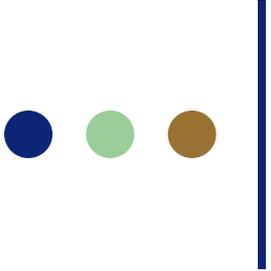


# Utah's Basic Health Program

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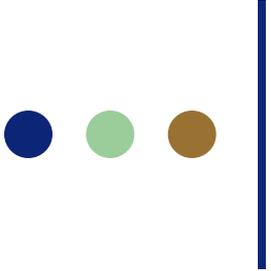
Health System Reform Task Force  
December, 2012

*The Association for Utah Community Health's mission is to support and represent its member organizations and work to increase access to health care for medically underserved populations.*



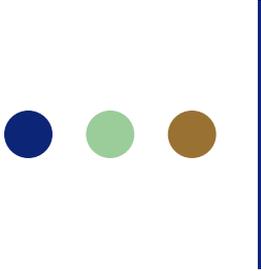
# Overview

- State Considerations for Implementing a Basic Health Program
- Background on the Basic Health Program
- Summary of Urban Institute's Analysis of the Basic Health Program in Utah
- Other Considerations
- Questions



# Considerations for Policy Makers

- What is the impact of having a Basic Health Program in Utah?
  - For the state
  - For eligible individuals
- What is the Impact of the Basic Health Program on the non-group Exchange?
- What is the fiscal risk to the State?



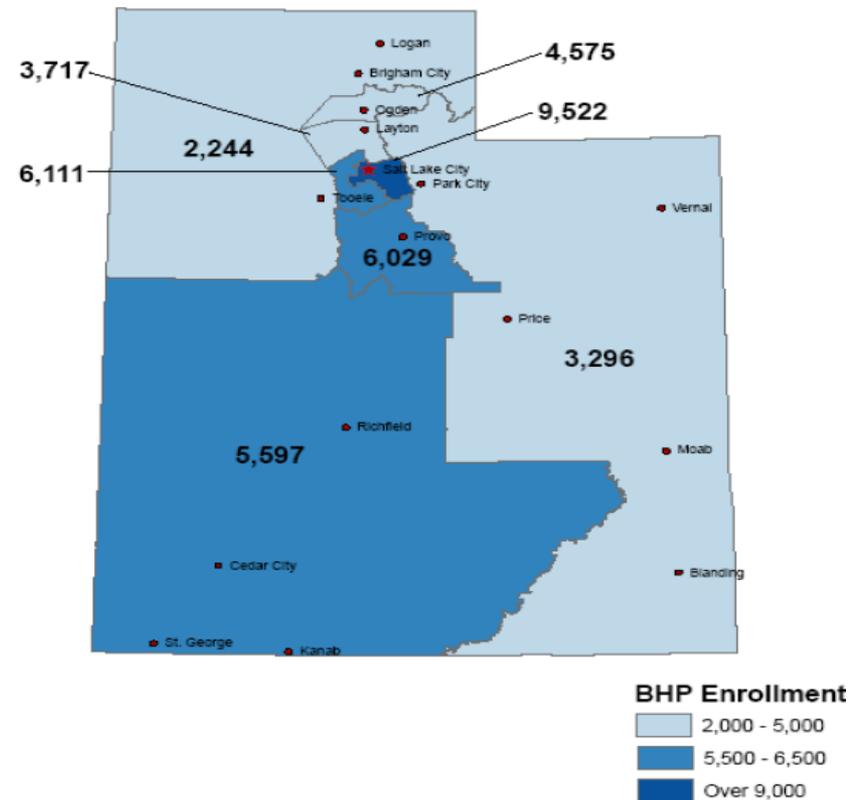
# Structure, Funding, and Eligibility of the Basic Health Program (BHP)

- Section 1331 of the Affordable Care Act (ACA) gives states the option to create a BHP
  - Operated by the State
  - State contracts with one or more managed care plans to offer insurance
  - Benefits are pegged to the Essential Health Benefit level established by the state for the Exchange
- Funded by 95% of the eligible subsidy dollars for premiums and cost sharing
  - State would receive periodic lump-sum payments and end of the year reconciliation
- Eligibility
  - State residents under the age of 65 with income between 138%-200% FPL
  - Legal immigrants with income below 138% FPL not eligible for Medicaid
  - Individuals with access to affordable employer sponsored insurance are NOT eligible for the BHP
- Urban Institute estimates there are 55,000 Utahns eligible for the BHP; and between 31,000 to 41,000 who would enroll if implemented

