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Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population:

Background and an Alternative Approach

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Overview/Summary

Under federal health reform, modest-income adults above 138% of the poverty level will be eligible for tax credits via Exchange coverage, while those under 138% of poverty will be eligible for Medi-Cal. People whose incomes change across this line could face substantial impediments to continuity of care, because the provider networks and associated costs in Medi-Cal and private-market health plans are often very different.

This particular problem could be mitigated if Medi-Cal plans and their provider networks were to fully participate in the Exchange. However, this could cause other access or cost problems. Where two or more Medi-Cal network plans were offered in a given geographic area, their lower premiums would reduce federal tax credits but not enrollees' contribution amounts. The tax credit reductions could render efficient mainstream plans unaffordable for other Exchange enrollees, such as temporarily unemployed persons who are between jobs and whose continuity of care could rely on affordable access to plans in which their usual doctors participate. And adding significant Exchange enrollment to Medi-Cal plans could further compromise Medi-Cal recipient access to Medi-Cal providers, whose capacity will already be stretched by Medi-Cal expansions under reform.

To improve continuity and affordability for former Medi-Cal enrollees, the state could adopt the Basic Health Program (BHP) option in lieu of Exchange coverage for persons with incomes up to 200% of poverty and have the same plans participate in both programs. But it could also preclude affordable access to more mainstream plans and continuity of care for a number of persons between jobs who would seek assistance through the BHP (though an Exchange-operated BHP might address that concern). A BHP could also arrange for parents and children under 200% FPL to enroll in the same plan. But a BHP would present other problems, including substantial uncertainty about the level of federal funds, which would be limited to 95% of what would otherwise be spent on tax credits and cost-sharing subsidies. For multiple reasons, these funds could well be much lower than some estimates assume, and are subject to federal reconciliation in subsequent fiscal years. Adopting a BHP would also greatly reduce the number of tax-credit recipients who will constitute the cohesive core population for the California Health Benefits Exchange. This could greatly diminish the ability of the Exchange to attract high value plans. Because of this difference in the Exchange's potential market role, legislation which conditionally authorizes a separate BHP program could greatly complicate development and implementation of the Exchange.

An alternative approach could achieve continuity and affordability goals without these downside risks. Medi-Cal plans would be available through the Exchange as a continuing coverage source for (former) Medi-Cal enrollees who may also subsequently convert back to Medi-Cal. The Exchange also could offer one Medi-Cal essential community provider network plan to all Exchange enrollees. Because this plan would be the lowest rather than the second-lowest-priced plan (and other Medi-Cal plans would not be generally available to all Exchange participants), tax credits would be based on an efficient mainstream plans. Enrollees in Medi-Cal plans would thus realize cost savings analogous to those they could realize under a Basic Health Program, while all Exchange enrollees would have the affordable access to efficient mainstream plans envisioned in federal and California law. The state could also arrange for the Exchange to offer CHIP coverage for children (i.e., with federal matching funds) so that children and parents could enroll in the same plans.

Background / Pertinent Objectives under Health Reform

The California Health Benefit Exchange (CHBE), and health insurance market reforms under the federal Patient Protection and Affordable Care Act (PPACA) more generally, are designed to achieve affordable access to care and to allow individuals to choose the health plan / care system that best meets their personal needs.

A key premise is that competition among health plans for individual enrollment, with apples-to-apples price and performance data, will lead to lower costs for individual consumers. The intent is that cost reductions should be driven by improved efficiencies and reductions in unnecessarily high payments for services, and that consumers will be able to afford a plan which they find acceptable.

Another important objective, referenced in the CHBE authorizing legislation, is to achieve continuity of care and associated health plan and provider relationships for individuals and families who, because of income increases, shift from Medi-Cal to Exchange coverage.[1] Continuity is important for reasons ranging from proper and efficient care for people who are in a course of treatment when their eligibility changes, to incentives for health plans to provide effective preventive and primary care services that reduce longer run costs.

The Challenge

In any given year, a significant number of people experience changes in earnings or family size that cause their income, relative to the poverty level, to cross the 138%-of-poverty threshold that (after 2013) will divide Medi-Cal eligibility from tax-credit eligibility (for adults).[2] Because Medi-Cal and commercial plans have substantially different provider networks, people could face disruption of their provider and care relationships as their income changes. They will include persons with temporarily reduced incomes, e.g., workers who are between jobs with employer coverage, who may desire and expect affordable access to mainstream health plans and providers. They will also include lower income persons who lose eligibility for Medi-Cal due to increased income or other changes such as declining family size. Under health reform, this population will qualify for federal tax credits to help them pay for coverage through the new Exchange. Data about the volatility of income for low- and modest-income working people are presented in Addendum B (preliminary—additional updates forthcoming later in July).

But, for lower income people, the contributions required under PPACA for "benchmark" Exchange plan (the second lowest cost "silver" level plan) range from 4% of income at 150% of poverty to 6.3% of income at 200% of poverty. These contribution levels may be considered unaffordable for low-income people, especially recent Medi-Cal recipients with depleted resources.

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[1] AB 1602 (2010) specifies that the Exchange may collaborate with the pertinent state agencies "to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network" as their eligibility switches from tax credits to public coverage or vice-versa. [§100504(a)(7) of the Government Code, as added by AB 1602 §8]

[2] Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges *Health Affairs*, 30, no.2 (2011):228-236. <http://content.healthaffairs.org/content/30/2/228.full.html>

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Potential discontinuity problems would be mitigated *if* Medi-Cal-participating plans were available to Exchange enrollees. However, many of these plans do not now offer coverage in the commercial insurance market. Others are subsidiaries of carriers that do offer commercial coverage, but use different provider networks (and payment rates) for their public and commercial-market plans.[3]

Full Exchange Participation by Medi-Cal Plans

One option to alleviate discontinuity problems would be for Medi-Cal plans to participate fully in the Exchange on the same basis as all other plans. However, it is unlikely that such plans could do so using only their existing Medi-Cal provider networks and payment rates, which are significantly below typical premiums in the commercial market. Only relatively few ambulatory care providers are willing to accept very low (often below-cost) public-program payment rates for significant portions of their patient load.[4] Thus, unless they offer higher payment rates, Medi-Cal plans could have difficulty contracting with sufficient providers to assure adequate access. Further, many providers, particularly hospitals, that now accept very low (often below-cost) payment rates for public-program patients would balk at accepting those same payment rates for higher income "commercial" patients. (Under federal law, Exchange-participating plans would be available to all Californians regardless of income.)

Further, Medi-Cal plans that rely heavily on federally qualified health centers (FQHCs) could face significant increases in their own outlays, particularly for primary care. Under Medi-Cal, plans typically pay FQHCs rates similar to what they pay individual physicians. The Medi-Cal program then supplements the payments from health plans to conform with federal requirements for full reimbursement of FQHCs' costs.[5] In the Exchange, however, plans are required to pay FQHCs their full costs out of the plan's premium revenue—the state would no longer "make up the difference" outside the plans' capitation rates.

However, primary care represents only a portion of total costs, and Medi-Cal per capita expenditures for families generally remain considerably lower than commercial rates, even when the state's additional payments to FQHCs are included. Also, some Medi-Cal plans rely on physician groups which contract (on a capitated basis) *only* with Medi-Cal plans.[6] A number of such groups exist, and apparently have cost structures that have allowed them to operate at those rates. These physician groups may well be willing to be offered to higher income groups at rates not much greater than their Medi-Cal rates. (Unlike other physician groups, they would not be foregoing commercial plan payments for patients they already serve).

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[3] At present, with the exception of Kaiser-Permanente, physician groups that contract with Medi-Cal managed care plans tend not to contract with commercial HMOs. See, e.g., page/slide 10 in Cattaneo and Stroud, Inc., "HMO & Medical Group Activity in California, 2004-2010," December 2010. < http://www.cattaneostroud.com/reports/2004-2010_GroupActivity.pdf>. As a result, many people whose subsidy source changes would have to change providers.

