are lower income.[xiii] The answer is likely to vary between states and is difficult to predict. However, some analysts suggest that BHP and Exchange risk might be pooled, resolving this uncertainty.[xiv]

Conclusion

In evaluating whether to pursue the BHP option, it is critical for state decision makers to understand and weigh the various elements of the program and evaluate how these are likely to play out in the context of the unique circumstances present in their state. Existing state analyses and federal reports help to advance the knowledge in the field and provide insight into many of the fundamental issues. While states are awaiting federal guidance and many critical policy issues remain open to debate, the field has reached consensus on several key issues. As additional state analyses are completed, this trajectory toward greater clarity will continue to evolve.

Summary Table of State BHP Analyses Published as of February 2012: Methodological / Modeling Results

State	Source / Author	Commissioned By	Publication Date	Methods / Sources	Program Features Modeled	Enrollment Levels	Cost Benefit Results
California	Mercer / CHCF	California HealthCare Foundation	6/28/2011	Estimates based on CPS and other state specific data and studies	BHP modeled on Medicaid rates, baseline BHP premium and cost sharing subsidy requirements	723,400 adults	BHP surplus of 25 – 70% depending on cost and financing estimates
California	IHPS / CHCF	California HealthCare Foundation	6/2011	Compiles elements of other previously published studies	Not applicable	Not applicable	BHP should be able to offer coverage at a lower cost than in Exchange – specific surplus calculations not modeled
Connecticut	Urban Institute	State	11/18/2010	Gruber micro-simulation model	BHP modeled on Medicaid rates, baseline BHP premium and cost sharing subsidy requirements	57,000 adults (16,000 HUSKY adults 133 – 185% FPL, 41,000 otherwise covered in Exchange)	BHP surplus of 7 – 13% (in 2017)
Maryland	Maryland DHMH / Urban	State	10/18/2011	Urban micro-simulation model (preliminary – full study to be released Dec 2011)	BHP modeled on Medicaid rates, baseline BHP premium and cost sharing subsidy requirements	77,000 adults	BHP surplus of 20%
Massachusetts	Milliman	Consultant	4/2011	Data from existing state programs (Comm Care / Comm Choice)	Modeled baseline BHP costs and financing by income level	N/A (did not estimate enrollment)	BHP surplus of 24%
Minnesota	John Gruber / Gorman Actuarial	State	11/18/2011	Gruber micro-simulation model, administrative and health insurance market data	Modeled a number of options for BHP design and cost structure	104,000 – 155,000 enrolled depending on program design	BHP operating loss of 18% – 48% depending on program design

Summary Table of State BHP Analyses Published as of February 2012: Methodological / Modeling Results

State	Source / Author	Commissioned By	Publication Date	Methods / Sources	Program Features Modeled	Enrollment Levels	Cost Benefit Results
New York	Community Service Society / Gorman Actuarial / Manatt	Consumer Organization	6/2011 (Revised 12/2011)	Estimates based on CPS and administrative / health insurance market data	BHP modeled on Medicaid/ FHP, with 10% increase in provider rates and higher AV than required for BHP (94% AV or 98% AV for all participants)	617,500 adults in seven eligibility groups	BHP break-even on an operating basis, net savings of $954 million per year (28% of annual program costs) due to state cost saving offsets
New York	Urban Institute	State	2/2/2012	Urban Micro-simulation model	BHP modeled on Medicaid rates and Medicaid plus 25%. Assumes adults pay $100 for premiums per year and receive coverage with a 98 percent AV.	468,000 adults	When counting state savings offsets, operating surplus at both Medicaid rates (28%) and Medicaid plus 25% (13%). Without state savings offsets, surplus at Medicaid rates(14%) and slight shortfall (-4%) at Medicaid rates plus 25%.
North Carolina	Milliman	State	3/31/2011	Estimates based on CPS, MEPS and administrative / health insurance market data	BHP modeled on Medicaid rates, baseline BHP premium and cost sharing subsidy requirements	179,500 eligible, enrollment not estimated	Not estimated, suggested for future study
Tennessee	State of Tennessee Department of Finance and Administration	State	10/31/2011	None apparent	BHP modeled at baseline gold/platinum AV without cost sharing subsidy	N/A (did not estimate enrollment)	Not modeled – BHP rejected as risky to the state

Summary Table of State BHP Analyses Published as of February 2012: Methodological / Modeling Results

State	Source / Author	Commissioned By	Publication Date	Methods / Sources	Program Features Modeled	Enrollment Levels	Cost Benefit Results
Washington	Milliman	State	12/2011	Estimates based on CPS, MEPS and administrative / health insurance market data	BHP modeled on Medicaid rates, baseline BHP premium and cost sharing subsidy requirements	133,700 eligible, enrollment not estimated	BHP surplus of 21% based on the reported difference between program revenue and "minimum costs" – also cites Dorn, Buettgens and Carroll (Sept 2011) estimate of 11.4% margin for Washington, noting that it is one of the smallest across the states.

Resource List

Benjamin, E. and A. Slagle, Community Service Society of New York, “Bridging the Gap: Exploring the Basic Health Insurance Option for New York”, June 2011.

Blavin, F., Blumberg, L. and Buettgens, M. “ACA Implementation in NY: Using the Health Insurance Policy Simulation Model (HIPSM) to Estimate Coverage and Cost Implications.” Urban Institute, February 2, 2012.

Curtis, R. and E. Neuschler, ”Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population: Background and an Alternative Approach,” Institute for Health Policy Solutions, July 5, 2011.

Curtis, R. and E. Neuschler, “Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program (BHP) in California,” Institute for Health Policy Solutions, September 2011.

Day, R., B. Garrett, C. Connolly, McKinsey and Company, “The Basic Health Plan—An Emerging Option for States,” March 24, 2011.

Dorn, S. “SustiNet Policy Options: Cost and Coverage Estimates.” SustiNet Partnership Board, November 18, 2010.

Dorn, S. “The Basic Health Program Option under Federal Health Reform: Issues for Consumer and States,” Academy Health/Robert Wood Johnson Foundation, March 2011.

Dorn, S., M. Buettgens and C. Carroll, Urban Institute, “Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States,” Association for Community Health Plans, September 2011.

Families USA, “The Basic Health Option: Will It Work for Low-Income Consumers in Your State?” Families USA, July 2011.

Graves, J.A., R. Curtis and J. Gruber.“Balancing Coverage Affordability and Continuity under a BasicHealth Program Option.”*New England Journal of Medicine* 2011; 365:e44, December 15, 2011.

Gruber, J. and B. Gorman. “Coverage and Financial Impacts of Market Reforms and a Basic Health Plan (BHP) in Minnesota.” November 18, 2011. [DRAFT, published online]

Institute for Health Policy Solutions, “Fiscal Risks from Differences in BHP vs. Federal Tax Credit Income-Test Timing,” Institute for Health Policy Solutions, September 2011.

Milligan, C. “The Basic Health Plan.” Maryland Department of Health and Mental Hygiene, Health Care Financing. October 18, 2011.

Mercer, “The State of California Financial Feasibility of a Basic Health Program” for the California HealthCare Foundation, June 28, 2011.

Milliman, “North Carolina Health Benefit Exchange Study.” Prepared for North Carolina Department of Insurance, March 31, 2011. [DRAFT, published online]

Milliman, “Healthcare Reform and the Basic Health Program Option, Modeling Financial Feasibility,” Reform Center Health Intelligence, April 2011.

Milliman, “Planning Washington’s Health Benefit Exchange” June 2011; and “The Federal Basic Health Option: An Analysis of Options for Washington State.” December 2011.

Rosenbaum, S. Health Reform GPS, “The Basic Health Program,” June 29, 2011.