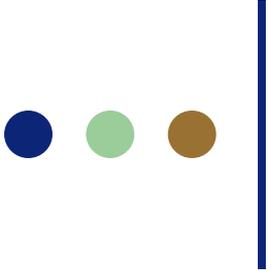
# Geographic Distribution of Utah's BHP Population

- BHP eligibles are located throughout the state
  - Approximately 70% of the population is located along the Wasatch Front
  - Approximately 18% are located in the Southwest corner of the state

BHP Enrollment in Utah,  
High Take-Up Scenario



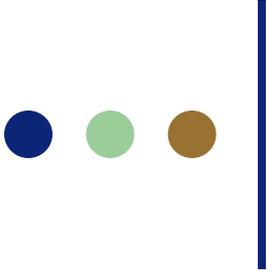
Source: The Basic Health Program in Utah, Urban Institute, October 2012



# Characteristics of BHP eligibles

- Slightly healthier than others projected to receive non-group coverage
- Approximately 14% are legal immigrants not eligible for Medicaid
- Majority are men under the age of 44, with no dependants
- Majority are uninsured

Source: The Basic Health Program in Utah, Urban Institute, October 2012

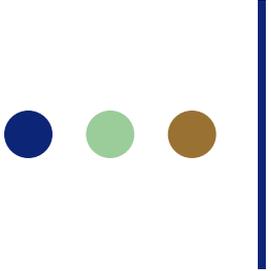


# Fiscal Impact to the State

- Federal payments to the state are expected to exceed the cost of providing coverage to BHP enrollees
  - These savings are primarily achieved by the state setting provider reimbursement rates that are lower than private market rates
- Federal payments were calculated based on estimated Exchange subsidy amounts for Utah's current small group market
- Coverage Costs were modeled on the cost sharing in Utah's CHIP B and CHIP C plans
  - Using CHIP B (\$120 premium) the state would receive an additional \$300/enrollee in federal payments
  - Using CHIP C (\$300 premium) the state would receive an additional \$1,100/enrollee in federal payments
- These estimates could vary if the premiums on the Exchange are notably lower than current pricing in the small group market, lowering the amount of federal payments the state received
- Reconciliation process may reduce the amount of federal payments

Source: The Basic Health Program in Utah, Urban Institute, October 2012





# Estimated Administrative Cost to the State

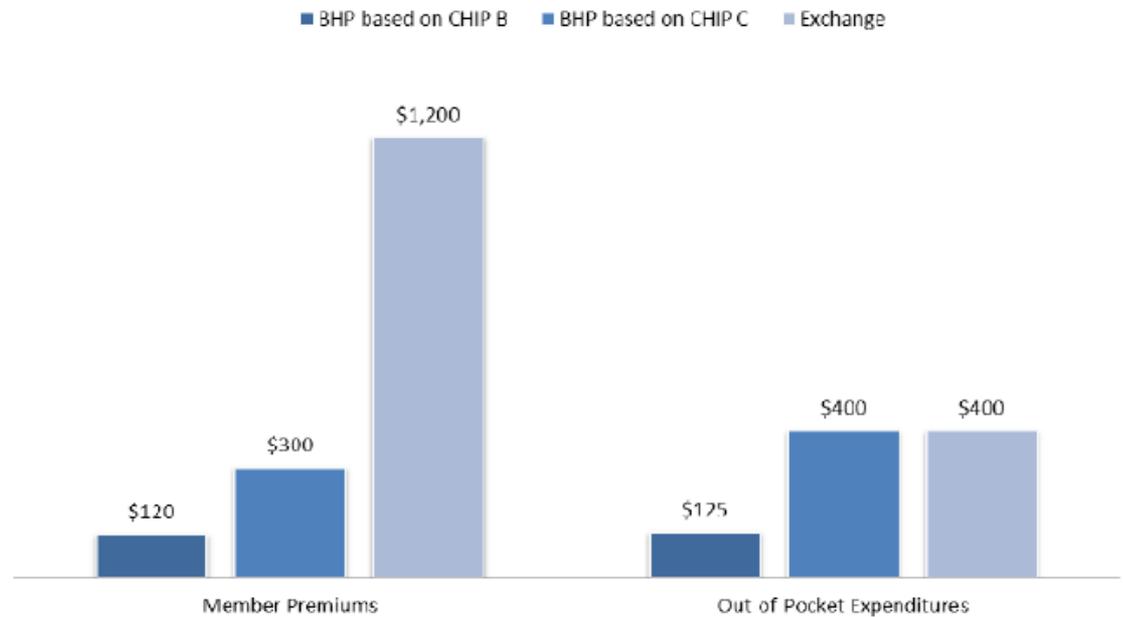
- Urban Institute estimated that the administrative cost to the state will be less than 4 percent
- Keys to keeping administrative costs low
  - Close coordination between the BHP and Medicaid
  - Ensure eligibility determination is built into the IT infrastructure for the Exchange