[4] For example, in 2008, only about 25 percent of physicians provided care for 80 percent of Medi-Cal patients (percentage of Medi-Cal visits), and Medi-Cal patients represented 30 percent or more of caseload for only one-quarter of primary care physicians. Andrew B. Bindman, M.D., Philip W. Chu, M.D., Kevin Grumbach, M.D. (University of California, San Francisco), *Physician Participation in Medi-Cal, 2008*, California HealthCare Foundation, July 2010. <http://www.chcf.org/publications/2010/07/physician-participation-in-medical>

[5] Section 1902(bb) of the Social Security Act [42 U.S.C. 1396a(bb)].

[6] Cattaneo and Stroud, Inc., *op.cit.*

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In areas with more than one Medi-Cal plan, it seems likely that multiple Medi-Cal plans would seek to participate in the Exchange and compete to be the lowest-priced plan offered in order to attract enrollment. Despite the challenges outlined above, it is not unreasonable to conjecture that Medi-Cal plans might be able to offer significantly lower premiums than mainstream plans could in the Exchange.

If two or more Medi-Cal plans in a geographic area did participate in the Exchange, Exchange enrollees' ability to afford plans providing access to providers they find acceptable could be severely compromised. For example, as detailed in Appendix A, a single adult earning $20,000 per year could have pay 12.1%, rather than 5.1%, of her income to enroll in an efficient mainstream plan, such as a PPO with a tight network or an integrated-delivery-system-based HMO. Moreover, in this situation, affordability for people who enrolled in one of the (two or more) Medi-Cal plans would not be improved despite the lower premium prices—they would still have to pay the percentage of their income specified in PPACA.[7]

Alternative Approaches

Some Medi-Cal plans will not be able to obtain sufficient provider capacity to serve both the reform-expanded Medi-Cal population and the higher income Exchange population. This reality, and the potential drawbacks associated with full participation of Medi-Cal plans in the Exchange, suggest that it would be prudent to investigate other, more limited approaches that would improve continuity and affordability of coverage for people who leave Medi-Cal due to increased income. Goals for these more targeted approaches would include:

- Increase the probability that people who lose eligibility for Medi-Cal due to (modestly) increased income would be able to maintain their plan and provider relationships (again, even if their benefits changed somewhat).

- Use the savings associated with lower provider payment rates to reduce costs relative to Exchange "benchmark" plan contribution requirements for folks in this income range.

- Allow parents and children under 200% of poverty to enroll in the same plan / provider network (even if the cost-sharing requirements or specific benefit coverage were somewhat different between the adult coverage and the Healthy Families program). Research has shown that children are more likely to use care if they are enrolled in the same plan as their parents.[8]

A better targeted approach could achieve these goals and make it easier for Medi-Cal plans to convince their providers to accept lower than commercial reimbursement rates, possibly Medicare rates, for the "new" population.

[7] Due to how tax credits are calculated under PPACA, affordability would be improved if only one plan was available through the Exchange at Medi-Cal rates. But if two or more plans were offered at low Medi-Cal rates, the tax credit amounts would be adjusted downward to reflect this fact. How the structure of the tax credits creates this result is explained in detail in the Appendix.

[8] Common sense suggests that parents will know better how to get care for their children if they are familiar with how the health plan works because they use it themselves. Available research documents that children are more likely to use care if their parents use care. And the effect is even stronger if both parent and child are insured. See Karla Hanson, "Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Revisited." *Inquiry* 35:294-302 (Fall 1998).

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Two potential "more targeted" alternatives are: state adoption of a "Basic Health Program" option; or limited Exchange participation by Medi-Cal plans.

"Basic Health Program" Option

PPACA gives states the option of establishing a Basic Health Program (BHP) in lieu of Exchange coverage for low-income individuals (i.e., with incomes up to 200% of poverty) who are not eligible for Medicaid.[9] To qualify, states must assure that BHP enrollees receive at least the "essential health benefits" required under PPACA and do not have to contribute more toward premiums than if they had enrolled in the "benchmark" plan in the Exchange. Further, cost-sharing requirements cannot exceed those of a "platinum" Exchange plan (90% actuarial value) for BHP enrollees under 150% of poverty and those of a "gold" plan (80% AV) for other BHP enrollees.[10]

If California adopted the BHP option and contracted with Medi-Cal plans, it could:

- Provide continuity of plans and providers for populations switching between Medi-Cal and the BHP.

- Provide coverage for the BHP-eligible population at a lower cost than Exchange coverage—assuming payment rates similar to Medi-Cal rates. (See, for example, a recent analysis by Mercer.[11] Note, however, these estimates do not include state supplemental cost payments to FQHC. While PPACA does not expressly address the issue of BHP payments to FQHCs, which must be reimbursed their full costs by Exchange plans and under Medicaid. But, it is not clear what federal rules or adjustments might pertain.)

- These savings (in excess of a 5% reduction taken by the federal government) would be passed on to BHP enrollees in the form of lower premiums, lower cost-sharing or additional benefits.[12]

    - Further, BHP enrollees whose income increases during the year would not be subject to year-end reconciliation payments, as they could be if they received prospective federal tax credits for coverage through the Exchange.

Thus, the BHP could improve continuity for former Medi-Cal recipients as well as reduce costs and/or improve benefits to Californians in the target income range. In addition, to the extent that the BHP offered plans that participate in Healthy Families, parents and children between 138%

[9] The eligible population includes recent legal immigrants who have not been in the U.S. long enough to qualify for Medicaid.

[10] Note that, under PPACA, the BHP thus could have somewhat greater participant cost sharing than would occur via Exchange coverage, where federally funded cost-sharing "fill-in" subsidies are to bring the AVs for these groups to 94% and 87%, respectively.

[11] Mercer, "State of California: Financial Feasibility of a Basic Health Program," report prepared for the California HealthCare Foundation, June 27, 2011. <http://www.mercer-government.mercer.com/basic-health-program/feasibility> Note, however, that Mercer made some simplifying assumptions that may not be justified and did not include in its quantitative estimates some important issues that could significantly affect its conclusions (such as a number of the issues raised in the present paper).

[12] The federal funds made available under the BHP option can only be used to reduce premiums and cost-sharing or to provide additional benefits for BHP enrollees, not for any other purpose.

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and 200% of poverty could enroll in the same plan. Note, however, that this would not be the case for the many parents above 200% of poverty whose children would still be enrolled in Healthy-Families-plan coverage up to 250% of poverty statewide (and up to higher income limits in some counties).

But, if the state adopted the BHP option, persons from 138% to 200% of poverty would no longer be eligible to enroll in the Exchange or to receive federal tax credits, and the state would receive 95% of the amount the federal government would otherwise have spent on tax credits and cost-sharing-reduction subsidies for everyone entitled to enroll in the BHP. The unknown calculation of this cap creates an uncertain degree of fiscal risk for the state.

Federal Funding-Level Uncertainties

It is not yet known exactly how the federal government will estimate what it would otherwise have spent on this population. Given the federal government's deficit situation, extremely careful scrutiny seems likely: people in the BHP income range will account for over 70% of total federal subsidies through the California Exchange, according to a recent estimate.[13] In this light, it is sensible to assume federal guidelines and actions will seek to assure that federal spending on BHP does not exceed (95% of) what federal costs for tax credits and cost-sharing subsidies would have totaled in the absence of a BHP program.

Key factors that would drive those federal expenditures include the person's income level and the premium for the benchmark plan, as well as the number of persons who receive credits. There are uncertainties regarding the calculation of each of these dimensions:

- Federal tax credit amounts will directly reflect the premium for benchmark "silver" plans in the Exchange.[14] A $100-lower premium for that plan would mean the tax credit would be $100 less per month. And it would translate to a higher percentage reduction in the tax credit than in the (larger) total premium [15] The actual federal subsidy amounts that would be available for a BHP would thus be highly sensitive to the benchmark-plan premium level.

  An assumption of individual benchmark premiums averaging $486 per month (Mercer's "higher scenario" estimate[16]) rather than a CBO-based estimate of $392 per month[17]—a

[13] M. Buettgens, J. Holahan and C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," March 2011, Table 4.

[14] PPACA specifies a percentage of income that people at different income levels (relative to the poverty level) would be expected to contribute toward a benchmark health insurance plan. The amount of the tax credit available to a particular individual or family is calculated by deducting that expected contribution from the premium for the second-lowest-cost "silver" plan available to the individual or family.