State of Tennessee,“Comments on Exchange Functions in Individual Market: Appendix E: Analysis of Basic Health Program (BHP) Option.” Submitted to the Centers for Medicare and Medicaid Services pursuant to request for comments CMS-9974-P, October 31, 2011.

7

Appendix 1 – Basic Health Plan Financial Feasibility Actuarial Analysis

The information presented here provides the reader with the background and details related to the data sources, methodology, assumptions and results for modeling the financial feasibility of the BHP. The process of assessing the financial feasibility of the BHP option included the following analyses:

- Estimate the size and demographic characteristics of the population eligible for the Exchange in New Hampshire and the subsets likely to enroll in the BHP and the Exchange
- Estimate the Silver Level benefits and premiums likely to be offered in the Exchange
- Calculate the federal premium and cost sharing subsidies that would be made available to fund the BHP based on the estimated second lowest cost Silver Level plan offered in the Exchange
- Estimate the premiums that would be required to fund health care benefits to the BHP population, up to 200% of the federal poverty level (FPL) at Medicaid provider payment rates
- Calculate the difference between the estimated federal BHP subsidies available and the estimated BHP premiums

Section 1: Demographic Characteristics

To assess the demographic characteristics of New Hampshire residents eligible to enroll in the BHP and the Exchange, Mercer consulted several resources of studies and population data. The primary data source utilized to estimate these populations was the United States Census Bureau annual Current Population Survey (CPS) dataset. The CPS survey breaks down the population of all fifty states using several criteria, as follows:

- Income expressed as a percentage of FPL
- Age
- Gender
- Parent/Childless adult
- Citizen/Non-citizen
- Insurance status:
  - Private individual policies
  - Employer sponsored insurance (ESI)
  - Government sponsored (Medicaid, Medicare, Military/CHAMPUS-TRICARE)
  - Uninsured

Basic Health Program Plan Population Assumptions

In estimating the size of the BHP eligible population, Mercer incorporated the following working assumptions about the operation of the BHP in the state of New Hampshire:

- The BHP risk pool will consist entirely of adults, ages 19 – 64
- Children below 200% FPL will be covered by the Children's Health Insurance Program (CHIP), or Medicaid and will not be enrolled in the BHP
- Although the lower bound income level for the BHP is officially 133% FPL, it will effectively be 138% FPL; due to the 5% disregard allowed for the Medicaid expansion to 133% FPL, which raises Medicaid eligibility to 138% FPL
- Individuals with existing government provided health benefits, (Medicaid, Medicare and Military/CHAMPUS-TRICARE), will remain in these respective programs and will not be eligible for, or covered by the BHP
- The number of individuals with ESI will not change significantly with the implementation of the ACA in 2014, assuming the employers who drop coverage will roughly be offset by other employers who will choose to provide ESI, given the ACA premiums subsidies, which will make it more affordable. The *2011 Mercer National Survey of Employer-Sponsored Health Plans* finds that only 6% of large employers plan on terminating coverage when the ACA is implemented. Although 20% of small employers responded, saying they plan on terminating coverage, this has not occurred in Massachusetts where similar reform legislation has been in effect for several years. Thus, we assume this actual result may be replicated nationally
- Virtually all individuals below 200% of FPL, with privately purchased individual policies, will migrate to the BHP due to the incentives of lower premiums and low cost sharing relative to their current coverage
- The number of individuals over age 65 ineligible for Medicare is likely very small relative to the rest of the population estimates and are not considered in this analysis

Other Potential Populations that Could Transfer to the Basic Health Program

Although these populations could be transferred from Medicaid to the BHP, they are not counted in our estimate (although they are discussed in the Policy Options section of the report):

- Pregnant women, 138% – 200% FPL
- Women with Breast and Cervical Cancer, 138% – 200% FPL
- Medicaid for Employed Adults with Disabilities (MEAD), 138% – 200% FPL
- Any other Medicaid eligibles in the 138% – 200% FPL range, which would move to the Exchange if the state reduced Medicaid coverage to 133% FPL

Other Data Sources, Projections and Considerations

Mercer also reviewed uninsured estimates from several studies and reports to validate the calculation of the estimate of the demographics of the New Hampshire Exchange eligible population. While most focused on the larger states and the nation as a whole, the Buettgens & Hall paper, "Who Will Be Uninsured After Health Insurance Reform?", published by the Robert Wood

Johnson Foundation in March 2011 listed an uninsured number for New Hampshire of 136,000, which is very close the 134,000 produced by the CPS data in our model.

Obviously, with a plethora of unknown variables and undetermined specifics of the ACA, these projections are speculative and subject to change.

The current New Hampshire uninsured population is estimated to be about 10% and these studies project the state's uninsured rate will drop to less than 5% after ACA implementation. The Buettgens & Hall study projects a reduction in the uninsured, comparable to the results achieved in Massachusetts under its 2006 health care reform law; where the uninsured percentage of the population dropped from 10.4% in 2006 to 4.4% over a three year period, or a 58% reduction.

Estimation of Basic Health Program Eligible Population

This section presents the data source(s), methodology and acknowledgement of the influence of factors that may impact the estimates utilized for this analysis. Outlined below is discussion data to determine the estimated number of individuals that would be eligible between 138% and 200% of the FPL. This population represents individuals that would be eligible for the BHP and/or Exchange.

To estimate the BHP eligible population, Mercer used the New Hampshire CPS data for the three calendar years 2007, 2008 and 2009, downloaded from the Census Bureau website. Because the CPS represents a population sample, some of the finer gradations of specific categories are subject to distortion due to inadequate sample sizes. For this reason, we blended the data from the three years, 20% for 2007, 30% for 2008 and 50% for 2009. The most recent year was given the heaviest weighting due to the overall decrease in incomes since the current recession began in 2008.

The CPS data segregates populations by age into brackets of: 0 – 2, 3 – 10, 11 – 17, 18 – 20, 21 – 24, then eight 5-year age brackets, from 25 – 64, and from 65 – 85. Because 18 year olds will not be covered by the BHP, one-third of the 18 – 20 age bracket was removed.

The CPS data also segregates populations by income level in 25% increments, from 0% to 200% FPL; 50% increments from 200% to 500% FPL; and everyone 500% FPL and above. Because 138% is approximately halfway between 125% and 150%, half of the population in this income bracket will be covered by Medicaid and was removed. It should be noted here that the 2009 CPS data set is very close to the total 2010 New Hampshire population, as published by the U. S. Census Bureau.

Three characteristics of the CPS dataset have relevant impacts on the calculation of the potential Exchange and BHP eligible population. First, the CPS data survey period covers the span of the entire calendar year, as opposed to a point in time. Thus someone who had health insurance coverage for part of the year can be counted as either insured, or uninsured.

Second, the CPS data have a history of understating the Medicaid population. In recent years, this understatement has been the subject of analysis and research papers, which has helped improve the CPS data collection and tabulation process. The Medicaid coverage estimates, compared to actual Medicaid enrollment, have improved significantly. The understatement of Medicaid

enrollment was 26% in the 2007 CPS data, 9% in 2008 and less than 15% in 2009. However, the Medicaid undercounts in CPS would be largely confined to those below 138% FPL and would not have a significant impact on this BHP feasibility analysis.

Third, the CPS objective is to measure coverage by insurance type (e.g. ESI, Medicaid, Medicare, etc.) which appears to result in double counting of those individuals covered by more than one source (e.g., TRICARE and ESI for retired military). The result is the number of insured individuals by coverage type can exceed the total number of insured individuals. We observed this double counting occurs more at higher levels of income (especially above 400% FPL) and at older ages, consistent with this assumption. To some extent, the understatement of the Medicaid covered population is offset by the overstatement of the dually covered population.

