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POLICY BRIEF

BRIDGING THE GAP: EXPLORING THE BASIC HEALTH INSURANCE OPTION FOR NEW YORK

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POLICY BRIEF

BRIDGING THE GAP: EXPLORING THE BASIC HEALTH INSURANCE OPTION FOR NEW YORK

By Elisabeth R. Benjamin and Arianne Slagle

The Affordable Care Act (ACA) constitutes a historic opportunity for New York State to offer health coverage to nearly 2.6 million uninsured New Yorkers. The establishment of a Health Insurance Exchange, the creation of federal subsidies to help individuals purchase insurance, and expansions in Medicaid eligibility will make it much easier for New Yorkers to select plans and enroll in coverage.

But many low-income residents will still face steep fiscal cliffs between the Medicaid program, which is effectively free for beneficiaries, and the relatively expensive private plans offered through the state-based Exchange. This problem is especially acute in high cost-of-living states, such as New York, where low-income people have little disposable income.

One provision of the ACA offers states an important opportunity to ameliorate this affordability gap for low-income residents by providing significant federal funding to establish a Basic Health Plan (BHP). Under a BHP, states can provide affordable, comprehensive coverage for people below 200 percent of the federal poverty level (FPL), which is roughly $37,000 for a family of three.

This report details the implications of offering a BHP in New York. Specifically, it describes: the amount of federal funding that would be available; the take-up rate by various eligible population groups; the cost of offering a comprehensive public look-alike product; the types of plan options the State could potentially offer; and the impact the establishment of a BHP would have on New York's Exchange and the rates of the uninsured upon the full implementation of the ACA in 2014.

If adopted, New York could build off of its existing Medicaid expansion program, Family Health Plus (FHP), to offer high-quality coverage with no co-premiums to an estimated 467,000 New Yorkers.

The Community Service Society of New York (CSS) is an informed, independant, and unwavering voice for positive action that serves the needs of low-income New Yorkers.

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If adopted, New York could build off of its existing Medicaid expansion program, Family Health Plus (FHP), to offer high-quality coverage with no co-premiums to an estimated 467,000 New Yorkers. As summarized in Table 1, New York State would receive nearly $2.6 billion in federal financing for its BHP. These federal financing estimates are conservatively based on HMO small group premiums instead of New York's current expensive individual market premiums or other more generous small group products. Based on the medical claims costs in New York's existing FHP program, it would cost New York State approximately $2.5 billion to offer a comprehensive BHP plan with no monthly co-premiums, for a total net operating margin of $27 million.

TABLE 1
Summary of Financing, Cost, and Savings Estimates for New York's BHP Program

Estimated Number of BHP Enrollees	**467,000**
Estimated Federal Funding	$2,580,299,000
Estimated BHP Program Costs	$2,553,619,000
Sub-Total: Net Operating Margin	$26,680,000
State Cost Savings Offsets	$510,752,000
Provider Rate Increase	($255,362,000)
Plan Design at 94% Actuarial Value	$104,229,000
Net Financial Impact of BHP for New York State	$386,299,000

Establishing a BHP is a particularly attractive option for the State of New York in that it would alleviate the State's current costs of providing public coverage to several groups of residents, including: (1) parents of children who receive public coverage above the new federal Medicaid income threshold (through the FHP program); and (2) legal immigrants who receive State-only funded public insurance coverage. By moving these populations into a BHP, the state could generate an additional savings of $511 million.

A series of plan options, with varying levels of benefits, is also explored. Based on the plan design chosen, there is a greater potential for state savings which could be used to increase provider reimbursement rates. As described in Table 1, even if New York adopted a slight increase in enrollee-cost sharing and enhanced provider reimbursement rates, BHP still would generate a net financial gain to the State of around $386 million annually (see Table 1).

Not only would a BHP engender significant savings for the State, it would also reduce the potential number of uninsured New Yorkers come 2014. Without a BHP, low-income New Yorkers would either have to pay potentially cost-prohibitive premiums in the Exchange or a penalty and forgo coverage altogether. Our estimates indicate that if the State were to offer a free or very low-cost BHP, nearly 100,000 more New Yorkers are likely to gain coverage.

In summary, this Policy Brief urges New York to consider seriously adopting a BHP for the following reasons:

- A BHP would offer 467,000 low-income New Yorkers more affordable and comprehensive coverage than they would receive in the Exchange;
- Federal financing is adequate to cover the costs of offering a BHP in New York State;
- Adopting a BHP will potentially generate roughly $511 million in State savings;
- Due to having no or very low co-premiums, nearly 100,000 more New Yorkers are likely to gain coverage if New York adopts a BHP.

Introduction

The Affordable Care Act (ACA) of 2010 seeks to guarantee quality, affordable coverage to nearly everyone living in the United States. The ACA builds upon the two existing pillars of health coverage: employer-based coverage and public coverage (Medicaid, State Children's Health Insurance program, and Medicare). It augments the level of consumer protections in the private insurance market, placing stringent regulations to hold health plans accountable and setting new standards for the financial risk exposure of enrollees.

With notable exceptions, the ACA requires most people to have health coverage. Large employers must automatically

enroll their employees in coverage, thus maintaining the existing system for those who have job-based coverage. Small businesses are not required to offer coverage, but are eligible for tax credits if they do so, in order to stem the current decline in small group coverage.

To facilitate the purchase of affordable coverage by individuals and small businesses, states have the option to establish local, state or regional Exchanges—marketplaces which will offer insurance for individuals and small businesses. Exchanges provide important opportunities for collective, or bulk, purchasing and risk spreading across a large number of people.[1]

Exchanges also will ease the complex task of purchasing coverage by categorizing insurance products according to their actuarial values (AV), as described in the sidebar. To ensure a standard level of quality on the Exchange, only "qualified health plans" are allowed to participate—plans which offer at least the minimum "essential health benefits" and criteria prescribed by the federal government. Qualified health plans will fit into four different categories based on actuarial level: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%).

Importantly, the Exchanges will offer advanceable and refundable tax credits or "premium subsidies" of up to the cost of Silver-level coverage for people with incomes up to 400 percent of the federal poverty level (FPL), or $73,000 for a family of three. Additionally, to protect against medically-related personal bankruptcies, the ACA includes an annual cap on cost-sharing equal to $5,950 for an individual and $11,900 for a family, and annual deductible limits of $2,000 for individuals ($4,000 for families) small group coverage. As displayed in Table 2, people with incomes below 400 percent of FPL who enroll in a Silver-level plan will be eligible for a reduction in the annual cap on cost-sharing by as much as two-thirds, depending on income.

People earning between 100 and 250 percent of FPL who enroll in a Silver-level plan are also eligible for an additional cost-sharing subsidy. Cost-sharing subsidies are described in the ACA as increases in the actuarial value of a Silver-level plan: for the poorest people with incomes below 150 percent of FPL, the AV increases from 70 to 94 percent; for people with incomes between 150 and 200 percent of FPL, the AV increases from 70 to 87 percent; and for people with incomes between 200 and 250 of FPL, the AV increases from 70 to 73 percent.