[15] Note that the tax credit is always less the full benchmark plan premium (due to the "expected individual contribution"). Thus, a given dollar increase in the benchmark premium and tax-credit amount will constitute a higher percentage increase in tax credits. So, for an individual whose expected contribution is $100 per month, a benchmark premium that is 25% higher ($500 rather than $400) would generate a tax credit that is 33% higher ($400 rather than $300).

[16] Mercer, *op.cit.*

[17] We estimate the annual premium for a mainstream benchmark plan in 2014 to be $4,700. This figure was conservatively deflated from CBO's national estimate of $5,200 for 2016. In the CHCF's California Employer Health Benefits Survey, 2010, premiums for employment-based HMO coverage were only slightly lower in California compared to the nation as a whole.

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24% difference—would result in a federal subsidy fund estimate (for an enrollee at 175% of poverty) that is approximately 31% higher than we believe is realistic "conservative" estimate. We believe $392 per month ($4,700 per year) is a realistic estimate of the benchmark-plan price in 2014 for two reasons:

- First, CBO's national estimate should be applicable for California, because in 2010 premiums for employment-based HMO coverage were only 1.5% lower in California compared to the nation as a whole, and the difference was not statistically significant.[18] CBO's national benchmark-premium estimate for 2016 was $5,200 per year. Deflating this estimate to 2014 by only 5.2% per year yields $4,700 per year or about $392 per month.
- Second, adjusting current CalPERS rates yields a similar result, as follows:
  (1) The average of Kaiser Permanente and Blue Shield Net Value HMO state-employee rates for 2012 (already posted) is $547.42 per month.[19] (Blue Shield Net Value is the second-lowest-cost plan in northern California in 2012.[20])
  (2) Assuming these plans have an actuarial value of 90%,[21] adjusting them to 70% AV reduces this estimate to $425.77 per month.
  (3) Comparing the age distribution of Exchange-eligible adults in the tax-credit range with the age distribution of California state employees indicates that the Exchange population should be about 18% less expensive.[22] Applying this factor reduces our estimate to $349.13 per month.
  (4) Finally, inflating to 2014 at 5.25% per year[23] (the average of the 2011-12 increases for these two plans) yields $386.75 per month, or $4,641 per year.

➤ Federal subsidy dollars could be significantly lower than otherwise anticipated due to differences in the income periods used to determine federal tax credits vs. those used for traditional subsidy programs. Federal tax credits and cost-sharing subsidy levels are to be based upon annual income, not shorter-term current income.[24] In fact, tax credits will be reconciled to actual calendar-year income on the individual's tax return, resulting in year-end adjustments to the amount paid,[25] and PPACA specifically directs the Secretary to take those year-end reconciliation amounts into account when determining the amount of federal BHP

[18] California HealthCare Foundation, *California Employer Health Benefits Survey*, December 2010.

[19] <http://www.calpers.ca.gov/eip-docs/member/health/2012-health-info/state-premiums.pdf>.

[20] In southern California, it is the third-lowest-cost plan. Except for one employee-association plan, all rates for state employees are statewide rates.

[21] Mercer (*op.cit.*) says CalPERS plans "typically reflect actuarial values in excess of 90%."

[22] Age distribution of California state employees from California Department of Personnel Administration <http://www.dpa.ca.gov/personnel-policies/workforce-planning/summary-statewide-demographics%205-5-11.pdf>. (Preliminary health plan data indicates average age of CalPERS health plan enrollees may even older than all permanent state employees.) Age distribution of Exchange-eligible population (no employer coverage, no government coverage, income between 150% and 400% FPL) from IHPS tabulations of U.S. Census Bureau's Current Population Survey using the online CPS tabulator. Relative cost of the two populations estimated using the Kaiser Family Foundation's Health Reform Subsidy Calculator <http://healthreform.kff.org/Subsidycalculator.asp>.

[23] Kaiser's 2012 CalPERS rate is 7% higher than its 2011 rate. For the Blue Shield Net Value HMO, the 2011-12 increase was 3.5%. The average of these increases is about 5.25%.

[24] PPACA §1412(b)(2) and §1411 generally.

[25] Internal Revenue Code §36B(f)(2), as added by PPACA §1401 and amended by Pub.L. 111-309 and Pub.L. 112-9.

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funding.[26] (Federal policymakers are well aware of the budgetary implications of these tax-credit polices, which Congress has amended twice since original enactment in order to reduce federal costs.) This is different than public programs like Medi-Cal, Healthy Families and presumably BHP, which base eligibility and subsidy amounts on income determined at the time of application, with no year-end "reconciliation."[27]

This difference would mean a BHP recipient with increasing income would not have a potential income tax liability at year end.[28] But it also could mean what federal tax-credit spending otherwise would have been for this population, and thus federal funding available for BHP income populations in California, could be hundreds of million dollars less than is assumed by estimates to date.[29]

- These differences in measured income could also increase the population eligible for BHP vs. the population compared to that which otherwise would have received tax credits. Further, a BHP with uniformly lowered contribution requirements could result in greater population shifts from employer coverage. Federal estimates of reductions in employer coverage vs. individual subsidized coverage and associated federal tax-credit costs varied across evolving versions of federal reform, depending in part on this variable.

  If there is evidence of such increases in federally subsidized populations in a state with a BHP relative to other states, the estimate of federal tax-credit costs that otherwise would have occurred (i.e., federal funds for the BHP) might be reduced accordingly.[30]

- The Exchange's benchmark plan price used to determine tax credits could be higher than it otherwise would have been in the absence of a BHP. For example, the substantially reduced

[26] PPACA §1331(d)(3)(A)(ii) states: "The Secretary … shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals [enrolled in BHP], including … whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been … enrolled" in a qualified health plan offered through the Exchange.

[27] PPACA specifically provides that the switch to using modified adjusted gross (household) income to determine Medicaid eligibility does *not* change the requirement under title XIX to "determine an individual's income as of the *point in time* at which an application for medical assistance … is processed." (Emphasis supplied.) Section 1902(e)(H)(i) of the Social Security Act [42 U.S.C. 1396a(e)(H)(i)], as added by PPACA §2002 and amended by HCERA §§1004(b)(1)(A) & 1004(e).

[28] We assume a BHP would not retrospectively collect reconciliation payments from individuals; and if California decided to do so, it would be much more cumbersome administratively than reconciliation through the income tax.

[29] Recent preliminary national estimates of such differences indicate an order of magnitude of $2 to $3 billion, taking into account the latest statutory revision of the upper limits on "reconciliation" payments by income level. John A. Graves, "The Optimal Design of Prospective Subsidies for Health Insurance Under the Patient Protection and Affordable Care Act," Harvard University, (forthcoming update) June 2011. Note also that estimates from the Urban Institute indicate that California will account for about 14%-15% of the national total of tax-credit subsidies. (Calculated by the present authors from M. Buettgens, J. Holahan and C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," March 2011, Table 4.) In combination, these estimates suggest a difference of roughly $300 to $400 million annually. Further analysis by Dr. Graves and Jonathan Gruber is planned to estimate what such cost differences might be for Californians whose income at initial application is in the BHP income range, taking into account applicable income fluctuations.

[30] PPACA §1331(d)(3)(A)(ii) further provides that the Secretary's determination of BHP funding amounts "shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States."

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size of the Exchange's "core" population of tax-credit recipients could reduce its scale economies and ability to attract the most cost-effective plans.

It is possible that the federal calculation of funds available for the BHP could estimate what tax-credit spending would otherwise have been based on an Exchange benchmark plan premium that is adjusted for pertinent factors.[31] *Additional examples: The Exchange benchmark plan premium used to determine BHP funding might be adjusted downwards in the case where Exchange premiums include costs of federally required full-cost payment of FQHCs but the state's BHP program does not. Or, given the priority on reducing the federal deficit, the federal government might challenge arrangements under which a state BHP permits its participating plans to use (100% federal) BHP funds to offset low health plan and provider payment rates under state-matched Medicaid.*

Given the importance of such factors to the level of federal tax-credit spending, the federal government will likely consider all of them in its efforts to assure budget neutrality for a BHP. In addition, PPACA specifically directs the Secretary to adjust funds in subsequent years to correct errors made in the calculation of federal BHP funds advanced in any prior year.[32] In short, the state would be "on the hook" for BHP outlays that exceed adjusted estimates of what federal tax-credit spending otherwise would have been, and those estimates could well be much lower than projected in other reports.