Because of the double counting of the insured populations, our estimate for the New Hampshire population eligible for the Exchange is defined as the current Uninsured Population plus those with Individual/Private Insurance.

The final step in the process of estimating the BHP and Exchange eligible populations is to remove the undocumented immigrants within each income bracket. Due to the small number of undocumented immigrants, Buettgens & Hall estimate reside in New England; the impact of removing these individuals from the Exchange eligible population is negligible.

The resulting BHP eligible population estimate is approximately 55% male (45% female) with an average age of 39 and is shown in Table 1 below. Population estimates may fluctuate from the figures presented here. For the BHP feasibility analysis the total estimate has been rounded to 18,000 individuals.

Table 1 – BHP Eligible Population Estimate

	< 150% FPL		150% – 200% FPL		
	Females	**Males**	**Females**	**Males**	**Total**
19 – 24	608	797	1,005	734	3,144
25 – 34	260	805	986	2,506	4,556
35 – 44	497	402	1,738	1,043	3,680
45 – 54	389	460	1,327	2,231	4,407
55 – 64	86	123	1,133	761	2,103
Total	1,840	2,587	6,189	7,274	17,891

Estimation of Remaining Exchange Eligible Population

To estimate the Exchange eligible population, we included all ages between 0 and 64 above 200% FPL and ages 19 – 64, for those between 138% and 200% FPL. Because the New Hampshire CHIP expansion covers children up to 300% FPL, we removed those between ages 0 and 18 below 300% FPL.

Individuals with incomes below 400% FPL are eligible for Exchange subsidies and more likely to purchase insurance through the Exchange; we have segregated the Exchange population into two subgroups: those between 200% and 400% FPL and those 400% FPL and above.
After removing the estimated undocumented immigrants in each income bracket, the remaining Exchange eligible population estimate is approximately 55% male (45% female) with an average age of 39 and is shown in Table 2 below.

Table 2 – Exchange Eligible Population Estimates

	200% – 400% FPL		400% FPL and above		
	Females	**Males**	**Females**	**Males**	**Totals**
0 – 18	2,724	3,022	1,991	1,983	9,735
19 – 24	4,555	3,489	1,992	3,116	13,165
25 – 34	5,808	7,916	2,368	5,245	21,346
35 – 44	5,747	5,723	1,472	2,628	15,546
45 – 54	4,803	7,594	2,734	2,229	17,341
55 – 64	5,034	4,668	1,913	3,240	14,858
Total	28,671	32,411	12,470	18,440	91,992

Estimation of Basic Health Program and Exchange Enrolled Populations

The BHP and Exchange eligible population estimates overstate the number of individuals that will actually enroll. Once the ACA law takes effect in 2014, there will remain three significant categories of these eligible populations who will remain uninsured:

- Those who are unaware of these coverage options or those who are aware but have no interest in, or need for health coverage and never bother to enroll
- Those who do enroll, but fail to pay regular monthly premiums due to the cost, or inconvenience
- Those who enroll only when they have acute health care needs and lapse as soon as that need has been resolved and they no longer have immediate health concerns

With respect to those who are eligible, but never bother to enroll, the Kaiser Family Foundation estimates that the New Hampshire Medicaid/CHIP participation rate in 2009 was 87.1%; meaning that 12.9% of those eligible for Medicaid/CHIP are not enrolled. Given that these programs are entitlements, at low to no cost to the members, there should be minimal monetary disincentive to enroll. Thus, the 12.9% non-participation rate could be considered to be a lower-bound percentage of those who will fail to enroll in the BHP and the Exchange, both of which will require premium and cost sharing payments by members.

Given that under a BHP there would likely be monthly premium and out of pocket cost sharing, we estimate a participation rate of about 70% among the subsidized populations in the BHP and the Exchange, and a participation ratio of only half that level of those with incomes above 400% FPL who are not eligible for federal Exchange subsidies. We also assume the non-participation ratios will be greater for the younger ages and less for the older ages who have more health needs and are more responsible. Thus, the net estimate of the BHP eligible population that is expected to

enroll and pay premiums is about 12,000, and the net estimate of the Exchange eligible population that is expected to enroll and pay premiums is about 55,000.

The demographic profile of the uninsured BHP eligible population expected to enroll and pay premiums is approximately 55% male (45% female) with an average age of 41 and is shown in Table 3.

Table 3 – Estimated Demographic Profile of BHP Enrollees

	< 150% FPL		150% – 200% FPL		
	Females	**Males**	**Females**	**Males**	**Total**
19 – 24	304	399	503	367	1,572
25 – 34	156	483	592	1,503	2,734
35 – 44	348	281	1,217	730	2,576
45 – 54	311	368	1,061	1,785	3,526
55 – 64	77	111	1,019	685	1,892
Total	1,197	1,642	4,392	5,070	12,300

The demographic profile of the uninsured Exchange eligible population expected to enroll and pay premiums is approximately 54% male (46% female) with an average age of 41 and is shown in Table 4 below.

Table 4 – Estimated Demographic Profile of Exchange Enrollees

	200% – 400% FPL		400% FPL and above		
	Females	**Males**	**Females**	**Males**	**Totals**
0 – 18	1,907	2,115	1,394	1,388	6,804
19 – 24	2,733	2,093	598	935	6,358
25 – 34	3,775	5,145	770	1,705	11,395
35 – 44	4,023	4,006	515	920	9,464
45 – 54	3,603	5,695	1,025	836	11,159
55 – 64	4,027	3,734	765	1,296	9,823
Total	20,067	22,790	5,067	7,079	55,002

The second and third categories of the uninsured population are related and can be partially measured by the lapse rates of existing BHPs. While there are monetary penalties (which increase with income) for failing to pay premiums and continue coverage once an immediate health need passes, the ACA allows for a generous 90-day grace period of continued coverage once a member ceases to pay monthly premiums and there is no waiting period or underwriting when re-enrolling after a gap in coverage. The result will be that healthier lives will tend to lapse, while those with acute and chronic health care needs will tend to remain covered, driving up the average per capita cost.

The State of Washington Basic Health Plan started in 1989 and has more than two decades of experience. While it covers the same population as the ACA BHP, those earning less than 200% FPL, it also covers those below 138% FPL, down to the state's Medicaid income limits of 74% for parents and 0% for childless adults. The current monthly premiums for a 42 year-old in the plan range from $100.00 for those earning 140% FPL and $180.00 for those earning 180% FPL, which are higher than the projected member premiums in the Exchange.

In 2008 and the first part of 2009, approximately 4% of the Washington BHP membership lapsed each month. Once an enrollment cap was enforced in 2009 and a waiting list was created for those who wanted to enroll but could not, the monthly lapse rate dropped to about 3% in 2010. This decrease in the lapse rate is consistent with the adverse selection assumption, which holds that the remaining population will be less healthy and more diligent in paying their monthly premiums to avoid losing their valued coverage for any period of time.

While some of the Washington BHP lapses are due to (a) changes in income, (b) replacement by other coverage – ESI, Medicaid or Medicare, (c) movement out of state, and (d) death, the level of adverse selection present is significant and measurable. The adverse selection present among the New Hampshire BHP population would be similar, but is not considered in the scope of this analysis.

Section 2: Essential Health Benefits

The Essential Health Benefits (EHB) were designed in the ACA to model large employer group coverage, such as the Federal Employee Health Benefits Program (FEHBP). Using this guidance, we have defined the Exchange benefits as shown in the table below.