For the lowest income residents of the United States, Medicaid coverage will be expanded to eligible people with incomes up to 139 percent of FPL, or around $25,760 a year for a family of three. Taken together, these measures are estimated to provide coverage to nearly 32 million people nationwide, with roughly equal numbers of newly insured through the expansion of Medicaid and coverage through the Exchange or through private employers.[2] In New York, nearly 1.2 million uninsured are expected to gain new coverage.[3]

Levels of Coverage on the State Health Benefit Exchange

Insurance Exchanges will be used to facilitate the purchase of qualified health plans offered at different actuarial values (AVs). An AV is the percentage of total medical costs that an insurance plan pays. The difference is the amount a consumer or employer pays. Plans with higher AVs have lower out-of-pocket costs for members:

PLATINUM LEVEL = 90% AV
GOLD LEVEL = 80% AV
SILVER LEVEL = 70% AV
BRONZE LEVEL = 60% AV

While consumers are free to choose any plan, under the ACA, people who enroll in a Silver level plan may receive additional cost-sharing subsidies, depending on income.

TABLE 2: SUBSIDIES AND OUT-OF-POCKET COST PROTECTION IN THE ACA

Annual Costs for a Family of Three (2 adults, 1 child) in the Exchange			
FPL	Income	Family Annual Co-Premium	Reduced Annual Out-of-Pocket Cap
100%	$18,530	$366	n/a
200%	$37,060	$2,335	$3,967
300%	$55,590	$5,281	$5,950
400%	$ 74,120	$7,041	$7,933

Addressing Affordability Concerns: The Basic Health Plan Option in the ACA

The ACA significantly expands access to quality, affordable health coverage to low- and middle-income individuals and families. However, despite efforts to ensure affordability for low-income people come 2014, those earning over 138 percent of FPL will still face steep eligibility cliffs between the effectively free Medicaid program and the relatively expensive private plans offered through the state-based Exchanges. Even with federal subsidies, many of the roughly seven million uninsured working families in the Unites States with incomes between 139 and 200 percent of FPL may face significant financial hardships purchasing coverage through the Exchange—especially if they live in a high cost-of-living state.

Section 1331 of the ACA provides states with flexibility to help bridge the gap in affordability between the effectively free Medicaid program and private coverage in the Exchange by providing states with a significant federal funding opportunity to offer a Basic Health Plan (BHP) for people with incomes below 200 percent of the FPL.[4] Eligibility to enroll in a BHP program is limited to people who are under the age of 65, who are ineligible for Medicaid, and who have incomes below 200 percent of FPL. If a state elects to offer a BHP, individuals eligible for the BHP would be precluded from purchasing subsidized coverage through the Exchange.

States that opt to offer a BHP will be required to set up a trust fund for the program. The ACA authorizes the federal government to pay into the BHP trust fund 95 percent of what the federal government would have paid in premium tax credits, plus 100 percent of the cost-sharing subsidies that the state's BHP enrolled population would have received had they instead bought a plan on the Exchange.[5] To qualify for this funding, a BHP must offer the federally mandated "essential health benefits," a medical-loss ratio of at least 85 percent, and out-of-pocket premium costs no greater than what an enrollee would have received on the Exchange.[6] States which offer a BHP must also establish a competitive procurement process for selecting health plans.[7] Once these requirements have been met, states would have wide latitude to design their BHP benefits and cost-sharing structure.

New York's Public Insurance Programs

New York is a nationally recognized "leader state" in providing access to affordable, high quality health coverage for its low-income residents. Family Health Plus (FHP), a Medicaid expansion program created under the State's Section 1115 Waiver program, offers coverage above the Medicaid threshold of 78% of FPL for qualifying adults. FHP coverage is available to childless adults with incomes up to 100% of the FPL and parents up to 150% of FPL. Additionally, New York offers free coverage through its Child Health Plus (CHP) program to children in families with incomes below 160% of FPL and subsidized coverage to children in families up to 400% of FPL.

As of April 2011, there are approximately 2.9 million New Yorkers covered in Medicaid Managed Care, 403,000 enrollees in FHP, and 407,000 in CHP (New York State Department of Health, April 2011). New York receives a 50% federal match for both its Medicaid and FHP programs, and 65% federal matching funds for its CHP program. The state pays 100% of the cost for more than 110,000 legal immigrants in its public insurance programs who are ineligible for federal matching funds.

Why Should New York State Policymakers Consider the BHP Option?

For the State of New York, there are two significant benefits of opting into the BHP. First, BHP could offer financial security to low-income residents by ensuring their access to affordable and stable coverage. Second, a BHP would bring substantial cost savings to the State by enabling it to obtain increased federal funding while simultaneously maintaining comprehensive affordable coverage to low-income residents.

Ensuring Financial Security with Affordable Coverage

For New York's low-income consumers, BHP provides an affordable bridge between Medicaid and coverage on the Exchange. Premiums for a family of three on the Exchange will begin at around $730 a year for those at 139 percent of FPL, and escalate from there. Many New Yorkers with incomes below 200 percent of FPL have significant amounts

of debt, with little or no disposable income left to pay for health insurance premiums: 40 percent have credit card debt; 26 percent have medical debt; and 32 percent report having no savings at all.[8] A BHP could provide a lower-cost—or free—option for families struggling to break even.

BHP would bring substantial cost-savings to the State by enabling it to obtain increased federal funding while simultaneously maintaining comprehensive affordable coverage to low-income residents.

In addition to easing the financial burdens of low-income individuals, a BHP would also lead to greater coverage rates if built off of New York's existing FHP program. As described later in this Policy Brief, if a free or low cost BHP program were available, roughly 100,000 fewer families would opt to forgo coverage and pay penalties than would do so if their only option were the relatively expensive coverage available to them in the Exchange.

As displayed in Table 3, the State could choose to design a BHP which could be free or cost as much as $2,335 annually. But in the Exchange, the annual cost of co-premiums for coverage would reach the upper limits of the affordability schedule, ranging from $366 to $2,335, for people with incomes between 139 and 200 percent of FPL. Finally, a BHP without co-premiums, or even very low premiums, would make low-income New Yorkers less likely to experience significantly fewer coverage disruptions or gaps in coverage related to income fluctuations. This is a serious concern as experts estimate that nearly 50 percent of low-waged workers will fluctuate between Medicaid and Exchange eligibility within any given year.[9]

In short, by adopting a BHP, low-income New Yorkers could have better, more affordable, and potentially seamless coverage.

Generating State Savings

Next, for the State, a BHP presents two important opportunities to replace State funding for public coverage with federal financing while simultaneously maintaining comprehensive and affordable coverage for currently eligible populations and expanding access to coverage for still more.

First, like many other states, New York's existing Medicaid expansion program, FHP, offers coverage above the federal Medicaid gross income eligibility ceiling of 139 percent of FPL.[10] The FHP program covers parents with incomes up to 150 percent of FPL (coverage is also offered to childless adults with incomes up to 100 percent of FPL).[11] While New York could eliminate coverage for FHP enrollees above 139 percent FPL and require this population to enter the Exchange, the federal financing available for BHP would enable New York to continue to provide free or very low cost coverage to this population without expending State funds.