Med-Cal Uncertainties

It is not clear what effects a BHP offering Medi-Cal plans would have on Medi-Cal recipients and on state costs for that program. Those effects could be substantial and negative.

- If the BHP reduced enrollee costs by contracting with Medi-Cal plans, the entire subsidized population up to 200% of poverty would be reliant on Medi-Cal network providers whose capacity is already stretched and will be further stretched by major Medi-Cal population expansions in 2014. Given how low Medi-Cal's (often below-cost) payment rates now are, it appears that a BHP plan could both reduce recipient costs and pay higher plan (and in turn provider) rates than Medi-Cal, which some hope could offset provider losses incurred under that program.

  But especially in light of how stretched Medi-Cal provider capacity is, the effects of such a BHP on Medi-Cal might be different than what is intended. Paying higher rates for the BHP population could well result in either compromised access for Medi-Cal enrollees or increased pressure and need for significantly increased Medi-Cal payment rates and thus costs.

Establishing a BHP would also involve a range of other potential problems, if it were structured like a traditional state subsidy program and not operated by the Exchange. (A subsequent paper

[31] While it would not be possible to directly ascertain what the benchmark premium would have been in the absence of a BHP, an estimate might be made, for example, on the basis of comparisons to outside market premiums, employer group premiums or Medicare costs and of observations of these relative costs in other states.

[32] PPACA §1331(d)(3)(B).

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will describe and assess different approaches a CHBE operated BHP might logically use to address such problems.) These problems could include:[33]

Continuity and Access Limitations

- While 138% to 200% of poverty is a very narrow income range within which to design a separate program, a BHP that essentially is an extension of Medi-Cal might simply shift the "discontinuity" problem from 138% of poverty to 200% of poverty. But, if the BHP did *not* essentially extend the income eligibility range for Medi-Cal plans and providers, but rather contracted with plans with provider networks that varied from Medi-Cal and the Exchange, there would be *two* "discontinuity" points for adults, rather than just one.

- Moreover, if the BHP contracted with plans and providers different from those that serve private markets, it would not provide a realistic "continuity" option for former Exchange or employer-coverage participants whose income temporarily fell below 200% of poverty during a spell of unemployment. More generally, Medi-Cal plans' lower costs are often associated with substantially constrained access to care—e.g., physician participation substantially lower for Medi-Cal than for commercial plans.[34]

Effects on California Health Benefits Exchange

- The establishment of a BHP would substantially reduce the size of the Exchange's core tax-credit population. The most reliable published estimates showing tax-credit recipient counts above and below 200% of poverty are those by the Urban Institute, which indicate a reduction of about *one-half*. Estimates reflecting simple tabulations of household survey data estimates indicate one-third. (See Table 1 on the next page.)

- Thus, the population that is to obtain coverage only through the Exchange would be reduced from roughly one-half to one-quarter of the total individual market. Further, depending on actual benchmark-plan premium levels, a BHP could also greatly reduce the share of young adults in the Exchange's core population.[35]

These changes could greatly diminish the Exchange's ability to attract and offer high-value health plans, which would not need to participate in the Exchange in order to reach three out of four individual market purchasers.

[33] Removing the BHP population from the individual market could also affect the risk profile of individual-market plans both inside and outside the Exchange.

[34] Andrew B. Bindman, M.D., Philip W. Chu, M.D., Kevin Grumbach, M.D. (University of California, San Francisco), *Physician Participation in Medi-Cal, 2008*, California HealthCare Foundation, July 2010. <http://www.chcf.org/publications/2010/07/physician-participation-in-medical>

[35] For example, if the benchmark-plan premium for the average-age single adult enrollee is $392 per month in 2014, tax credits would phase out (only) for single young adults at about 290% FPL (under the 3:1 age-rating band), but be available up to 400% FPL for other adults. This would mean that the Exchange's core tax-credit population above 200% FPL would have a substantially lower percent of young adults than it would if it included those under 200% FPL as well.

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Table 1: Distribution by Income of Exchange Enrollees under 400% of Poverty: Comparison of Estimates from Different Sources

	Total (000s)	Under 200% FPL	200%-400% FPL
Urban Institute[36]	2,312 *(100%)*	1,257 *(54.4%)*	1,055 *(45.6%)*
Mercer[37]	2,170 *(100%)*	723 *(33.3%)*	1,524 *(66.7%)*

Notes: FPL = federal poverty level. The population above 400% FPL is omitted because Exchange enrollment among those not eligible for tax credits is extremely difficult to predict and will depend in part on decisions yet to be made by the Exchange Board, and on carriers' responses to those decisions.

Sources: See footnotes for sources and an additional comment.[38]

In short, a Basic Health Program should be able to offer Medi-Cal plans at a lower cost to participants than they would pay for a mainstream coverage in the Exchange. This could also extend better continuity of care to participants moving from Medi-Cal. However, there are a number of potentially significant problems, including significant uncertainties and risks regarding federal funding levels, a substantially reduced California Health Benefits Exchange core population enrollment, and compromised access to providers and continuity of care for other populations, such as those who are between jobs.

One might attempt to address those risks and uncertainties by making BHP implementation conditional on favorable determinations sometime in the future. But this would create a great deal of uncertainty, and would require conditional planning and development work both for the state agencies charged with BHP development and for the California Health Benefits Exchange. This would be particularly problematic for the Exchange, because its size and marketplace roles could be substantially altered if there is a BHP and thus a much smaller "core" Exchange population.

[36] M. Buettgens, J. Holahan and C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," The Urban Institute, March 2011, Table 3. <http://www.urban.org/url.cfm?ID=412310>.

[37] Mercer, *op.cit.*

[38] The Urban Institute's figures may seem surprising, since a simple estimate of the apparently eligible population—those under 400% FPL who do not now have employer coverage or government coverage and do not qualify for Medicaid—yields a smaller share under 200% FPL, like that shown in the Mercer estimate. But this population includes people who declined an offer from their or their spouse's employer and either remained uninsured or bought nongroup coverage. Declining an "affordable" offer of employer coverage disqualifies a person from eligibility for tax credits. According to an analysis of 2006 national data from the MEPS household survey, "decliners" of employer coverage (among apparent Exchange eligibles—the uninsured plus nongroup purchasers) are about 30% more prevalent between 200% and 400% FPL than below 200% (where not being offered employer coverage at all is more frequent). Based on CPS coverage source data by income, the differential in California may be larger. Also, employer offers made to workers under 200% FPL are less likely to be considered "affordable" (since "affordability" is measured as a percentage of income). The Urban Institute's estimates take these and other factors into account. Further, people who are not eligible for a tax credit are much more likely to decide to purchase outside the Exchange (e.g., stay with a low-cost "grandfathered" nongroup plan they already have, or newly take up their employer's coverage to avoid a tax penalty).

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Another Alternative: Limited Medi-Cal-Plan Participation in the Exchange

Allowing Medi-Cal plans to participate in the Exchange on a targeted basis could address the continuity and affordability problems for individuals and families on Medi-Cal whose income increases and for other low-income Exchange enrollees. Because such an approach could avoid some major disadvantages associated with the other alternatives discussed above, it seems prudent to consider it.

The Exchange will face many challenges for successful implementation, and a major reduction in the Exchange's core population due to a Basic Health Program or compromised financial access to commercial plans due to Medi-Cal-plan-based tax credits could compound those challenges. As the Exchange gains experience and is in a better position to assess the implications of participation of these plans, and as potential changes play out regarding the federal and state Medicaid policies and roles, California could decide its longer-term approach on a more informed and considered basis.

There are three potentially separable components of this alternative:

1. Continued enrollment in Medi-Cal plan option for recipients moving to the Exchange:

Under the first component, all Medi-Cal plans (meeting applicable standards) could participate in the Exchange to serve people who were enrolled in that plan under Medi-Cal but who have lost eligibility for Medi-Cal due to increased income.[39,40] Access to these plans might be further limited to those whose income does not exceed 200% of poverty or, if they are parents, whose children are enrolled in that plan under the Healthy Families program, for two reasons: First, below 200% of poverty, federal supplemental cost-sharing reductions bring the actuarial value of Exchange coverage closest to Medi-Cal. Second, as noted earlier, private providers might balk at accepting lower than commercial reimbursement rates for higher income adult patients.