Table 5 – Health Benefits Modeled

Inpatient Facility	**Outpatient Professional**
• Medical/Surgical	• Outpatient Surgeries
• Maternity	• Emergency Room Visits
• Mental Health	• Lab/Radiology
• Substance Abuse	• Physician Maternity
• Other Inpatient	• EPSDT/Wellness
	• Primary Care Physician (PCP) Office Visits
Outpatient Facility	• PCP Other Medical Services
• Emergency Room	• Specialty Office Visits
• Surgery	• Specialty Other Medical Services
• Hospital Outpatient Pharmacy	• Outpatient Mental Health
• Lab	• Outpatient Substance Abuse
• Radiology	• Chiropractor
• Physical/Occupational/Speech Therapies	• Podiatrist
• Hospital Outpatient Pharmacy Other	• Physical Therapy
	• Speech and Occupational Therapies
	• Professional Other
Pharmacy	
• Brand	**Outpatient Other Non – Rx**
• Generic	• Home Health/Home Nursing
• Pharmacy Other	• Durable Medical Equipment and Supplies
	• Emergency Transportation

The Institute of Medicine (IOM) report released on October 7, 2011, recommends that the Secretary of Health and Human Services (HHS) define the EHB based on typical small group plans, exclusive of state mandates. This suggests a smaller level of benefits and stresses the objective of affordability compared to overall broad coverage of the vast majority of medical service types. However the IOM made no recommendations for inclusion, or exclusion of specific benefits in its report. Note that the Secretary of HHS is not bound by the IOM recommendations.

On December 16, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) issued a bulletin indicating that the definition of EHB would be delegated to the states, with the following initial guidance of the intended regulatory approach, that the EHB:

- Encompass the 10 categories of services identified in the ACA

- Reflect typical employer health benefit plans
- Reflect balance among the categories
- Account for diverse health needs across many populations
- Ensure there are no incentives for coverage decisions, cost sharing, or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Provide States a role in defining EHB
- Balance comprehensiveness and affordability for those purchasing coverage

CCIIO suggested four benchmark plan types for 2014 and 2015, to best reflect the statutory standards for EHB in the ACA:

- the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market
- any of the largest three State employee health benefit plans by enrollment
- any of the largest three national FEHBP plan options by enrollment, or
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State

The bulletin also stated that if a state does not exercise the option to select a benchmark health plan, CCIIO intends to propose that the default benchmark plan would be the largest plan by enrollment in the largest product in the state's small group market. While this bulletin does make some progress in defining the EHB, it does not reduce the potential variance of the scope of the final EHB for pricing purposes.

Fortunately, the Exchange premiums, BHP subsidies and BHP premiums would all be based on the same EHB package. Thus, absent any additional state mandated benefits that New Hampshire wants to add (over and above the federal EHB), any benefit cost included (or excluded) from the EHB in the Exchange, would also be included (or excluded) from the BHP costs. Consequently, the BHP feasibility analysis would not be significantly impacted by varying definitions of the federal EHB.

Section 3: Silver Level Benefits and Premiums Offered in the Exchange

Section 1331 of the ACA authorizes the BHP and defines the premium and cost sharing subsides based on the EHB, yet to be fully defined by the Secretary of the Department of Health and Human Services (DHHS). As a margin of conservatism, Mercer estimated the 2014 Silver level premiums based on the average level of claims from commercial and employer plans from the New Hampshire Department of Insurance (DOI) All Payer Claims Database (APCD) from calendar years (CY) 2009 and 2010, which likely have lower benefit levels than will be required by the final EHB definition.

The Silver level of benefits is defined by the ACA as having an actuarial value of 70%, meaning that 70% of the total health benefit costs (excluding plan administration, risk and profit charges) are paid by the plan, with the remaining 30% paid by the member in the form of deductibles, coinsurance and copayments.

The demographic profile used to estimate the Silver level premiums offered in the Exchange in 2014 was described Section 1 and developed from the CPS dataset at the 200% FPL and above. Mercer adjusted this demographic profile by assuming that younger people, who are less likely to have ongoing health care needs, will be slightly less likely to comply with the federal mandate to purchase coverage through the Exchange, while older people, conversely, are slightly more likely to have ongoing health care needs and be more likely to comply with the federal mandate to purchase coverage through the Exchange.

Therefore, while we assume an average of 70% of the Exchange eligible population between 200% and 400% FPL will enroll, we assume that only 60% of the youngest age brackets will enroll and 80% of the oldest age brackets will enroll. This adjustment increased the average age of the estimated enrolled population by about two years.

We also assumed the population that enrolls in the Exchange will be primarily in the 200% –400% FPL income bracket because they are eligible for the premium and cost sharing subsidies. Those with incomes exceeding 400% FPL will not have any subsidies available to them under the Exchange and may be able to find more attractive coverage options outside the Exchange. Thus we further reduce the number of individuals above 400% FPL purchasing coverage through the Exchange by half. The demographic profile of the uninsured Exchange eligible population expected to enroll and pay premiums is 54% male with an average age of 41 and estimated to be 55,000.

In addition to adverse selection due to age, the enrolled population in the Exchange will experience adverse selection in all age brackets at both extremes of the health spectrum. Less healthy individuals with above average health care risk will select, against the insurers in the Exchange, by enrolling at premium levels insufficient to cover the health care risks they present. While some of the healthier individuals with little to no health care risk will opt out of the Exchange and avoid the unnecessary and unreasonably high health care premiums.

This adverse selection, which will increase the average risk levels of the members who purchase coverage in the Exchange, will be somewhat offset by the fact that the BHP premium and cost sharing subsidies will be based on the second lowest Silver level premium offered in the Exchange.

As with any other product or service in the marketplace, Mercer anticipates that there will be a range of premiums offered at the Silver level by the health insurers participating in the Exchange, some of which will overestimate the resulting risk pool (at higher premium levels), while others will underestimate the resulting risk pool (at lower premium levels). Thus, it's possible that the BHP premium and cost sharing subsidies, based on the second lowest Silver level premium offered in the Exchange, will underestimate the ultimate risk level and be lower than the average. Consequently, to be conservative, Mercer developed the BHP subsidy estimate by not including an adverse selection risk loading into the projected 2014 Silver level premium estimate.

To project future health care costs from the APCD base data, Mercer used current annual commercial health care unit cost and utilization trends of 8%, to project costs to the first year of Exchange operation in 2014.

To be conservative, we set the health plan administrative loading at 15%, although 20% will be allowed for individual policies sold in the Exchange. As another margin of conservatism, because this section of the ACA has yet to be clarified, we used 95% of the cost sharing subsidy calculation instead of 100%. See the discussion below on the issue of 95% versus 100% for the cost sharing subsidy.

The resulting weighted average Silver level premium for the year 2014, priced for the demographics above, as calculated from the APCD base data projected to 2014, is $493 PMPM. As a comparison, the Community Service Society (CSS) estimated the 2014 Silver level premiums in New York to range from $367 PMPM for health maintenance organizations (HMOs) to $520 PMPM for preferred provider organizations (PPOs), while a March 2011 Milliman BHP analysis based on Massachusetts Commonwealth Choice data, estimated a 2014 Silver level premium of $542 PMPM. And in California, Mercer estimated the 2014 Silver level premiums to range from $441 to $486 PMPM.

The *Kaiser/Health Research Educational Trust 2010 Survey of Employer-Sponsored Health Benefits* showed that the average cost of employer sponsored coverage in the northeast exceeded the west by 20% for HMOs, 3% for PPOs and 11% for point of service plans. Similarly, the *2011 Mercer National Survey of Employer-Sponsored Health Plans* showed per employee health care costs in New England to be 7.4% greater than New York and 5.4% greater than California. While the risk profiles, benefits and cost sharing vary among employers and regions of the country; these comparisons were included to demonstrate a reasonableness check of Mercer's independent Exchange estimate.