Second, if New York chooses to implement a BHP, the State would be able to essentially replace significant State funding for public coverage of legal, but not qualified, immigrants with federal financing for the BHP. As a result of litiga-

TABLE 3: BHP COULD CREATE AN AFFORDABLE BRIDGE BETWEEN MEDICAID AND COVERAGE ON THE EXCHANGE

Annual Premium Costs for a Family of Three (2 adults, 1 child)					
FPL	Income	Medicaid	BHP		Exchange
100%	$18,530	$0	$0		$366
139%	$25,570	n/a	$0–$782	v.	$782
150%	$27,465	n/a	$0–$1,099	v.	$1,099
200%	$37,060	n/a	$0–$2,335	v.	$2,335
300%	$55,590	n/a	n/a		$5,281

tion brought over a decade ago, New York, like a number of other states,[12] currently offers public coverage to most groups of legal immigrants using State-only funds.[13] Under the ACA, all legal immigrants with incomes below 200 percent of FPL are eligible for the BHP.[14] Shifting 86,400 legal immigrant adults from New York's Medicaid program into a BHP would result in considerable savings to the State.

How Would a BHP Work in New York State?

There are substantial benefits to both the State and low-income residents which auger in favor of adopting a BHP in New York. Nonetheless, important questions remain.

- Can New York successfully operate a BHP with the funding that is likely to be available for the program?
- Who and how many people would be covered?
- What types of provider reimbursement levels would be adopted (e.g., public or commercial)?
- What are the possible cost-sharing levels and plan designs that New York might consider for its BHP, and how would they impact the financial viability of the program?
- What impact would adopting BHP have on the State Exchange and/or rates of the uninsured?

These questions and others are addressed on the right.

Who Would Participate in BHP? Membership Projections and Take-Up

Designed to coincide with the establishment of state Exchanges and the individual mandate to carry health coverage, states will have the opportunity to launch their BHP programs beginning in 2014. Individuals who fail to obtain coverage will face an annual fine (with some exceptions for financial hardships, religion and immigration status). Those earning below the income tax filing thresholds (86 percent of FPL for single filers and 128 percent of FPL for couples in 2010) will be exempt from the mandate, but this exemption would not apply to the population groups eligible for BHP, described in the following pages.

Methodology and Data Sources

This Policy Brief consists of original policy research and data analysis conducted by the Community Service Society of New York and our research partners, Gorman Actuarial and Manatt Health Solutions. Our analytical work included two substantive components: (1) population, eligibility and take-up; and (2) financing and cost modeling.

Population, Eligibility and Take-up Methodology

Baseline data on health insurance coverage, age, income and other demographics in New York State was drawn from a three-year blend of the 2008, 2009 and 2010 Current Population Survey Annual Social and Economic Supplement (CPS ASEC), adjusted forward to 2010 CPS ASEC for the overall population and for the uninsured. We then estimated the population, health insurance coverage and characteristics of New York's undocumented immigrants based on the work of Jeffrey Passel of the Pew Hispanic Center and excluded them from the CPS ASEC data to achieve a profile of potential BHP eligible uninsured.

The populations of eligible adults in several specific eligibility groups was estimated using supplemental data provided by the New York State Department of Health (NYSDOH) and other sources.

- Parents 139–150% FPL enrolled in Family Health Plus was derived from data provided by NYSDOH, distributed based on the income mix of Medicaid-enrolled parents in the CPS ASEC.
- Legal immigrant adults in state-only funded Medicaid was drawn directly from NYSDOH data.
- Adults 139–200% FPL in Healthy New York was estimated based on the 2009 Healthy New York program reports and personal communication with the New York State Department of Insurance.
- Adults 139–200% FPL in Direct Pay coverage was estimated based on personal communication with officials from the New York State Department of Insurance, distributed by income and age using the CPS ASEC. Numbers were increased

continued on next page

The following seven groups of residents would potentially enroll in New York's BHP:

(1) currently uninsured adults with incomes between 139 and 200 percent of FPL (including citizens and legal immigrants);

(2) parents with incomes between 139 and 150 percent of FPL currently enrolled in Family Health Plus;

(3) legal immigrant adults who are currently enrolled in Medicaid;

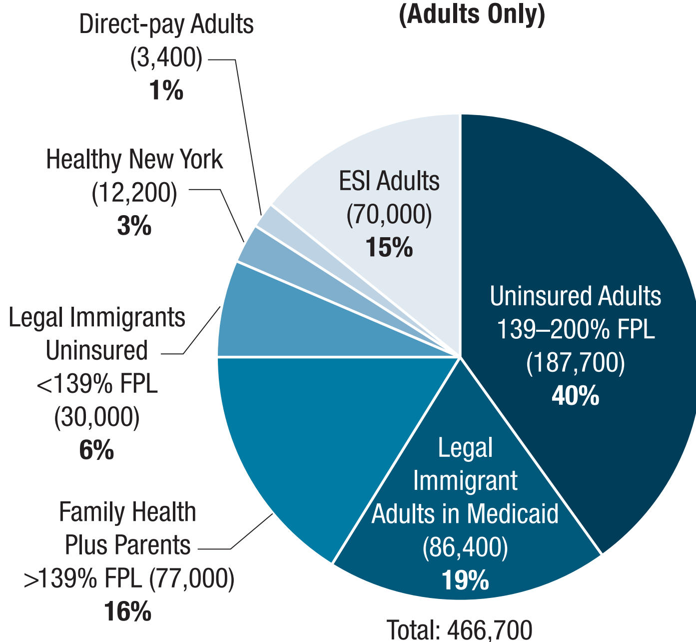
(4) legal immigrant adults with incomes below 139 percent of FPL who are currently uninsured;

(5) adults currently enrolled in Healthy NY as individuals or sole proprietors with incomes below 200 percent of FPL;

(6) adults with incomes between 139 and 200 percent of FPL who are currently insured in the Direct Pay market; and

(7) adults with incomes between 139 and 200 percent of FPL who currently have employer-sponsored insurance (ESI).

TABLE 4
New York State BHP Membership Projection by Current Coverage (Adults Only)



Methodology and Data Sources Continued...

based on the United Hospital Fund Report titled "Merging the Markets: Combining New York's Individual and Small Group Markets into common risk pools," 2008.

The take-up assumptions for each of the BHP eligible populations are discussed in detail below in the section titled "Who Would Participate in BHP? Membership Projections and Take-Up."

Financing and Cost Modeling

We estimated both the financing that would become available to New York State to fund a BHP and the costs of covering our projected BHP take-up population. For the financing component, given the extreme prices as a result of adverse selection in the individual market, we used commercial HMO and PPO small group products as a proxy for what individual premiums will be in 2014. We collected premiums for major carriers in the following locations: New York City, Buffalo, Rochester, Syracuse, Albany and Long Island. We trended these rates forward to 2014 and made several other adjustments. We estimated the premium tax credits and cost-sharing subsidies that would be available to projected BHP enrollees in the Exchange, and calculated the federal financing likely to become available to fund New York's BHP. In addition, based on data from NYSDOH and the 2009 Healthy New York program reports, we estimated several cost-saving offsets that would accrue to the State if a BHP were implemented.