A provision of the Public Health Service Act (one that was broadened by PPACA to apply to the individual as well as the small-employer market) could provide a basis for a state to permit such "limited participation" in the Exchange.[41] In short, Medi-Cal plans would be permitted to

[39] Such plans would have to meet all criteria for Exchange participation, except that the adequacy of their networks would be assessed based on a lower expected total enrollment than if they were "regular" Exchange plans.

[40] These plans presumably would still have to meet the minimum standards to be "qualified" to participate in the Exchange, including appropriate licensure. Exploring what that would entail is beyond the scope of this initial concept paper; informal consultations with cognizant federal officials would be advisable.

[41] Despite PPACA's general guarantee-issue requirement, a network plan can deny coverage to new employer or individual applicants if it can demonstrate to the applicable State authority that "it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees." [PHSA §2702(c)(1)(B), as renumbered and amended by PPACA §1563. Once this provision is invoked, the plan is prohibited from issuing any new coverage in its service area for 6 months.] That is, the plan's obligation to maintain adequate access to providers for its existing groups, and to accept new members who join those groups, trumps the broader requirement to accept new groups (and individuals not affiliated with such groups).

The purpose of the guarantee-issue requirement is to preclude a health plan from selectively enrolling healthier individuals or groups while refusing enrollment to higher cost individuals or groups. This exception in the law recognizes that there can be legitimate provider-capacity reasons for a plan not to accept *any* new enrollment (except new enrollees in existing groups).

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continue to serve their current enrollees who move to the Exchange, but would be recognized as being unable to adequately serve additional individuals in the Exchange, given their obligation to provide access to Medi-Cal recipients under their existing Medi-Cal contracts.

Because these limited-Exchange-participation Medi-Cal plans would not generally be available to Exchange enrollees, they would presumably not be included in determining the "second-lowest-cost 'silver' (benchmark) plan" for tax-credit purposes. But former Medi-Cal enrollees in these plans would be able to apply their Exchange tax credit toward their premium, and would qualify for the reduced cost-sharing available to all Exchange enrollees at their income level.

This could allow Exchange enrollees under 200% of poverty to retain coverage through their previous Medi-Cal plan with no premium contribution requirement in most cases. This would also mean that those with initially lower incomes could increase during the year to 200% of poverty (or more depending on age and family size) without incurring a reconciliation cost at year end.

2. A low-cost Essential-Community-Provider-plan option for all low income Exchange enrollees:

Under the second component, the Exchange could offer one Medi-Cal plan per area to provide a lower cost option for all low-income Exchange participants. This could be the plan that provides the highest percentage of its primary care services (or a more broadly defined set of services) through essential community providers or, in a case where that plan submits premiums too high to meet affordability goals for low-income Exchange enrollees, the plan with the highest percentage of essential community provider services which does meet that goal.

This essential-community-provider-network plan would be intended to be the lowest-cost plan that is broadly available to all Exchange enrollees (not the *second*-lowest-cost benchmark plan that determines tax-credit amounts).[42] In addition to former Medi-Cal enrollees, it would also likely be attractive to recent legal immigrants who, although poor, do not yet qualify for Medi-Cal but do qualify for tax credits; to Exchange enrollees whose incomes are unstable and may fall to Medi-Cal levels, and who may already utilize, or reside in areas convenient to, essential community providers; and to low-risk, near-poor, tax-credit-eligible adults who would otherwise be most likely to forego coverage and remain uninsured. The latter population's take-up of a low-cost plan alternative could improve the Exchange and individual market risk pool, which would be shared with all plans via risk adjustment, and should in turn help reduce individual market premiums.

Applying this provision, this approach would rely on a finding that the Medi-Cal plan does not have network capacity to serve additional private market enrollees—and therefore the plan is not required to guarantee issue coverage in the Exchange or in the individual market more generally—but *does* have the capacity to continue to serve current enrollees (and their family members), even if their source of payment changes. In this case, the lack of capacity might derive from participating providers' unwillingness to accept additional patients at Medi-Cal rates.

[42] The addition of a Medi-Cal essential-community-provider-network plan to the Exchange's offerings would mean that the second-lowest-cost plan—benchmark for tax-credit purposes—would now be the commercial plan that would otherwise have been the lowest-cost plan. But, while tax-credit amounts would be somewhat smaller as a result, it seems highly likely that such a commercial plan would be within a few percentage points of the premium for its next-lowest-priced commercial competitor. Hence, the reduction in the tax-credit benchmark would most likely be minimal in comparison to the reductions associated with a Medi-Cal benchmark plan.

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Note that Medi-Cal plans participating in the Exchange could be permitted to charge premiums higher than their Medi-Cal rates.[43] Nevertheless, these plans could be offered at very low cost to their enrollees, because, as under a Basic Health Program, premiums should be less than the tax credits calculated on the basis of the benchmark mainstream plan.

- If the Medi-Cal plan's premium was in the range of $1,400 per year less than the estimated "benchmark" plan premium, then the tax credit would cover the *entire* premium for most Medi-Cal plan enrollees under 200% of poverty.[44] (See Table 2 on the next page.)

Note also that this proposed approach would not preclude another Medi-Cal or Healthy Families plan that is not currently licensed to serve the commercial market from obtaining such a license and seeking to offer coverage through the Exchange. However, except for the plan with the most essential community provider participation, such a plan would presumably have to demonstrate that it has a provider network and capacity that is accessible and can serve the larger, and socio-demographically varied, population in the Exchange.[45] So, as discussed earlier, this would generally necessitate having to offer a broader provider network and charge (and pay) substantially higher rates for its Exchange / commercial enrollees. (Commercial carriers that currently participate in Medi-Cal or Healthy Families typically use a different provider network for those programs than for the commercial market). If so, their Exchange enrollees would often need to change providers when their income declines to Medi-Cal levels, thus compromising the continuity of care objective.

In sum, the limited-Exchange-participation measures described above address the continuity-of-coverage-and-care and affordability issues for those who enroll in Medi-Cal provider-network plans.

- By applying their tax credit toward the premium for their Medi-Cal network plan, they will realize significant savings (analogous to savings under a BHP approach) because that premium will be considerably less than the benchmark premium on which the tax credit is calculated. Again, the Medi-Cal plan premium should be less than the tax-credit amounts at these income levels, translating to zero or very low premium payments for these persons with depleted resources.[46] There should also be the same or greater budgetary room as under a BHP to increase plan and provider payments, which may be essential where current Medi-Cal payment levels are below actual costs of care.

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[43] As noted earlier, charging higher rates would likely be necessary because, in particular, plans in the Exchange are required to pay federally qualified community health centers their full costs out of the plan's premium revenue—the state would no longer "make up the difference" outside the plans' capitation rates, as it does under Medi-Cal.

[44] Due to the interaction of the tax-credit structure and age-rating for Exchange enrollees, younger childless single enrollees would begin to pay very modest premiums starting around 170% of poverty. But, even at 200% of poverty, their premium liability would be only 35% as much as (i.e., 65% less than) it would have been if they had enrolled in the benchmark plan.

[45] California law authorizes the Exchange to "determine the minimum criteria a carrier must meet to be considered for participation in the Exchange," so the Exchange could adopt provider access / network adequacy standards in addition to those required for licensing.

[46] Under this alternative approach, individuals enrolling in a Medi-Cal network plan would have their full tax credit amount available to apply toward their (lower-than-"benchmark") premium, while a BHP would receive 95% of estimated tax credits. And, as noted earlier (see note 28), the addition of a single Medi-Cal network plan to the Exchange's offerings is expected to result in only a minimal reduction in tax-credits amounts.