Federal BHP Premium and Cost Sharing Subsidy Calculations

The BHP federal premium and cost sharing subsidy formula is not clearly defined. Section 1331(d)(3)(A)(i) of the ACA defines it as, "… equal to 95 percent of the premium tax credits… and the cost sharing reductions under section 1402 …" which can be interpreted as either:

- 95% X (premium subsidy + cost sharing subsidy) or
- 95% X premium subsidy + 100% X cost sharing subsidy

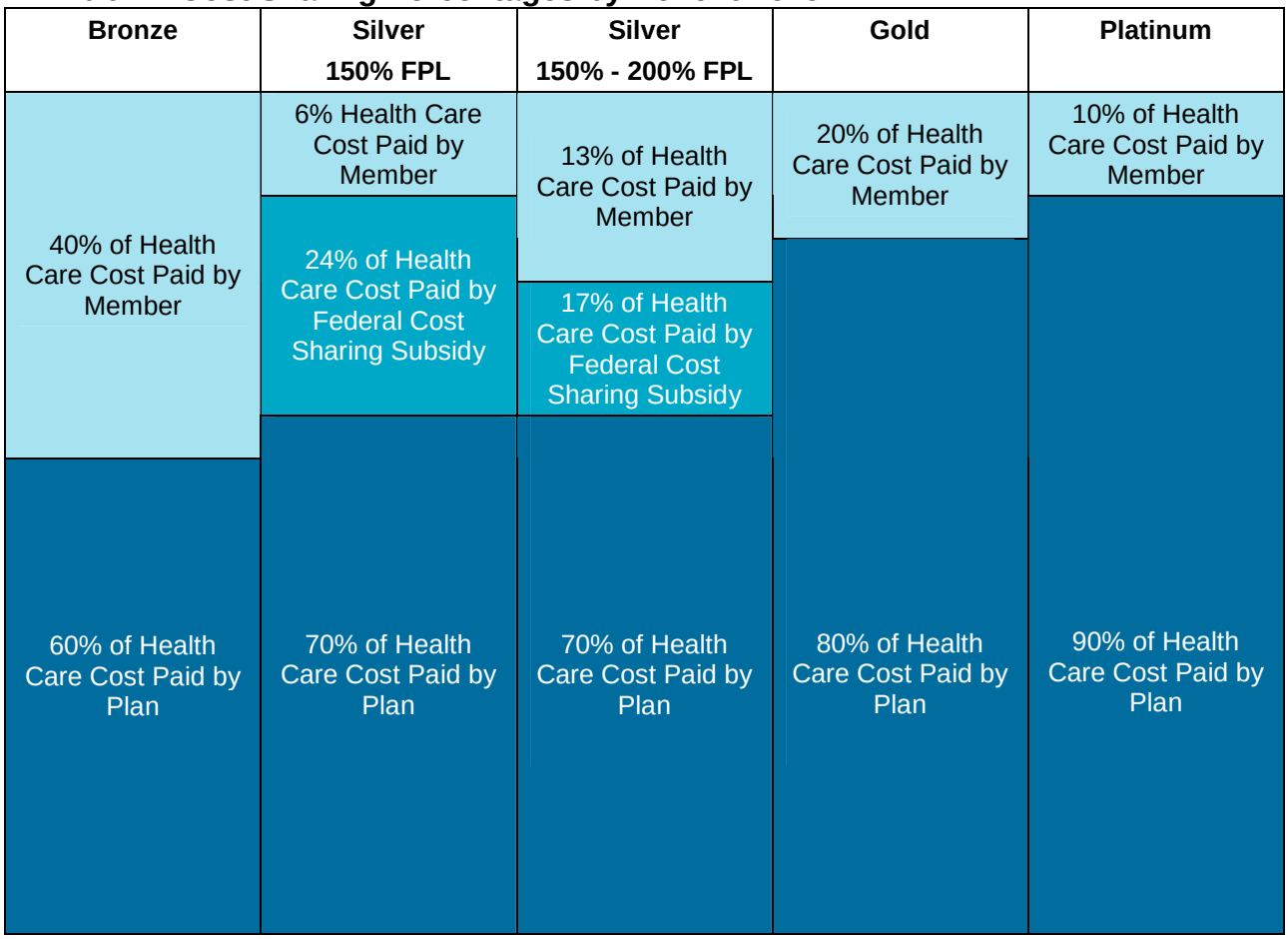
The Premium Tax Credit is defined mathematically as:
The Premium (for the second lowest Silver Level Benefit Plan) – the member share of premium, as determined by the applicable premium offset percentage (based on income as defined in Section 1401(b)(3)(A)(i) and as specified in Table 4 below).

Table 6 – Premium Offset Percentages (of Income)

	Low end premium offset %	High end premium offset %	Cost sharing (actuarial value)
100% – 133% FPL	2.00%	3.00%	94%
133% – 150% FPL	3.00%	4.00%	94%
150% – 200% FPL	4.00%	6.30%	87%
200% – 250% FPL	6.30%	8.05%	73%
250% – 300% FPL	8.05%	9.50%	None
300% – 400% FPL	9.50%	9.50%	None

Section 1402(c)(2), defines the additional cost sharing subsidy as "… the issuer of a qualified health plan … shall further reduce cost sharing under the plan in a manner sufficient to ─ (A) in the case of an eligible insured whose household income is … not more than 150% of the poverty line … increase the plan's share of the total allowed costs of benefits provided under the plan to 94% of such costs; … in the case of an eligible insured whose household income is more than 150% but not more than 200% of the poverty … increase the plan's share of the total allowed costs of benefits provided under the plan to 87% of such costs." Mercer interprets this language to mean that those between 100% and 150% FPL have plans with an effective actuarial value of 94% (paying an average of 6% cost sharing) and those between 150% and 200% FPL have plans with an effective actuarial value of 87% (paying an average of 13% cost sharing). See Exhibit 1 below for cost sharing percentages by benefit level.

Exhibit 1 – Cost Sharing Percentages by Benefit Level



Mercer estimates the 2014 FPL for a single adult will be $12,196, which would generate the Exchange premium offset amounts shown in Table 7 below.

Table 7 – Estimated Exchange Premium Offset Calculation

			Premium	
One adult FPL	**Annual Income**	**Offset Percentage**	**Annual**	**Monthly**
100% FPL	$12,196	2.00%	$244	$20
138% FPL	$16,830	3.29%	$554	$46
144% FPL	$17,502	3.65%	$640	$53
150% FPL	$18,294	4.00%	$732	$61
175% FPL	$21,343	5.15%	$1,099	$92
200% FPL	$24,392	6.30%	$1,537	$128

Figures in the table are rounded.

The 138% level is used in this table since FPL levels below this will be coved by Medicaid (133% FPL plus 5% income disregard). The number of people estimated below this income level (legal immigrants not currently eligible for Medicaid) is very small. Since 144% FPL is midway between the lower BHP population income segment of 138% – 150% FPL and 175% FPL is midway between the upper BHP population income band of 150% – 200% FPL, Mercer used the 144% and 175% midpoints to represent the average of each population segment for pricing purposes.

Using this Exchange demographic profile, the weighted net federal BHP premium and cost sharing subsidy in 2014 is estimated to be $495. Calculations are shown in Table 6 below.

Table 8 – Calculation of the Estimated BHP Subsidy PMPM (lower scenario)

	Combined
Total Projected Health Care Cost	$599
– 30% Member Cost Sharing	$180
= 70% Plan covered Health Care Cost	$419
+ 15% Administrative Loading	$74
= Silver Level Premium PMPM	$493
– BHP Premium Offset	$83
= Gross Premium Subsidy	$410
x 95% = Net Premium Subsidy	$390
Gross Cost Sharing Subsidy	$111
x 95% = Net Cost Sharing Subsidy	$105
Total Estimated BHP Net Subsidy	**$495**

Figures in the table are rounded.