To estimate the costs of covering the projected BHP population, we first gathered claims data on New York's FHP program from the State's 2009 Q4 Medicaid Managed Care Operating Reports (MMCOR). Using the FHP program as our baseline, we then estimated the relative risk and morbidity factors for each of the BHP population groups, and finally calculated a blended cost per enrollee per month based on membership projections. Full details of our cost modeling and assumptions are detailed below in the section titled, "How Much Would Offering a BHP Cost New York State?," as are a series of sensitivities and estimates of costs or savings under differing plan designs, provider reimbursement, and other program features.

Each of these seven groups of people has distinct characteristics which require a separate take-up analysis, briefly described below. This analysis uses the existing FHP program model and consequently assumes that there will be no co-premiums and very limited cost-sharing (e.g., co-payments) in a New York BHP. Because of the maintenance of effort obligation on states to continue their SCHIP programs through 2019, children are not included in this analysis.[15] All take-up estimates are based on the most current population data available for each eligible group, with no assumptions as to changes in population size or mix before 2014.

- **Uninsured adults with incomes between 139 and 200 percent of FPL:** Under the BHP, roughly 268,200 uninsured adults with incomes between 139 and 200 percent of FPL would become newly eligible for coverage.[16] However, these adults are only eligible if they do not have access to affordable insurance coverage from their employer. In this case, coverage is considered to be "affordable" if the employee's share does not exceed 8 percent of their income. Approximately 70 percent of this population (187,700) will enroll in the BHP, with the remainder taking up job-based coverage, opting to pay penalties and remain uninsured, or, in rare cases, securing an exemption from the individual mandate.[17]

- **Family Health Plus parents with incomes between 139 and 150 percent of FPL:** An estimated 77,000 parents with incomes between 139 and 150 percent of FPL were enrolled FHP in 2009.[18] This population would be eligible to transition to coverage through the BHP. If New York does not opt into a BHP in 2014, there will be strong fiscal pressures for the State to roll back the FHP eligibility level to the new federal Medicaid gross income eligibility ceiling of 138 percent of FPL. Assuming there is no co-premium for BHP, we project that 100 percent of these 77,000 FHP parents with incomes above 138 percent of FPL will enroll in the BHP.

- **Legal immigrants in State-only Funded Medicaid:** As a result of a court case[19] brought in the wake of the 1996 federal welfare reform law,[20] New York pays the entire costs of Medicaid and/or FHP coverage for approximately 86,400 legal (non-qualified) immigrant adults.[21] The State does not receive federal matching funds to help offset the costs of extending coverage to this group and, as a result, New York State currently pays the full cost of their coverage. Under the ACA, federal financing is restored for these legal immigrants who participate in BHP (including those now covered with State-only funding). Given this fiscal incentive, the State is likely to transfer 100 percent of the legal immigrants (86,400 individual adults) currently enrolled in Medicaid or FHP into the BHP.

- **Uninsured lawful immigrants with incomes below 139 percent of FPL:** Roughly 150,000 uninsured legal immigrant adults in New York have incomes below 139 percent of FPL. (Uninsured legal immigrant adults with incomes between 139 and 200 percent FPL are included in the overall numbers of uninsured adults in this income group detailed above.) These individuals are currently eligible for state-only funded Medicaid or FHP, but remain uninsured. While low-income legal immigrants will be eligible for the BHP, we estimate that only 20 percent will enroll in the program due to administrative hurdles, long-standing fears of engaging with government programs, and their exclusion from the individual mandate given their low income levels. We estimate final enrollment from this population will be 30,000.

- **Healthy NY:** As of July 2009, an estimated 12,200 individual and sole proprietor adults were enrolled in the Healthy NY program with incomes below 200 percent of FPL.[22] Under the ACA, all health plans that offer coverage in the individual and small group markets will need to include an "essential health benefits package" starting in 2014.[23] Healthy NY does not meet this standard because it does not cover treatment for mental health and substance abuse disorder services and prescription drugs. Assuming that Healthy NY is discontinued in 2014, we estimate that 12,200 or 100 percent of the individual and sole proprietor adults enrolled in Healthy NY with incomes below 200 percent of FPL will enroll in the BHP.

- **Direct Pay:** An estimated 3,600 adults with incomes between 139 and 200 percent of FPL currently purchase coverage in the individual—or "Direct Pay"—market.[24] Given the exorbitant price of insurance in this market (over $10,000 per year for an individual or $24,000 per

year for a family), typically only people who are either very wealthy or very sick pay for this type of coverage.[25] The very sickest in this group, who have already shown that they have the means to purchase this coverage despite the high premiums, are unlikely to disrupt their coverage and will likely remain in the "Direct Pay" market—even though their eligibility for coverage under the BHP would make them ineligible for subsidized coverage through the Exchange.[26] However, we project that the vast majority of this population, an estimated 3,400 people (95 percent of the total eligible) will drop their existing coverage and enroll in BHP.

- **Employer-sponsored insurance:** Roughly 375,500 adults in New York with incomes between 139 and 200 percent of FPL have employer-sponsored insurance (ESI).[27] Those with ESI would only be eligible for the BHP in the event that: (1) they are paying more than 8 percent of their income for their share of the coverage;[28] (2) their employer were to stop offering coverage to them, or; (3) their employer were to increase employee premiums to greater than 8 percent of the employee's income. Based on a review of existing literature on substitution of coverage, or "crowd out," we estimate that 70,000 current ESI members will enroll in the BHP. This equals 15 percent of the final BHP take-up population, and roughly 20 percent of current ESI enrolled adults with incomes between 139 and 200 percent of FPL.

Combining these seven groups, an estimated 466,700 adult New Yorkers will enroll in the BHP when the plan is fully implemented (see Table 5).

Is There Adequate Federal Financing to Establish a BHP in New York?

In determining the feasibility of offering a BHP, New York first must consider whether there is sufficient, and sustainable, federal funding. However, direct federal financing for a BHP is only part of the funding picture. In addition to federal financing, New York State is also likely to be able to recoup significant cost-saving offsets from eliminating or reducing State-funded expenditures by shifting certain populations (such as legal immigrants) from State-only funded programs into a BHP where federal funding is available. While such funding would not necessarily be dedicated to funding the State's BHP, New York could consider these cost-saving offsets as a financial benefit of adopting a BHP.

TABLE 5
Membership Projections (Adults Only)

	0-138% FPL	139-150% FPL	151-200% FPL	Total Eligible	Take-Up (%)
Uninsured Adults 138-200% FPL	—	28,000	240,200	268,200	187,700 (70%)
Family Health Plus Parents >138% FPL	—	77,000	—	77,000	77,000 (100%)
Legal Immigrant Adults in Medicaid	86,400	—	—	86,400	86,400 (100%)
Legal Immigrants Uninsured <138% FPL	150,000	—	—	150,000	30,000 (20%)
Healthy New York	—	1,200	11,000	12,200	12,200 (100%)
Direct Pay Adults	—	400	3,200	3,600	3,400 (95%)
Sub-Total	**236,400**	**106,600**	**254,400**	**597,400**	**396,700**
ESI Adults	n/a	n/a	n/a	n/a	**70,000**
Grand Total					**466,700**

Federal Financing Estimate

Under the ACA, the federal funding that each state will receive for a BHP is based on two components: (1) the amount of premium tax credits that BHP enrollees would have received if they enrolled in the second lowest-cost Silver plan on the Exchange, of which the state will receive 95 percent; and (2) an added offset for the cost-sharing subsidies that the same enrollees would have also received on the Exchange.[29] Under the ACA, a state must establish a trust to receive federal support for the BHP. These funds may be used to lower premiums or cost-sharing for BHP enrollees, or to provide them with additional benefits. The ACA further provides for an annual reconciliation to ensure that federal financing is used appropriately.[30] At this time, the precise nature of this reconciliation has yet to be specified by federal officials, adding a certain level of uncertainty for State officials.