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Table 2: Monthly Contributions Required for Low-Cost "Medi-Cal Plan" Coverage in Exchange, if the Tax-Credit Benchmark Is A "Mainstream" Commercial Plan, for <u>an Average-Age Single Worker</u>

Average-Age Single Worker		Contribution for Mainstream "Benchmark" Plan (if premium = **$392** per month*)			Contribution for Medi-Cal Plan Costing 30% Less (**$275** per month†)		
Annual Income (2014)		Required Monthly Contribution		Tax-Credit Amount	Does Tax-Credit Amount Exceed Premium?	Required Monthly Contribution	
(dollars)	(% FPL)	(dollars)	(% of income)	(dollars)		(dollars)	(% of income)
140%	$16,030	$46	3.4%	$346	Yes	-0-	0.0%
~ ~							
190%	$21,755	$106	5.8%	$286	Yes	-0-	0.0%
200%	$22,900	$120	6.3%	$272	No	$3	0.2%

<u>Notes</u>: The "benchmark" plan on which the tax credit is based is the second-lowest-cost "silver" plan available to an Exchange enrollee.

* We believe $4,700 per year (or about $392 per month) to be a conservative estimate of the annual premium for the tax-credit benchmark plan in 2014, given that the benchmark plan is likely to be an efficient, narrow-network commercial plan. Mercer estimated a considerably higher range of $441 to $486 per month. Our figure was deflated from CBO's national estimate of $5,200 for 2016. (In the CHCF's California Employer Health Benefits Survey, 2010, premiums for employment-based HMO coverage were only slightly lower in California compared to the nation as a whole.)

† Mercer's (*op.cit.*) premium estimates for a plan based on Medi-Cal rates provided to Exchange enrollees under 200% of poverty range from $316 to $373 per month at an actuarial value (AV) of 100%. Adjusting the Mercer estimates for a 70% AV "silver" plan yields a premium range of $221 to $261 per month. Thus, our $275 per month estimate would allow for provider-payment rate increases of up to 24% above Medi-Cal levels. (Note that, although the premium is based on a 70% AV "silver" plan, the federally funded cost-sharing "fill-in" subsidies would bring the actual AVs to 94% for people under 150% of poverty and 87% between 150% and 200% of poverty.)

<u>Source</u>: Illustration by the Institute for Health Policy Solutions based on PL 111-148 as amended by PL 111-152.

Note that this approach should not appreciably complicate Exchange operations or its website. Medi-Cal enrollees needing to shift to Exchange coverage due to increased income of up to 200% of poverty would be given the option to remain in their Medi-Cal network plan (albeit with somewhat altered benefits and cost-sharing) or to choose any of the Exchange plans and cost-sharing fill-ins broadly available to all tax-credit recipients in their income range. Where offered, the essential-community-provider-network plan would simply be one of several plans regularly offered by the Exchange.

3. Same plan coverage for children and their parents available through the Exchange:

California could authorize the Exchange to offer CHIP coverage, so that lower as well as higher income children and their parents in the Exchange can enroll in the same health plans. There are a variety of alternative arrangements through which this could be achieved, which we intend to

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discuss in a future report. But we note here that we know of nothing in federal law that would preclude California from implementing such an arrangement.

Continuity for Other Exchange Enrollees Who Move to Medi-Cal

As described thus far, the limited-participation approach does not address the continuity-of-care issue for tax-credit recipients who are enrolled in a commercial plan (many of whose providers do not participate in a Medi-Cal network plan) and whose income falls, making them newly eligible for Medi-Cal. Two possible ways of addressing this issue are:

- The state could allow other Exchange plans to participate in Medi-Cal on a limited basis to continue enrollment of their subscribers who become eligible for Medi-Cal due to an income decrease that is expected to be temporary, e.g., due to loss of a job.
  - Capitation rates would no doubt be a difficult issue, but some Exchange plans might be willing to continue enrollment for a limited number of enrollees in view of the prospect that many of these enrollees would have reduced income only temporarily, combined with the economies that derive from reduced enrollment turnover.
  - Alternatively, capitation rates somewhat higher than typical Medi-Cal rates might be justified for such plans, in a budget-neutral way, recognizing that Exchange plans cannot retain their providers if they pay Medi-Cal rates and generally must include FQHCs and pay them their full costs. The state would therefore use the same funds it would otherwise have to spend on supplemental payments to FQHCs serving those patients through a Medi-Cal plan.

Conclusion

Because low-income people experience relatively frequent changes in income and other family circumstances, continuity of coverage and care as people move back and forth between Medi-Cal and Exchange eligibility could be a significant problem. Further, these and a number of other individuals with incomes slightly above Medi-Cal levels will have difficulty affording the premium-contribution requirements under health reform.

While implementing a Basic Health Program could allow California to address those problems, it could create continuity and provider access problems for others in this income range, and could involve a range of other potential downside risks. In particular, it is not known how the federal government will account for variables that would affect what its tax-credit spending would otherwise have been, and therefore what level of funds would be available for a BHP. Federal implementing rules and practices regarding the BHP option will not be known for some time, and could be altered over time.

State legislation could conditionally authorize the establishment of a Basic Health Plan, but that would create a great deal of uncertainty and conditional planning and development work for the state agencies charged with BHP development, as well as for the California Health Benefits Exchange, whose size and marketplace roles could be substantially altered if there is a BHP and thus a much smaller "core" Exchange population.

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It is therefore sensible to consider alternative approaches that could achieve the continuity and affordability objectives of a BHP. The alternative approach outlined herein could allow limited participation of Medi-Cal plans in the Exchange for continued coverage of current enrollees and for the broader availability of a low-cost essential-community-provider-network plan.

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Appendix A: What Would Happen If Medi-Cal Plans Participated in the Exchange at Rates Significantly Below Commercial Levels?

As noted earlier, it is unlikely that Medi-Cal plans could participate fully in the Exchange using *only* their existing Medi-Cal provider networks and payment rates, and charging premiums similar to the capitation rates they receive from Medi-Cal, which are significantly below typical premiums in the commercial market.

However, for reasons discussed in the main text, it is not unlikely that two or more Medi-Cal plans in a given geographic area would be able to offer premium rates in the Exchange that are significantly below the costs of mainstream Exchange plans. If so, Exchange enrollees' ability to afford plans providing access to providers they find acceptable could be severely compromised.

The reason for this perhaps counter-intuitive result has to do with the structure of the federal tax credit for Exchange coverage. The amount of the credit is based on the premium for the second-lowest-cost "silver" plan available to an enrollee.[47] (We will call this the "benchmark" plan.) If the enrollee chooses a more expensive plan, their tax credit amount is not increased; instead, they must pay the entire additional premium cost out of their own pocket. Thus, if the benchmark plan is a low Medi-Cal-priced plan, modest-income workers and their families would have to pay prohibitive amounts to enroll in a mainstream plan. Two examples are summarized here and detailed further in the next section of this Appendix.

- In one example, a single adult earning $20,000 per year would pay 5.1% of her income, or $1,027, for the "benchmark" Exchange plan. (See Table A-1.) The benchmark plan could be an efficient mainstream plan, such as a PPO with a tight network or an integrated-delivery-system-based HMO.[48] But if two Medi-Cal network plans were also offered and the benchmark premium became 30% less than the efficient mainstream plan premium,[49] the enrollee would have to pay the full premium difference to enroll in that plan. In this scenario, a single 42-year-old adult might typically have to pay $2,427 (12.1% of income) for the same mainstream plan.

- A second example is an older couple (see Table A-2) at 200% of poverty, who would face a much larger age-rated premium difference. They would have to pay almost 25% of their

[47] PPACA specifies a percentage of income that people at different income levels (relative to the poverty level) are expected to contribute toward health insurance. The amount of the tax credit available to a particular individual or family is calculated by deducting that expected contribution from the premium for the second-lowest-cost "silver" plan available to the individual or family.

[48] We estimate the annual premium for a mainstream benchmark plan in 2014 to be $4,700. This figure was deflated from CBO's national estimate of $5,200 for 2016. In the CHCF's California Employer Health Benefits Survey, 2010, premiums for employment-based HMO coverage were only slightly lower in California compared to the nation as a whole.

[49] We believe the estimated 30% "discount" for Medi-Cal plans to be conservative. The typical differential between Medi-Cal and commercial rates has been informally estimated by health plans to be considerably larger. Recent estimates by Mercer (*op.cit.*) for a Basic Health Program based on Medi-Cal rates, after adjustment to reflect the 70% actuarial value of a silver plan, yield premiums in the range of $221 to $261 per month or $2,654 to $3,133 per year. Thus, our "30% less" estimate shown in Table A-1 ($3,300 per year or $275 per month) would allow for provider-payment rate increases of up to 24% above current Medi-Cal levels.