In the absence of a BHP, the monthly member cash out-of-pocket costs in the Exchange are shown in the table below:

Table 9 – Exchange Premium and Cost Sharing by Income Threshold

		Lower BHP FPL band		**Upper BHP FPL band**		**Exchange FPL band**	
FPL band	**Medicaid**	**138%**	**150%**	**150%**	**200%**	**200%**	**400%**
Premium	$0	$45	$60	$60	$130	$130	$385
Cost share	$0	$30	$30	$70	$70	$140	$155
Total	$0	$75	$90	$130	$200	$270	$540

Section 4: Estimated 2014 BHP Premiums

The BHP subsidies will be calculated on an individual basis and are defined as the premium and cost sharing subsidies each person would receive for the second lowest Silver Level plan available in the Exchange. To approximate the aggregate Silver Level premiums available in the Exchange and the resulting BHP subsidies, we segregated the populations into two age groups: 19–44 and 45–64.

The 19–44 age group represents the younger, healthier (low cost) segment when women are in their childbearing years. The 45–64 age group represents the older, less healthy (high cost) segment, when chronic aging conditions such as heart disease and cancer begin to generate significant medical expenses.

A demographic profile is defined, as the relative distribution of a population by age and gender. Mercer adjusted the demographic profile of the BHP enrolling population slightly by assuming that younger people, who are less likely to have ongoing health care needs, will be less likely to comply with the federal mandate to purchase coverage. While older people, conversely, are more likely to have ongoing health care needs and be more likely to comply with the federal mandate to purchase coverage. The penalties that apply to this population for failing to purchase minimum essential coverage are $95 in 2014, $325 in 2015 and $695 in 2016.

While we assume an average of 70% of the BHP eligible population will enroll, we assume that only 50% of the youngest age brackets will enroll, while 90% of the oldest age brackets will enroll. This adjustment increased the average age of the estimated enrolled BHP population by about two years. The demographic profile of the uninsured BHP eligible population expected to enroll and pay premiums is 55% male with an average age of 41 and estimated to be 12,300 individuals.

Our estimate of the enrollment of the 138%–200% FPL income band (in the BHP) is greater than what we would estimate if a BHP was not offered. This is because we would assume a smaller percentage of individuals up to 200% FPL would actually enroll in the Exchange, as compared to a BHP due to the higher premiums and cost sharing requirements. We assume that approximately 70%, would enroll in a BHP, enticed by the additional incentives of reduced premiums and cost sharing. However, without these additional incentives in the Exchange, we assume that only 9,000, or roughly half of those in the low income band would enroll in the Exchange in the absence of a BHP option.

To estimate the BHP expenses in 2014 for this population, Mercer used the following assumptions in its modeling:

- Provider reimbursements based on New Hampshire current Medicaid levels
- The DHHS Medicaid data Physician category of service (COS) costs were increased to Medicare levels based on the estimate that
  - current NH FFS PCP reimbursements are 67.5% of Medicare
  - half of the Physician COS costs are paid for PCP services
- Combined (cost and utilization) annual Medicaid PMPM trends of 4%

- Administrative loading of 15% for managed care operations (including profit, risk and margin for contingencies)

The actual provider reimbursements paid by the Medicaid MCOs for services rendered to BHP members, is contingent upon which MCOs are awarded Medicaid managed care contracts and the reimbursements they negotiate with the participating Medicaid providers.

The following benefit and cost sharing assumptions were used for the BHP cost scenario:

- Medicaid benefits, which are estimated to be in excess of typical commercial plans, assumed to be excluded from the EHB and were removed from the historical Medicaid costs:
  - Dental
  - Methadone Treatment
  - Half of Behavioral Health COS
- Mercer priced a $10 monthly premium for the less than 150% FPL income group and a $20 premium for the 150% – 200% FPL income group
- Plan cost sharing by BHP income band as follows:
  - The 138% – 150% FPL income band was priced with mostly $10 inpatient and $5 ambulatory copayments, generating a plan actuarial value of 97%
  - The 150% – 200% FPL income band was priced with mostly $20 inpatient and $10 ambulatory copayments, generating a plan actuarial value of 94%

Reducing the total BHP health care expenses using the member premiums and cost sharing noted above, the resulting monthly net BHP premiums (net cost to the State) for this plan of benefits are estimated to be $385 PMPM, as shown in Table 10 below. This combined $385 PMPM net BHP cost to the State is $110 less than the estimated combined lower scenario federal BHP subsidy of $495 PMPM calculated in Section 3. This represents approximately 29% of the $385 BHP cost and could provide sufficient margin (assuming all other assumptions hold) to operate a BHP without additional State funding from a purely financial perspective based on provider reimbursement differentials.

Table 10 – Estimated BHP Premiums

	138% – 200% FPL
Total Projected Health Care Cost	$362
– 3% / 6% Member Cost Sharing	$19
= Plan Covered Health Care Cost	$343
+ 15% Administrative Loading	$60
= BHP Premium PMPM	$403
– BHP Member Premium	$18
= State Net BHP Premium	$385
– BHP Premium Subsidy	$495
= Net State BHP Cost/(Surplus)	($110)

In contrast to the information in Table 9, using these member premiums and cost sharing, the monthly member cash out-of-pocket costs in the Exchange with a BHP, are shown in Table 11 below:

Table 11 – BHP and Exchange Premium and Cost Sharing by Income Threshold

		Lower BHP FPL band		Upper BHP FPL band		Exchange FPL band	
FPL Band	**Medicaid**	**138%**	**150%**	**150%**	**200%**	**200%**	**400%**
Premium	$0	$10	$10	$20	$20	$130	$385
Cost Share	$0	$10	$10	$20	$20	$140	$155
Total	$0	$20	$20	$40	$40	$270	$540

In this low cost BHP scenario, the out-of-pocket cost for a BHP member at 138% FPL drops from $75 to $20, or 73% and the out-of-pocket cost for a BHP member at 200% FPL drops from $220 to $40, or 82%. While the BHP can make heath coverage more accessible and affordable for the lower income band that sits just above the Medicaid eligibility threshold, it also dramatically increases the out-of-pocket cost gap for someone at the 200% FPL cusp. At 199.9% FPL, this person would pay only $40 per month for health benefits, but at 200.1% FPL (a mere $44 increase in annual income, about $4 a month or 2 cents of an hourly wage) this person would be required to pay $270 a month for the same health care. This represents an increase of $230 a month, or $2,760 a year.

To address this potential concern, we modeled an alternative scenario with somewhat higher member premiums and cost sharing to smooth the slope of the out-of-pocket cost curve along the income scale. The following benefit and cost sharing assumptions were used for the alternative BHP cost scenario:

- Mercer priced a $20 monthly premium for the less than 150% FPL income group and a $60 premium for the 150% – 200% FPL income group
- Plan cost sharing by BHP income band as follows:
  - The 138% – 150% FPL income band was priced with mostly $20 inpatient and $5 ambulatory copayments and a $10 brand drug copayment, generating an actuarial value of 95%
  - The 150% – 200% FPL income band was priced with mostly $40 inpatient and $20 ambulatory copayments and a $20 brand drug copayment, generating an actuarial value of 88%

The resulting monthly net BHP premiums for this plan design are estimated to be $330 PMPM, which is $165 less than the estimated federal BHP subsidy of $495 PMPM. This represents 50% of the $330 PMPM BHP cost and could provide sufficient margin (assuming all other assumptions hold) to operate a BHP without additional State funding from a purely financial perspective based on provider reimbursement differentials.