Premium Tax Credits

In order to determine the premium subsidy portion of federal financing for New York's BHP, it is first necessary to estimate the cost of the second lowest-cost Silver-level plan that will be available in the State's Exchange in 2014. As an Exchange does not yet exist in New York, we began with a survey of the existing marketplace of health insurance premiums and products. We then adjusted the current premiums from 2011 to develop the estimated cost of a Silver product in 2014.

The average price for a Direct Pay product in New York State is currently over $1,000 per month for an individual.[31] Because there is so much adverse selection in the Direct Pay market, New York's small group products are perhaps a more realistic proxy for estimating costs in the 2014 Exchange marketplace.

New York's small group market has both Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) products. PPOs generally use a broader network, allow out-of-network provider utilization, and do not require referrals from primary care provider (PCPs) for specialty care. HMO products have a restricted network and require members to have a PCP act as a "gatekeeper" for specialty care, making it a less expensive product. To estimate the average cost of the second lowest-cost Silver plan in New York State, we first acquired regional pricing estimates for the most popular plans under both products with estimated actuarial values close to 70 percent. We then selected the second lowest Silver level premium for January 2011 by geographic region. Finally, we developed statewide average prices using a projected BHP distribution by region.

Table 6 shows the initial prices for the small group PPO and HMO products in New York in 2011 that would be equivalent to a second lowest-cost Silver Plan—$520 per month for a PPO and $367 per month for an HMO. By applying an

TABLE 6
Federal Funding Premium Tax Credit Estimate (Per Member Per Month Basis)

	Premium Tax Credit			
	Premiums based on PPO		Premiums Based on HMO	
	<150% FPL 0.94 AV	150-200% FPL 0.87 AV	<150% FPL 0.94 AV	150-200% FPL 0.87 AV
Second Lowest Cost Silver Plan CY 2011	$520	$520	$367	$367
Projected CY 2014 (9.9% trend)	$690	$690	$487	$487
State Mandated Benefits (6%)	-$41	-$41	-$30	-$30
Member Premium	-$50	-$89	-$50	-$89
Premium Tax Credit	$599	$560	$407	$368
95% of Premium Tax Credit	**$569**	**$532**	**$387**	**$350**

annual premium increase of 9.9 percent, the projected premiums for these products in 2014 would be $690 and $487, respectively. For the purposes of estimating federal financing, we then reduced these premiums by 6 percent to reflect New York's state-mandated benefits as, under the ACA, the federal government will not reimburse individual states for insurance benefits mandated under state insurance law over and beyond the essential benefit coverage.[32]

To determine how much these individuals are entitled to through premium tax credits, adjustments were made to subtract out the co-premium individual members would pay on the Exchange based on their income level (approximately $50 for people with incomes up to 150 percent of FPL, and $89 for people with incomes between 150 and 200 percent of FPL).[33] The remaining difference between the total and the co-premium paid is the amount of the premium credit. Finally, the premium tax credits are multiplied by 95 percent, which is the amount the federal government will pay the State for a BHP. Using a PPO rate, the amount of federal premium subsidy available is $569 per month for people with incomes below 150 percent of FPL and $532 per month for people with incomes between 150 and 200 percent of FPL. Using an HMO rate, the amount of federal premium subsidies would be $387 and $350, respectively.

Cost-Sharing Subsidy

The second component of the federal financing New York would receive for a BHP consists of the cost-sharing subsidies BHP enrollees would have been eligible for if they had sought coverage through the Exchange. Cost-sharing subsidies are expressed in the ACA as increases in the actuarial value of a 70 percent Silver-level plan to 87 percent for people with incomes between 150 and 200 percent of FPL and 94 percent for people with incomes below 150 percent of FPL.

It remains unclear as to how exactly these cost-sharing credits will be calculated, and there are several approaches that can be taken in order to calculate an estimated value.[34] We estimated the value of the cost-sharing subsidies by determining the difference between the medical claims of an individual enrolled in a 70 percent actuarial value Silver plan in the Exchange, and plans that have an actuarial value of 87 percent or 94 percent. To do so, we started with our premium estimates and subtracted out administrative costs, assuming that plans are operating at the New York State-permitted maximum of 18 percent. The remaining 82 percent of the premium represents actual medical claims. This estimate was then adjusted upward from 70 percent to the higher actuarial values of either 87 or 94 percent, with the difference being the cost-sharing subsidy (see Table 7).

Taken together, the total of the estimated premium tax credits and cost-sharing subsidies is the per member per month amount that will be available to New York for BHP financing. As described above, this amount will vary by the en-

TABLE 7
Federal Funding Cost Sharing Subsidy Estimate (Per Member Per Month Basis)

	Cost Sharing Subsidy			
	Premiums based on PPO		Premiums Based on HMO	
	<150% FPL 0.94 AV	150-200% FPL 0.87 AV	<150% FPL 0.94 AV	150-200% FPL 0.87 AV
Projected CY 2014 Silver Premium	$690	$690	$487	$487
Administrative Estimate (18%)	-$124	-$124	-$88	-$88
2014 Silver Medical Claims Estimate	$566	$566	$399	$399
Adjustment for Target Medical Claims*	$760	$703	$536	$496
Estimated Cost-sharing Subsidy	**$194**	**$137**	**$137**	**$97**

**Adjust by the ratio of 0.94/.70 for individuals up to 150 FPL and 0.87/0.70 for individuals 150 to 200 FPL*

TABLE 8
Total BHP Federal Funding Estimate (Per Member Per Month Basis)

		Total Federal Funding Estimate (With and Without 20% Utilization Reduction)			
		Premiums based on PPO		Premiums Based on HMO	
		<150% FPL 0.94 AV	150-200% FPL 0.87 AV	<150% FPL 0.94 AV	150-200% FPL 0.87 AV
No Utilization Reduction	95% of Premium Tax Credit	$569	$532	$387	$350
	Cost Sharing Subsidy	$194	$137	$137	$97
	Total Federal Funding (No Reduction)	**$763**	**$669**	**$524**	**$447**
With 20% Utilization Reduction	95% of Premium Tax Credit	$569	$532	$387	$350
	Cost Sharing Subsidy	$155	$110	$109	$78
	Total Federal Funding (20% Reduction)	**$724**	**$642**	**$496**	**$428**

rollee's income group and is dependent upon which product is used to generate the initial Silver product premium.