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income to obtain the efficient mainstream plan. Note that even if the benchmark Medi-Cal plan was only 20% below the efficient commercial plan, the couple's cost for the latter plan would still be over 18% of their income (not shown in table).

A scenario in which the tax-credit benchmark is based on Medi-Cal plans may also seem unlikely in the several California counties which offer only one Medi-Cal plan. But in a number of populous California counties, two or more plans are offered to Medi-Cal recipients; and in other counties, similar plans are offered to Health Families recipients.[50] In addition to county-sponsored plans, some of these are plans with distinct networks the sponsoring commercial carrier does not offer in the commercial market, and others are private plans that do not now participate in the commercial market. But once *any* Medi-Cal network plans are offered in the Exchange, competing private carriers seem likely to offer their own Medi-Cal network plans and prices to compete for enrollment of the many Exchange participants who could not afford to pay the price difference for a mainstream provider plan.

Moreover, once two or more Medi-Cal-type plans were offered in an area, affordability for people who enrolled in any of those plans would not be improved. One of these plans would be the tax-credit "benchmark," and its enrollees would have to pay the percentage of their income specified in PPACA. Rates for the other Medi-Cal-type plans would presumably be similar, so any savings from enrolling in the lowest-cost one would be minimal at best.[51]

[50] In a number of counties with Medi-Cal managed care, there is only one locally sponsored health plan. But in the "two-plan" counties, there is also a second Medi-Cal plan, usually from a commercial carrier but not using that carrier's commercial network. Where a single County Organized Health System (COHS) administers the Medi-Cal program, commercial-carrier-sponsored Medi-Cal plans sometimes operate as subcontractors to the COHS. Further, private plans participate in the Healthy Families program in a number of counties. If a locally sponsored Medi-Cal plan chose to participate in the Exchange at premiums lower than commercial rates, the commercially sponsored Medi-Cal plans might well decide to do likewise, in order not to cede low-income Exchange enrollment to the local plan.

[51] That is, affordability would be improved if *only one* Medi-Cal-type plan was available through the Exchange. But if two or more such plans were offered at low rates, the tax credit amounts would be adjusted downward to reflect this fact.

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Illustrative Examples Discussed in Detail

The following examples illustrate how the cost of enrolling in an efficient mainstream plan offered through the Exchange could increase significantly for a tax-credit recipient if two or more plans using public-program provider payment rates are offered through the Exchange and thus one of them becomes the "second-lowest-cost 'silver' plan"—the "benchmark" plan used to calculate tax-credit amounts.

- Suppose an efficient mainstream "benchmark" plan at the "silver" coverage level[52] costs $4,700 per year in 2014 for single coverage (for an average-age adult),[53] while a Medi-Cal plan would cost about 30% or $1,400 less, or roughly $3,300 per year.

- Under the contribution schedule in PPACA, a single individual earning $20,000 in 2010 (about 175% of poverty) would be required to pay about 5.1% of income, or $1,027 per year, toward coverage under the "benchmark" plan. (See Table A-1.) The remainder of the premium for that plan would be covered by the federal tax credit.

- If the "efficient mainstream plan" is the second-lowest-cost Exchange plan, then our illustrative worker will pay $1,027 per year, or just under $86 per month, to enroll in that plan.

- But, if the second-lowest-cost plan is the much less expensive Medi-Cal plan, then the tax credit would be based on the cost of that plan, and our illustrative worker would have to pay the entire $1,400 premium difference if she wanted to enroll in the "efficient mainstream plan."
  - In this case, the worker's total contribution for the efficient mainstream plan would be$2,427, or 12.1% of her income.
  - We believe the estimated $1,400 or 30% "discount" for Medi-Cal plans is conservative and already assumes some increase in payment rates for providers.[54] However, if the

[52] "Silver" plans have an actuarial value of 70%, which means that, on average across a standard population, the plan's cost-sharing structure would result in the plan paying 70% of the cost of the covered benefits. (All Exchange-participating plans must cover at least the federally specified "essential health benefits.") Note that these premiums for the 70% AV "silver" plan do *not* include the cost of the federal cost-sharing fill-in subsidy (equal to 24% AV for those under 150% of poverty and 17% AV for those between 150% and 200% of poverty).

[53] The $4,700 figure for 2014 was deflated from CBO's national estimate of $5,200 for 2016. In the CHCF's California Employer Health Benefits Survey, 2010, premiums for employment-based HMO coverage were only slightly lower in California compared to the nation as a whole. Use of a higher premium for the "benchmark" silver plan, such as that recently estimated by Mercer, would increase the premium differential and make the illustrations presented here even more dramatic.

[54] Recent estimates by Mercer (*op.cit.*) for a Basic Health Program based on Medi-Cal rates, after adjustment by IHPS to reflect the 70% actuarial value of a silver plan, yield annual premiums even lower than that shown for the "30% less" plan in Table A-1. Also, the typical differential between Medi-Cal and commercial rates has been informally estimated by health plans to be considerably larger than 30%. Therefore, even with the increased reimbursement for primary care services mandated by PPACA, we believe a 30% discount is a reasonable basis for this illustration. For example, Mercer (*op.cit.*) reports that Medi-Cal managed care hospital per diem rates are approximately 43% of commercial inpatient rates. Further, it is known than physician payments under fee-for-service Medi-Cal are well below even Medicare rates (56% of Medicare in 2008, per Medicaid-to-Medicare Fee Index, 2008, from Kaiser State Health Facts

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Medi-Cal "discount" was only 20% (i.e., the Medi-Cal plan cost $3,760), our $20,000-per-year worker would pay 9.8% of her income for the efficient mainstream plan. (Not shown in table.)

- On the other hand, if the Medi-Cal discount was 40% (i.e., the Medi-Cal plan cost $2,820), the worker would have to pay 14.5% of her income for the mainstream plan.

Table A-1 shows the contributions required at various income levels relative to poverty, for this same illustrative set of circumstances.

Under health reform, however, premiums in the individual and small-employer markets, both inside and outside the Exchange, can be age-rated; and the premium for the oldest adults can be as much as 3 times the premium for the youngest adults.[55] Roughly, that means that premiums for the oldest adults will be about twice the average premium amounts shown in Table A-1.

As a result, the cost and access implications of having the tax-credit "benchmark" based on a Medi-Cal-rate plan are much greater for older adults than for younger adults, and much greater for couples than for single individuals. The situation for older couples is illustrated in Table A-2.

- For example, if a Medi-Cal-priced plan was the tax-credit benchmark, an older couple at 300% of poverty would have to pay 21.6%, rather than 9.5%, of their income for coverage under the illustrative efficient mainstream plan.

- An older couple at 150% of poverty would have to pay28.2%, rather than 4%, of their income for that plan.

<http://www.statehealthfacts.kff.org/comparetable.jsp?ind=196&cat=4>. Original source: Stephen Zuckerman, Aimee Williams, and Karen Stockley, "Medicaid Physician Fees Grew By More Than 15 Percent From 2003 to 2008, Narrowing Gap With Medicare Physician Payment Rates," *Health Affairs*, April 2009; available at http://www.kff.org/medicaid/kcmu042809oth.cfm.

[55] States can, at their option, limit the amount of premium variation permitted based on age, or prohibit such variation entirely.