This alternate scenario provides the advantages of a larger BHP subsidy margin for the State and a more reasonable member out-of-pocket cost curve along the income scale. However, it does

increase member costs for this low income group and could potentially adversely affect the enrolling BHP risk pool as healthier members decide to opt-out.
The resulting monthly member cash out-of-pocket costs in the Exchange with a BHP are shown in Table 12

Table 12 – BHP and Exchange Premium and Cost Sharing by Income Threshold

		Lower BHP FPL Band		Upper BHP FPL Band		Exchange FPL Band	
FPL Band	**Medicaid**	**138%**	**150%**	**150%**	**200%**	**200%**	**400%**
Premium	$0	$20	$20	$60	$60	$130	$385
Cost Share	$0	$15	$15	$40	$40	$140	$155
Total	$0	$35	$35	$100	$100	$270	$540

Surplus/(Deficit) of Estimated Federal BHP Subsidies Over BHP Premiums

In calculating the calendar year (CY) 2014 BHP premium subsidy and BHP cost estimates, Mercer employed conservative assumptions where possible.

As noted above, the federal BHP subsidies do not include state mandated benefits, not defined as part of the EHB, which must be funded entirely by the states. According to the Council for Affordable Health Insurance 2010 report, New Hampshire has 44 state mandated benefits. An expansion above the level of EHB from which the federal subsidies are calculated, is one option for the State to consider when allocating this excess funding.

To assess the boundaries of the feasibility of the BHP option, we tested the scenario where the BHP has zero premiums and no member cost sharing to match Medicaid. The resulting monthly BHP premiums for this Medicaid plan design are estimated to be $426 PMPM. This $426 PMPM net BHP cost to the State is $69 less than the estimated federal BHP subsidy of $495 PMPM. This represents approximately 16% of the $426 PMPM BHP cost and could conceivably provide sufficient margin (assuming all other assumptions hold) to operate a BHP without additional state funding from a purely financial perspective based on provider reimbursement differentials.

This Medicaid scenario provides the best advantage to this low income population, which would also have the best chance of maximizing enrollment. This scenario would both cover the greatest number of eligible adults and result in the lowest morbidity level of the risk pool. However, the disadvantages to the State are that the surplus margin could result in a deficit if all of the assumptions do not hold and would limit the State's ability to add mandated benefits or increase provider reimbursements. The results of the three scenarios are summarized in Table 13 below.

Table 13 – BHP Scenario Results

PMPM estimates	$10 / $20 Premiums 3% / 6% Cost Sharing	$20 / $60 Premiums 5% / 12% Cost sharing	Zero premiums No cost sharing
Federal subsidy	$495	$495	$495
Net State BHP cost	$385	$330	$426
Excess/(Deficit)	$110	$165	$69

The evaluation and choice between the premium and cost sharing scenarios presented is not necessarily obvious. The scenario resulting in a $165 PMPM subsidy surplus might appear to offer the best protection to the State. Already mentioned, this scenario also has the highest premiums and cost sharing, likely generating the lowest participation (of the above three scenarios) and the highest level of morbidity in the BHP.

Conversely, the no cost Medicaid scenario might appear to present the greatest risk to the State's budget. However, this scenario will have the effect of generating the highest enrollment and the lowest level of morbidity in the risk pool; decreasing the likelihood that these unknown variables might deviate significantly far from the assumptions.

Section 5: Financial Feasibility Provider Access Issues

Conclusions on Financial Feasibility

Provided all of the assumptions listed above hold, under any scenario based on the estimated subsidy and costs modeled in this analysis, the result is that it would be financially feasible for New Hampshire to offer a BHP option at current Medicaid provider reimbursement levels – including the 2013 – 2014 PCP provider reimbursement increase – with no costs to the State.

These results are driven by the estimated differential in Medicaid versus commercial provider rates of reimbursement. These estimates are speculative at this early stage with so many provisions of the ACA undefined and specifics of the BHP undetermined. However, the gap between the estimated premium subsidy and projected health care cost to cover the BHP population is consistent with findings from other studies on this topic (e.g., the Mercer Connecticut BHP report, the Urban Institute's 50 state BHP analysis, and the CSS New York state report).

In New Hampshire, the excess of the federal subsidies over the resulting costs of a BHP could be used to increase provider reimbursement rates, reduce member premiums and cost sharing, expand benefits and extend outreach to enroll a greater share of this low income population.

As with Medicaid, MCOs operating a BHP bear the risk that the capitated premiums paid by the state are sufficient to cover the cost of providing the benefits. However, states operating a BHP will bear this risk. Thus New Hampshire needs to consider the BHP delivery system when assessing the overall risk to the state of implementing a BHP.

Perhaps the most significant caveat to the BHP modeling, calculations and conclusions contained in this report is the key unknown of the variation of the Silver Level premiums offered in the Exchange. These calculations and conclusions are based on the $493 PMPM weighted average estimate of Silver Level premiums from our micro-simulation modeling. Implicit in the use of this $493 PMPM premium estimate is that this will represent the second lowest Silver Level plan offered in the Exchange, or that the Silver Level premiums offered in the Exchange will be tightly clustered around this value. It is assumed that health plans may not have adequate information to accurately price health policies in the Exchange. The result may be rates that vary widely which could reduce BHP subsidy

If this were to occur, the no cost Medicaid scenario could not be implemented without additional State funding, while the low cost scenario would have significantly less margin to spare. However, plans that under price the market in 2014 (the first year of the Exchange) may very quickly increase their premiums in subsequent years (assuming the increases would be approved) and this BHP subsidy deficit may not last for more than a couple of plan years.

In contrast, the results in this analysis are largely immunized from the unknown assumption of the definition of EHB. If the EHB are greater, or less than those priced in this analysis, then the Exchange Silver Level premiums, along with the federal BHP subsidies, would increase more, or less at the same rate as the resulting BHP costs, with the resulting BHP subsidy excess or deficit relatively unaffected.

Similarly, the results in this analysis are largely immunized from the unknown assumption of the medical inflation and utilization trends from now until 2014. As long as commercial health care trends continue to exceed Medicaid trends, if the medical trends are greater, or less than those priced in this analysis, then the Exchange Silver Level premiums, along with the federal BHP subsidies, would increase more, or less at the same rate as the resulting BHP costs, with the resulting BHP subsidy excess or deficit relatively unaffected.

Finally, we did not include a "pent-up" demand loading assumption into either the estimated Silver Level premiums, or BHP costs. While this phenomenon is likely to occur, the financial feasibility of the BHP will not be affected. This is because any pent-up demand loading that increases BHP costs, will also occur in the Exchange, resulting in higher Exchange premiums and in turn, higher BHP subsidies.

Mercer is not advocating for, or against the BHP option. The results of this study indicate this may be a viable option for the State to consider, as it decides how best to implement the many provisions of the ACA. While the results of the analysis indicate this to be financially feasible; clearly implementation of a BHP would not be without some element of risk to the State.

Medicaid and BHP Provider Availability and Access

The ACA effectively expands Medicaid to 138% FPL, which is estimated to increase Medicaid/CHIP enrollment by about 42,000 by 2016. This enrollment expansion could place additional strain on the New Hampshire Medicaid provider networks, increase cost shifting to commercial carriers and reduce the access and availability to providers for Medicaid patients. Implementing a BHP would increase the Medicaid patient base by another 12,000, further exacerbating this impact.

Accrediting agencies such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) do not establish network adequacy standards, leaving these to be defined by the plans. Likewise, CMS does not establish network adequacy standards for Medicaid, leaving most managed care plans and State health care purchasers to develop them based on the unique circumstances, membership and geography. For instance, there are often different standards for rural versus urban areas; or in the ratio of providers to enrollees for primary care versus specialty care services.