The previous estimates assume that the utilization patterns of the BHP population will be similar to a commercial population. However, a recent report by the Kaiser Family Foundation raises the possibility that utilization of health services by BHP enrollees might be lower than their commercially-insured Exchange counterparts.[35] Accordingly, we include a sensitivity adjustment to show the difference in the available cost-sharing subsidy with and without this 20 percent utilization reduction (see Table 8).

Total Available Federal Financing

To generate an estimate of the total financing which would be available to New York State's BHP, we multiplied the total funding per member per month by the number of people estimated to enroll or "take-up" coverage under the BHP. As described in the previous section, take-up is estimated for seven potential populations:

(1) currently uninsured adults with incomes between 139 and 200 percent of FPL (including citizens and legal immigrants);

(2) parents with incomes between 139 and 150 percent of FPL currently enrolled in FHP;

(3) legal immigrant adults who are currently enrolled in Medicaid;

(4) legal immigrant adults with incomes below 139 percent of FPL who are currently uninsured;

(5) adults currently enrolled in Healthy NY as individuals or sole proprietors with incomes below 200 percent of FPL;

(6) adults with incomes between 139 and 200 percent FPL who are currently insured in the Direct Pay market; and

(7) adults with incomes between 139 and 200 percent of FPL who currently have employer-sponsored insurance.

Depending on whether the second lowest-cost Silver plan is based on a PPO or an HMO product, we estimate that the total amount of financing available for New York's BHP is between $2.6 and $3.8 billion, assuming a 20 percent reduction for the lower utilization levels typically incurred by low-income people (see Table 9).

State Cost Saving Offsets

If New York establishes a BHP, the State will generate significant annual savings from the transfer of three groups of beneficiaries from other State programs into the new program (see Table 10).

TABLE 9
Total Available BHP Funding

	Uninsured Adults	FHP	Legal Immigrants in Medicaid	Uninsured Legal Immigrants	Healthy New York	Direct Pay	ESI	Total
Premiums Based on PPO								
Take Up	187,700	77,000	86,400	30,000	12,200	3,400	70,000	466,700
Premium Tax Credit	$1,207,491,000	$525,516,000	$589,670,000	$204,746,000	$78,451,000	$21,892,000	$450,881,000	$3,078,647,000
Cost Sharing Subsidy	$322,966,000	$179,334,000	$201,227,000	$69,870,000	$20,942,000	$5,881,000	$121,322,000	$921,542,000
Total (No Util. Reduction)	$1,530,457,000	$704,850,000	$790,896,000	$274,617,000	$99,393,000	$27,773,000	$572,203,000	$4,000,189,000
Total (20% Util. Reduction)	**$1,465,864,000**	**$668,983,000**	**$750,651,000**	**$260,643,000**	**$95,205,000**	**$26,597,000**	**$547,939,000**	**$3,815,881,000**
Premiums Based on HMO								
Take Up	187,700	77,000	86,400	30,000	12,200	3,400	70,000	466,700
Premium Tax Credit	$797,999,000	$357,530,000	$401,177,000	$139,297,000	$51,835,000	$14,475,000	$298,167,000	$2,060,481,000
Cost Sharing Subsidy	$227,721,000	$126,447,000	$141,884,000	$49,265,000	$14,766,000	$4,146,000	$85,543,000	$649,773,000
Total (No Util. Reduction)	$1,025,721,000	$483,977,000	$543,060,000	$188,563,000	$66,601,000	$18,621,000	$383,710,000	$2,710,254,000
Total (20% Util. Reduction)	**$980,176,000**	**$458,688,000**	**$514,684,000**	**$178,710,000**	**$63,648,000**	**$17,792,000**	**$366,602,000**	**$2,580,299,000**

NOTE: *Totals may not sum due to rounding*

First, in 2014, with the expansion of Medicaid to 138 percent of FPL and the establishment of an Exchange with subsidies for people with incomes above this threshold, the State will likely experience budgetary pressures to eliminate its FHP program and simply pocket the ensuing savings. While the State has no obligation to establish a BHP, if were to do so, roughly 77,000 FHP enrollees with incomes between 139 and 150 percent of FPL will be transitioned out of FHP into BHP. Currently, the State and the federal government each pay 50 percent of their health care costs in FHP. With of the adoption of a BHP, the State would no longer need to contribute its share for this population, generating $118 million annually in savings beginning in 2014.[36] Advocates for low-income people will argue that these savings should be reserved for the BHP or other health programs.

Second, New York would be able to entirely shift the cost of Medicaid coverage for 86,400 legal immigrants who are

fully State-funded. These immigrants, with incomes up to 150 percent of FPL, would be enrolled into the BHP. This move would generate savings of $378 million annually beginning in 2014.[37]

Finally, roughly 12,200 Healthy NY enrollees with incomes below 200 percent of FPL would also be expected to enroll in the BHP program. As a result, the State would no longer have to pay a stop-loss subsidy to private insurers, generating $14 million annually in State savings beginning in 2014.[38]

In total, adopting a BHP would lead to annual savings of $511 million for New York State.

In total, adopting a BHP program would lead to annual savings of $511 million for New York State. While these savings should be considered a direct benefit of implementing a BHP, there is no requirement in the ACA that these funds be spent on the State's BHP. State savings could be redirected to other programs for vulnerable populations which do not directly benefit from the Affordable Care Act (e.g., certain immigrant populations), or used to meet other State funding priorities.

TABLE 10
Projected State Savings From Adopting a BHP (CY 2014)

State Cost-Savings Offsets	Amount
Family Health Plus Parents 139%-150%	$118,385,000
Legal Immigrants with State-only Coverage	$378,306,000
Healthy NY	$14,060,000
Total	**$510,752,000**

Grand Total of BHP Financing Estimates

In summary, accounting for both available federal financing and State cost saving offsets, we project that the funding available for a BHP in New York State would fall in the range of $3.8 billion to $4.3 billion if premiums were based on a PPO product, or in the range of $2.6 billion to $3.1 billion if premiums were based on an HMO product. Under the ACA, these federal funds must be dedicated to operating the BHP and for the benefit of BHP beneficiaries.[39] The additional funding that flows from State cost saving offsets ($511 million) also could be used to benefit BHP enrollees or it could be directed to other State funding priorities (see Table 11).

TABLE 11
Total BHP Funding Estimates

	Premiums based on PPO	Premiums Based on HMO
Take-Up	466,700	466,700
Premium Tax Credit	$3,078,647,000	$2,060,481,000
Cost Sharing Subsidy	$921,542,000	$649,773,000
Total Financing (No Utilization Reduction)	$4,000,189,000	$2,710,254,000
Total Federal Financing (20% Utilization Reduction)	**$3,815,881,000**	**$2,580,299,000**
Total State Cost Saving Offsets	$510,752,000	$510,752,000
Total BHP Funding (20% Utilization Reduction)	**$4,326,633,000**	**$3,091,051,000**
Total BHP Funding (No Utilization Reduction)	$4,510,941,000	$3,221,006,000

How Much Would Offering a BHP Cost New York State?

In order to estimate how much a BHP would cost the State, CSS estimated medical and administrative costs of a potential BHP. As a starting point, we assessed the financial viability of a BHP using the existing provider reimbursement rates, benefit package, and cost-sharing levels in New York State's FHP program, which has a 98 percent actuarial value, no enrollee premiums, and modest co-payments.