Source: The Basic Health Program in Utah, Urban Institute, October 2012

# The BHP is estimated to improve affordability

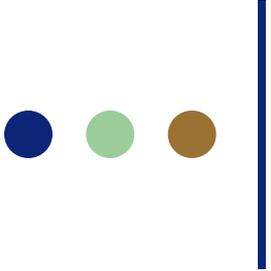
- Modeled cost sharing based on CHIP B (\$120 premium) and CHIP C (\$300 premium) levels
- Estimated Exchange premiums and out of pocket health care costs
- Both CHIP B and CHIP C plans offer coverage at lower premiums than would be available on the Exchange

Figure 2. Average Out-of-Pocket Costs for BHP Enrollees



Source: UI Analysis of ACS Utah Records, high take-up scenario.

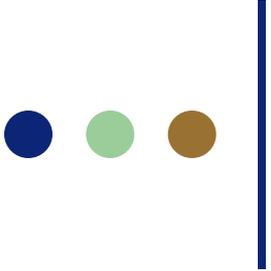
Source: The Basic Health Program in Utah, Urban Institute, October 2012



# Impact on the Exchange

- A common concern is that the BHP might undermine the Exchange
  - The BHP will shrink the size of the non-group market
- However, Urban Institute estimates Utah's non-group Exchange would be viable after implementing an BHP
  - Without a BHP, non-group enrollment in the Exchange is estimated to be approximately 160,000 individuals
  - With a BHP, non-group enrollment in the Exchange is estimated to fall to 125,000 individuals
- Urban Institute also found that implementing the BHP would not cause significant premium increases for the Exchanges non-group market
  - Estimate premiums would rise by less than 2%
  - This increase could be avoided if BHP enrollees are included in the same risk-sharing mechanisms that serve the non-group market

Source: The Basic Health Program in Utah, Urban Institute, October 2012



# Overall Effect of the BHP

## BHP Enrollees

- BHP will make coverage substantially more affordable for eligible individuals
- Improves continuity of care as income levels fluctuate
- BHP eliminates the risk of reconciling with the IRS for the individual, unless the state determined it wanted to reconcile with these individuals
- Lower provider reimbursements may result in limited networks

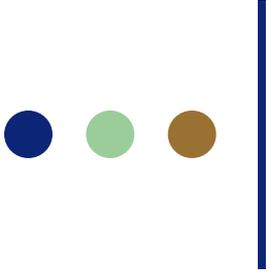
## State

- Federal funds are likely to exceed the cost of providing care
- Transfers the risk of reconciliation from the individual to the state

## Exchange and Private Market

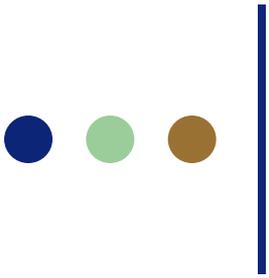
- Smaller, but viable Exchange
- Could cause a slight decrease in employer sponsored coverage
- Will transfer the issue of “churn” to individuals with higher incomes. This could be minimized by increasing cost sharing and premiums on a sliding scale the closer one gets to 200% of FPL.

Source: The Basic Health Program in Utah, Urban Institute, October 2012



# Other Considerations

- Expansion of Medicaid coverage to adults below 138% of FPL
  - If the state opts to not do a Medicaid expansion, the BHP may not be a good option for consumers or the state
- The Department of Health and Human Services has not yet issued guidance or rules for the BHP
  - How the BHP and the Exchange interact, particularly as it relates to risk sharing and risk pools
  - Use of excess federal funding to potentially increase provider reimbursements or to offset administrative costs to the state



# Questions?