In 2006, Massachusetts sought to achieve near universal coverage for state residents and in 2007 implemented the "individual mandate", similar to that called for under the ACA. Thus, the experience in Massachusetts provides a strong indication of the impact other states may need to plan for in the implementation of their Exchange programs. According to a paper published by The Kaiser Commission on Medicaid and the Uninsured, there were three key lessons:

- Insurance expansions can lead to a surge in the demand for primary health care, especially in medically underserved low income communities
- In addition to expanding insurance coverage, investments to expand the capacity of the primary care system that will care for the newly insured, as well as, for those who remain uninsured will be important
- Even post-reform, there will be a continuing need for sources of care for the uninsured

Prior to reform, community health centers had already been providing care to one out of every 13 Massachusetts residents and one out of every four low income residents, highlighting the importance of these safety net providers within the Massachusetts delivery system. When compared to private physicians, these health centers saw a larger share of low income and uninsured patients, further indicating that private physicians are unwilling to treat low income and uninsured patients.

Post reform, health centers found an overall organic increase in patient growth representing both insured and uninsured individuals, mainly in the adult age bands. However, what was unexpected is that many of the newly insured patients remained at the health centers, thus effectively changing the payer mix but not the clientele served. This is important to understand, as financing for most health insurance expansion is covered, in part, by the assumption that less money is needed for safety net providers assuming that expanded coverage is more plentiful through private physician offices and therefore less reliant on the safety net.

The Massachusetts Medical Society also conducted a Physician Workforce Study that indicated serious shortages of internists, family practitioners and some specialists. In general, physician workforce shortages are well chronicled nationally and Massachusetts' shortages are consistent with national trends. These shortages, in general, already decreased the primary care capacity within the Commonwealth, but did not appear to offer greater disparity between commercial capacity and their State insurance counterpart.

A thorough analysis of the New Hampshire Medicaid provider infrastructure should be undertaken to assess the impact of expanding the Medicaid eligible population, as required by the ACA; as well as, the additional impact of potentially adding the BHP population to this patient base.

Disclaimer \ Signature Page

Mercer has prepared these projections exclusively for the Endowment for Health, to estimate the range of the impact of federal Health Care Reform as it pertains to the Basic Health Plan and its state health insurance exchange. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability from the estimates.

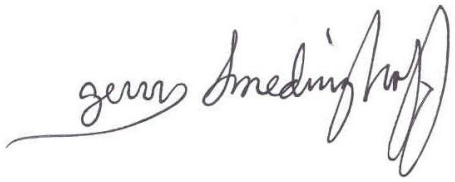
Further, the estimates set forth in this report have been prepared before all regulations needed to implement the Patient Protection and Affordable Care Act (PPACA) and Health Care Education and Reconciliation Act (HCERA), together referred to as the ACA, have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. The State is responsible for all financial and design decisions regarding ACA and HCERA. Such decisions should be made only after careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

For our analysis, we relied on data and information and other sources of data as described in this report. We have relied on these data without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data, and it should also be noted that our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

In addition, the projections we show in this report are dependent upon a number of assumptions regarding the future economic environment, medical trend rates, carrier behavior, the behavior of individuals and employers in light of incentives and penalties, and a number of other factors. These assumptions are disclosed in our report and have been discussed with the Endowment. While this analysis complies with applicable Actuarial Standards of Practice and Statements of Principles, users of this analysis should recognize that our projections involve estimates of future events, and are subject to economic, statistical and other unforeseen variations from projected values. To the extent that future conditions are at variance with the assumptions we have made in developing these projections, actual results will vary from our projections, and the variance may be substantial.

Lastly the Endowment understands that Mercer is not engaged in the practice of law. While this report may include commenting on legal issues or regulations it does not constitute and is not a substitute for legal advice. Mercer recommends that the State secure advice from its legal counsel with respect to any legal matters related to this report or otherwise. The information contained in this document and in any attachments is not intended by Mercer to be used, and it cannot be used,

for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.



Gerry Smedinghoff, ASA, MAAA, Mercer

Government Human Services Consulting
Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6500

[i] One state, Minnesota, found the projected federal BHP funds inadequate to cover program costs. See Gruber, J. and B. Gorman. "Coverage and Financial Impacts of Market Reforms and a Basic Health Plan (BHP) in Minnesota." November 18, 2011. [DRAFT] A second state, Washington, found the federal adequate only when supplemented by consumer cost sharing. See "The Federal Basic Health Option: An Analysis of Options for Washington State." December 2011.

[ii]Curtis, R. and E. Neuschler, "Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population: Background and an Alternative Approach," Institute for Health Policy Solutions, July 5, 2011.; Institute for Health Policy Solutions, "Fiscal Risks from Differences in BHP vs. Federal Tax Credit Income-Test Timing," Institute for Health Policy Solutions, September 2011.

[iii]E. Benjamin and A. Slagle, Community Service Society of New York, "Bridging the Gap: Exploring the Basic Health Insurance Option for New York," June 2011.

[iv] See, among others, S. Dorn, M. Buettgens and C. Carroll, Urban Institute, "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States," Association for Community Health Plans, September 2011; Milliman, "Healthcare Reform and the Basic Health Program Option, Modeling Financial Feasibility," Reform Center Health Intelligence, April 2011.; Mercer, "The State of California Financial Feasibility of a Basic Health Program" for the California HealthCare Foundation, June 28, 2011.

[v]E. Benjamin and A. Slagle, Community Service Society of New York, "Bridging the Gap: Exploring the Basic Health Insurance Option for New York," June 2011; S. Dorn, M. Buettgens and C. Carroll, Urban Institute, "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States," Association for Community Health Plans, September 2011; Milliman, "North Carolina Health Benefit Exchange Study." Prepared for North Carolina Department of Insurance, March 31, 2011.

[vi]Graves, J.A., R. Curtis and J. Gruber."Balancing Coverage Affordability and Continuity under a Basic Health Program Option." New England Journal of Medicine 2011; 365:e44, December 15, 2011.;Curtis, R. and E. Neuschler, "Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program (BHP) in California," Institute for Health Policy Solutions, September 2011.

[vii] [Cite our KFF paper?]; Milliman, "The Federal Basic Health Option: An Analysis of Options for Washington State." December 2011.

[viii]Benjamin, E. and A. Slagle, Community Service Society of New York, "Bridging the Gap: Exploring the Basic Health Insurance Option for New York", June 2011; Milliman, "Planning Washington's Health Benefit Exchange" June 2011; and "The Federal Basic Health Option: An Analysis of Options for Washington State." December 2011; Institute for Health Policy Solutions, "Fiscal Risks from Differences in BHP vs. Federal Tax Credit Income-Test Timing," Institute for Health Policy Solutions, September 2011.; Mercer, "The State of California Financial Feasibility of a Basic Health Program" for the California HealthCare Foundation, June 28, 2011.

[ix]Milliman, "The Federal Basic Health Option: An Analysis of Options for Washington State." December 2011.

[x]Curtis, R. and E. Neuschler, "Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population: Background and an Alternative Approach," Institute for Health Policy Solutions, July 5, 2011.; Milliman, "The Federal Basic Health Option: An Analysis of Options for Washington State." December 2011.

[xi]Dorn, S., M. Buettgens and C. Carroll, Urban Institute, "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States," Association for Community Health Plans, September 2011.

[xii]Benjamin, E. and A. Slagle, Community Service Society of New York, "Bridging the Gap: Exploring the Basic Health Insurance Option for New York", June 2011.;Dorn, S. "The Basic Health Program Option under Federal Health Reform: Issues for Consumer and States," Academy Health/Robert Wood Johnson Foundation, March 2011.

[xiii]Mercer, "The State of California Financial Feasibility of a Basic Health Program" for the California HealthCare Foundation, June 28, 2011.;Milliman, "The Federal Basic Health Option: An Analysis of Options for Washington State." December 2011.

[xiv]Dorn, S. "The Basic Health Program Option under Federal Health Reform: Issues for Consumer and States," Academy Health/Robert Wood Johnson Foundation, March 2011.