To estimate BHP program costs, we began with the existing claims costs for New York's FHP program—$200 per member per month in 2009.[40] We then made the following adjustments:

- **Added in the cost of carved-out pharmacy services and maternity care:** The prescription drug benefit under the FHP program has been administered through the Medicaid Program since 2008, and there are few pregnant women and births in FHP as a result of a State policy which transfers these women to Medicaid. As benefits under the BHP will include both of these services, we adjusted the medical costs by $49.98 for pharmacy and $3.50 for maternity.
- **Adjusted for morbidity differences of the various eligible populations:** We made morbidity adjustments to the various populations by using a blend of two different methods: (1) using data from the Medical Expenditure Panel Survey and self-reported health status to calculate health expenditure risk factors,[41] and (2) using actuarial age factors.[42]
- **Adjusted for selection and pent-up demand:** Since all the other populations eligible for BHP are currently insured, we only modeled selection and pent-up demand for the uninsured population. We modeled the selection impact using baseline data on the distribution of the uninsured by self-reported health status and assigning a take-up curve by this self-reported health status distribution. We then used health expenditure risk factors to calculate a selection adjustment, which increases the cost of this population by 13 percent. We have assumed the following take-up levels by self-reported health status:
  - Assumed 95 percent of those reporting poor health status will take-up.
  - Assumed 90 percent of those reporting fair health status will take-up.
  - Assumed 85 percent of those reporting good health status will take-up.
  - Assumed 75 percent of those reporting very good health status will take-up.
  - Assumed 40 percent of those reporting excellent health status will take-up.

In addition to this selection adjustment, we have also applied a 5 percent pent up demand assumption for uninsured BHP enrollees who may initially use services at a higher rate than their insured counterparts.

- **Varying cost structures across the state:** To account for the regional differences in per member per month premiums across the state, we modeled expense assumptions based on the expected BHP distribution of enrollment in nine different regions of the state: Central Region, Finger Lakes, Long Island, Mid-Hudson, Northeast, Northern Metro, NYC, Utica-Adirondack, and the Western region. The resulting area adjustment was an increase of 4.1 percent.
- **Trend Assumption:** After making all of these adjustments, we then applied an annual trend assumption of 7.9 percent to reflect expected annual increases in medical costs between the present (2009) and 2014.[43]
- **Administrative Expenses:** Finally, to express these claims costs as a complete expense, we added an additional 15 percent to the resulting 2014 projected BHP claims costs to account for administrative expenses.[44]
- **Enhanced Provider Reimbursement:** It is possible that New York State might choose to enhance provider reimbursement above the rates currently paid in its public insurance programs, including FHP. As such, we provide two sets of BHP cost estimates—one continuing the current FHP reimbursement levels, and one with a 10 percent enhancement to provider reimbursement (i.e., a 10 percent increase in the 2014 projected claims cost).

The end result is a projected total program cost of $2.6 billion (assuming FHP provider reimbursement levels). As described in greater detail below, this is slightly less than the federal financing available to fund the program. If the State were to adopt enhanced provider reimbursements of roughly 10 percent, the BHP would cost an additional $255 million, for a final program cost of $2.8 billion (see Table 12).

The end result is a projected total program cost of $2.6 billion.

What Kind of Benefits, or Plan Design, Would a BHP Have in New York?

Under the ACA, states are accorded a great deal of flexibility in plan design. While the statute mandates a selective procurement procedure, and encourages the use of managed care, there is no requirement as to whether the plans must be commercial or not-for-profit. Ultimately, issues surrounding selection of the plans and products are mostly left to the states.

However, the ACA does specify that enrollee cost-sharing in a BHP plan must "not exceed the cost-sharing required under a platinum level plan," or an actuarial value of 90 per-

TABLE 12
Projected BHP Expenses

NY BHP Projected Expenses	Uninsured Adults	FHP	Legal Immigrants in Medicaid	Uninsured Legal Immigrants	Healthy New York	Direct-Pay	ESI	Total
Total	$253	$253	$253	$253	$253	$253	$253	$253
Morbidity Adjustment	-$39	-$50	$9	-$39	$114	$507	$0	-$18
Selection	$28	$0	$0	$28	$0	$0	$0	$13
Pent Up Demand	$12	$0	$0	$12	$0	$0	$0	$6
Total Medical Claims	$254	$203	$262	$254	$367	$760	$253	$254
Area Adjustment (4.1%)	$10	$8	$11	$10	$15	$31	$10	$10
Annual Trend Assumption (7.9%)	$124	$99	$128	$124	$178	$369	$124	$124
CY 2014	$388	$310	$401	$388	$560	$1,160	$387	$388
Admin (15%)	$68	$55	$71	$68	$99	$205	$68	$68
Total Expenses (pm/pm)	$456	$365	$472	$456	$659	$1,365	$455	$456
Membership Take Up	187,700	77,000	86,400	30,000	12,200	3,400	70,000	466,700
Total Expenses	**$1,029,191,000**	**$337,174,000**	**$488,589,000**	**$164,495,000**	**$96,532,000**	**$55,660,000**	**$381,979,000**	**$2,553,619,000**
Total With 10% Provider Reimbursement Increase	**$1,132,110,000**	**$370,891,000**	**$537,448,000**	**$180,945,000**	**$106,185,000**	**$61,226,000**	**$420,177,000**	**$2,808,981,000**

cent, for people with incomes between 139 and 150 percent of FPL, and to "not exceed the cost-sharing required under a gold plan," or an actuarial value of 80 percent, for people with incomes between 150 and 200 percent FPL. In contrast, the ACA provides that people with incomes between 100 and 250 percent of FPL who enroll in a Silver-level plan in the Exchange, can qualify for an additional cost-sharing subsidy which operates as an increase in actuarial values to 87 or 94 percent, depending on an enrollee's income.

Essentially, this would mean that the same populations entitled to 94 percent and 87 percent actuarial values in the Exchange are only entitled to 90 percent and 80 percent values in a BHP (though a state is clearly free to offer higher value plans).

This seemingly contradictory approach to plan design for people in the Exchange versus the BHP program is puzzling.[45] It is unlikely that Congress intended to provide financing for the BHP based on the higher cost-sharing subsidies available in the Exchange while simultaneously permitting the states to adopt a BHP with lower actuarial values their programs. However, it appears that it did just that. Accordingly, a state is not prevented from then using this combined financing to create a BHP with a lower actuarial value (90 and 80 percent, depending on income) than would be required for the same individuals if they were covered through the Exchange (94 and 87 percent, depending on income).

In developing a proposed BHP plan design for New York, we began with New York's FHP plan design, which has a 98 percent actuarial value, to develop our baseline cost estimates used in the section titled "Is There Adequate Federal Financing to Establish a BHP in New York?", above. As described in the proceeding paragraphs, under the ACA, New York has a number of different actuarial value plan design options. We modeled the following four plan design options: (1) a plan with a 94 percent actuarial value, as required for those with incomes between 139 and 150 percent of FPL in the Exchange; (2) a plan with a 90 percent value, which is the floor for those in BHP with incomes between 139 and 150 percent of FHP; (3) a plan with a 87 percent actuarial value, as required for those with incomes between 150 and 200 percent of FPL in the Exchange; and (4) a plan with a 80 percent actuarial value, which, as described above, is the ACA floor for those in BHP population with incomes between 150 and 200 percent of FPL (see Table 13).