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Table A-1: Tax-Credit Amounts and Contributions Required for Exchange Coverage at Different Income Levels, under Different Assumptions about the Premium for the "Benchmark" Plan, for an Average-Age Single Worker

Average-Age Single Worker		If "Benchmark" Plan Costs **$4,700** per year			If "Benchmark" Plan Costs 30% Less (**$3,300** per year)			Cost for **$4,700** Plan if **$3,300** Plan Is "Benchmark"		
Annual Income (2014)		Required Contribution		Tax-Credit Amount	Required Contribution		Tax-Credit Amount	Required Contribution		Tax-Credit Amount
(dollars)	(% FPL)	(dollars)	(% of income)	(dollars)	(dollars)	(% of income)	(dollars)	(dollars)	(% of income)	(dollars)
$17,175	150%	$687	4.0%	$4,013	$687	4.0%	$2,613	$2,087	12.2%	$2,613
$20,000	175%	$1,027	5.1%	$3,673	$1,027	5.1%	$2,273	$2,427	12.1%	$2,273
$22,900	200%	$1,443	6.3%	$3,257	$1,443	6.3%	$1,857	$2,843	12.4%	$1,857
$28,625	250%	$2,304	8.1%	$2,396	$2,304	8.1%	$996	$3,704	12.9%	$996
$34,350	300%	$3,263	9.5%	$1,437	$3,263	9.5%	$37	$4,663	13.6%	$37
$40,075	350%	$3,807	9.5%	$893	$3,300*	8.2%	$0*	$4,700*	11.7%	$0*
$45,800	400%	$4,351	9.5%	$349	$3,300*	7.2%	$0*	$4,700*	10.3%	$0*
$51,525	450%	$4,700†	9.1%	$0†	$3,300†	6.4%	$0†	$4,700†	9.1%	$0†

Notes: The "benchmark" plan on which the tax credit is based is the second-lowest-cost "silver" plan available to an Exchange enrollee.

FPL = federal poverty level. The row highlighted in yellow is discussed in the text.

* No tax credit is payable because the benchmark plan premium is less than the percent-of-income contribution specified under PPACA.

† No tax credit is payable above 400% FPL.

Source: Illustration by the Institute for Health Policy Solutions based on PL 111-148 as amended by PL 111-152.

Preparation of this paper was supported by the California HealthCare Foundation, based in Oakland, California.

Table A-2: Tax-Credit Amounts and Contributions Required for Exchange Coverage at Different Income Levels, under Different Assumptions about the Premium for the "Benchmark" Plan, for a Couple in the Oldest Age Bracket

Couple in Oldest Age Bracket		If "Benchmark" Plan Costs **$18,800** per year			If "Benchmark" Plan Costs 30% Less (**$13,200** per year)			Cost for **$18,800** Plan if **$13,200** Plan Is "Benchmark"		
Annual Income (2014)		Required Contribution		Tax-Credit Amount	Required Contribution		Tax-Credit Amount	Required Contribution		Tax-Credit Amount
(dollars)	(% FPL)	(dollars)	(% of income)	(dollars)	(dollars)	(% of income)	(dollars)	(dollars)	(% of income)	(dollars)
$23,100	150%	$924	4.0%	$17,876	$924	4.0%	$12,276	$6,524	28.2%	$12,276
$30,800	200%	$1,940	6.3%	$16,860	$1,940	6.3%	$11,260	$7,540	24.5%	$11,260
$38,500	250%	$3,099	8.1%	$15,701	$3,099	8.1%	$10,101	$8,699	22.6%	$10,101
$46,200	300%	$4,389	9.5%	$14,411	$4,389	9.5%	$8,811	$9,989	21.6%	$8,811
$53,900	350%	$5,121	9.5%	$13,680	$5,121	9.5%	$8,080	$10,721	19.9%	$8,080
$61,600	400%	$5,852	9.5%	$12,948	$5,852	9.5%	$7,348	$11,452	18.6%	$7,348
$69,300	450%	$18,800†	27.1%	$0†	$13,200†	19.0%	$0†	$18,800†	27.1%	$0†

Notes: The "benchmark" plan on which the tax credit is based is the second-lowest-cost "silver" plan available to an Exchange enrollee. Due to age-rating, the premium for a person in the oldest age bracket is estimated to be twice the average premium, and the premium for a couple (in the same age bracket) will be twice the premium for an individual. Consequently, the premium amounts shown here are four times the amounts shown in Table A-1.

FPL = federal poverty level.

† No tax credit is payable above 400% FPL.

Source: Illustration by the Institute for Health Policy Solutions based on PL 111-148 as amended by PL 111-152.

Preparation of this paper was supported by the California HealthCare Foundation, based in Oakland, California.

Addendum B: Data from a SIPP[a] Analysis by John A. Graves, Ph.D.[b]

Income Is Volatile

Among low-income people, income relative to the poverty level tends to fluctuate considerably over time. This fact has implications for how many people could be expected to realize continuity of coverage and care under different health insurance program arrangements.

Table B-1 shows the number of Californians estimated to be uninsured and with incomes in the Basic Health Program (BHP) income range (139%-200% FPL)[c] at the beginning of a year,[d] and the number whose income was initially higher or lower but came into that range (and who were uninsured) for any 3-month period during the year. Notes appear on the last page.

Table B-1: Californians under Age 65 Who, at the Beginning of a Year or for Any 3-Month Period During that Year, Are Uninsured and Have Income between 139% and 200% FPL, by Income Level at Beginning of Year

	Number (millions)
People who are uninsured and not offered employer coverage,* and whose income is between 139% and 200% FPL at the beginning of the year.	0.8
People whose income was initially above 200% FPL but who, during the following year, experience at least one period in which they are uninsured and their income falls into the BHP range.	2.0
People whose income was initially below 139% FPL (so they qualify for Medi-Cal) but who, during the following year, experience at least one period in which they are uninsured and their income rises into the BHP range.	1.8

Notes: FPL = federal poverty level. BHP = Basic Health Program (under §1331 of the Affordable Care Act).

* In this preliminary modeling, the "no employer offer" criterion could only be applied for the initial determination (at the beginning of the year).

Although this preliminary tabulation includes children under age 19 who would not be eligible for a BHP because they are eligible for Medi-Cal or Healthy Families at these income levels, this fact should not significantly affect the basic thrust of the data, because children comprise only about 1/6th of the insured (both in general and at these income levels).

Source: Tabulations of the Survey of Income and Program Participation by John A. Graves, Ph.D., Vanderbilt University School of Medicine, with support from the California HealthCare Foundation. Presentation by Institute for Health Policy Solutions.

Preparation of this paper was supported by the California HealthCare Foundation, based in Oakland, California.

Key observations:

- The number of Californians who are uninsured and income-eligible for a BHP over the course of a year is much larger than the number who qualify at the beginning of the year (although these results do not try to estimate how many would actually seek to enroll in BHP).
- Approximately the same number of Californians move down into the BHP income range, and are also uninsured, from income levels above 200% FPL as move up from below 139% FPL.

Additional analyses of applicable income-change data are planned and should be available before the end of July 2011.

Notes to Addendum B

[a] Estimates presented here are from the 2001 panel of the Survey of Income and Program Participation (SIPP), a longitudinal survey of U.S. households conducted by the Census Bureau. Participating households were interviewed in person at baseline and then again every four months for up to four years. During each interview round the respondents are asked about a number of topics including employment and income, participation in social programs, and monthly enrollment in public and private sources of health insurance. Because of this structure, SIPP is the primary source for data on income fluctuation over time. One newer 3-year SIPP panel is available—2004. It was not used here because it experienced very large attrition from the sample in year 3, making it extremely difficult to get reliable 3-year income estimates.

[b] John A. Graves, Ph.D., is Assistant Professor at the Vanderbilt University School of Medicine. While at Harvard, he completed a paper entitled, "The Optimal Design of Prospective Subsidies for Health Insurance Under the Patient Protection and Affordable Care Act" <http://people.fas.harvard.edu/~jagraves/optimal_design_111910.pdf>, which also relied on analysis of the 2001 SIPP panel. Because of the relevance of that paper and Dr. Graves' familiarity with SIPP, IHPS asked Dr. Graves, working in connection with Jonathan Gruber, Ph.D., of MIT, to prepare some basic data pertinent to understanding the implications of income dynamics in California. The California HealthCare Foundation graciously supported Dr. Graves' analysis.

[c] Having income in the BHP range does not automatically imply eligibility for BHP. The person also must not be eligible for "affordable" employer coverage (as defined in the ACA) and not eligible for Medicare, Medicaid or CHIP (Healthy Families).

[d] The "initial" eligibility determination (before the start of the year) used the most recently available tax-return income, as required under PPACA, or income over the prior 3 months where no tax return was filed or filing status had changed. Also, the "initial" determination required that people be both uninsured and without an offer of coverage from an employer. In this preliminary analysis, the "no employer offer" criterion could not be applied to the estimates "during the year," due to time and resource constraints.

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