TABLE 13
Plan Design Options

	FHP	BHP Option 1	BHP Option 2	BHP Option 3	BHP Option 4
Inpatient Co-pay	$25	100	250	500	1000
PCP Office Visit Co-pay	$5	10	10	15	35
Specialist Co-pay	$5	10	15	20	50
ER Co-pay	$3	50	75	75	100
Outpatient Surgery Co-pay	$0	0	125	250	500
Radiology	$1	5	5	10	20
Lab	$0.50	5	5	10	20
Pharmacy:					
▪ Generic	$3	5	10	10	10
▪ Brand	$6	15	15	25	35
▪ Non Formulary	$6	15	15	25	50
Estimated Actuarial Value	**98%**	**94%**	**90%**	**87%**	**80%**

TABLE 14
BHP Plan Design Scenarios and Their Respective Additional Savings

Benefit Analysis	BHP Baseline Scenario	BHP Scenario 1	BHP Scenario 2	BHP Scenario 3	BHP Scenario 4
Up to 150 FPL	0.98	0.94	0.90	0.94	0.90
150 to 200 FPL	0.98	0.94	0.90	0.87	0.80
Total Government Expenses	$2,553,619,000	$2,449, 390,000	$2,345,161,000	$2,349,896,000	$2,203,026,000
Monthly Member Cost	$456	$437	$419	$420	$393
Percent Savings		-4.1%	-8.2%	-8.0%	-13.7%
Total Dollar Savings		**$ (104,229,000)**	**$ (208,459,000)**	**$ (203,724,000)**	**$ (350,593,000)**

Adopting any one of the BHP plan design options in Table 13 would yield additional program cost savings because our original cost estimate of $2.6 billion was based on the current FHP program, which has a 98 percent actuarial value plan for all enrollees. The potential savings from each of these plan designs are displayed as "Scenarios" in Table 14, as follows:

- Under Scenario One, all BHP enrollees would be enrolled in a plan design with a 94 percent actuarial value, and the program would have an additional 4 percent in savings, or $104 million.
- Under Scenario Two, all BHP enrollees would be enrolled in a plan design with a 90 percent actuarial value, and the program would generate 8 percent savings, or $208.5 million.
- Under Scenario Three, BHP enrollees would be split according to income, so that people with incomes below 150 percent of FPL would enroll into a plan with a 94 percent actuarial value, and people with incomes between 150 and 200 percent of FPL would enroll into a plan with an 87 percent actuarial value. Under Scenario Three, the program would generate 7.9 percent in savings, or $203.7 million.
- Under Scenario Four, people with incomes below 150 percent of FPL would enroll into a plan with a 90 percent actuarial value, and people with incomes between 150-200 percent of FPL would enroll into a plan with an 80 percent actuarial value. Under Scenario Four, the program would generate 13.8 percent in savings, or $350.6 million.

Accordingly, the ACA offers significant latitude to the states to design a plan with varying levels of enrollee cost-sharing. The conditions in a high-cost-of-living state, like New York, where low-income families have little, if any, disposable income, would militate towards adopting either the Baseline Scenario or BHP Scenario 1.

What Impact Would a BHP Have on New York Rates of Insurance?

New York policymakers have asked what impact the adoption of a BHP would have on the number of people remaining uninsured after the ACA is fully implemented in 2014. As discussed throughout this paper, even with premium and cost-sharing subsidies, buying coverage in the Exchange remains cost-prohibitive for many, if not all, low-income New Yorkers.

If New York does not adopt a BHP, Exchange enrollees would have to pay premiums ranging from 3 percent to 6.25 percent of family income on the Exchange, even after receiving premium tax credits. Given these substantial premiums, and especially given that these families are at near-poor income levels, it is likely that significantly fewer eligible uninsured would take-up coverage in the Exchange than would take-up free coverage under a BHP.

There are two major groups of BHP-eligible New Yorkers who would face the dilemma of trying to find coverage on the Exchange within their family budgets: (1) the 268,200 uninsured adults with incomes between 139 and 200 percent

TABLE 15
Impact of BHP on Rates of Uninsurance (Includes Uninsured 139-200% and FHP Parents 139-150%)

	With BHP	Without BHP – Exchange Only		
		Scenario 1	Scenario 2	Scenario 3
Eligible Uninsured & FHP population	345,200	345,200	345,200	345,200
Take-up rate	77%	60%	50%	40%
Insured	264,700	207,100	172,600	138,100
Remaining Uninsured	80,500	138,100	172,600	207,100
Additional Uninsured without a BHP	**—**	**57,600**	**92,100**	**126,600**

of FPL; and (2) the 77,000 FHP enrollees with incomes between 139 and 150 percent of FPL. Earlier in this Issue Brief, we assumed a 70 percent take-up rate in the BHP program for eligible uninsured people with incomes between 139 and 200 percent of FPL, and 100 percent take-up rate for the FHP enrollees. The overall take-up rate we estimate between the two groups is 77 percent.

Offering free (or low-cost) coverage through BHP would result in between 57,600 and 126,600 fewer uninsured New Yorkers

It is difficult to estimate the exact number of additional individuals who would opt to pay penalties rather than purchase insurance. Nonetheless, using three simple price sensitivity scenarios, we have produced a range of estimates for how many New Yorkers are likely to remain or become uninsured if absent the adoption of free or low-cost BHP.

Table 15 shows varying levels of take-up for these two groups combined, from a high of 77 percent in a free BHP program to set of hypothetical take-up Scenarios in the Exchange, which describe take-up levels ranging from 40 to 60 percent. As the table shows, if New York adopts a BHP, we estimate that roughly 80,500 New Yorkers from these two eligibility groups would remain uninsured.[46] If New York does not adopt a BHP, we estimate that there will be somewhere between 138,100 and 207,100 uninsured New Yorkers, depending on how many people take-up coverage in the Exchange.

In summary, offering free (or low-cost) coverage through a BHP would result in between 57,600 to 126,600, or a midpoint of 92,100, fewer uninsured New Yorkers.

What Impact Would a BHP Have on New York's Exchange?

There are two threshold questions that must be addressed in determining the impact New York's adoption of a BHP would have on the future State Health Insurance Exchange:[47] First, would the development of a BHP adversely impact the Exchange's viability and purchasing power? Second, would the adoption of a BHP undermine the Exchange's ability to adequately spread risk and avoid adverse selection?

BHP's Impact on Exchange Viability and Purchasing Power

Many policymakers legitimately question whether the adoption of a BHP would remove large number of enrollees from New York's Exchange and consequently have the unintended consequence of diluting the Exchange's potentially formidable purchasing power. These policymakers rightfully note that the number of participants in the Exchange is a critical factor in whether insurance carriers will be motivated enough to participate in the Exchange and bid competitively for members.

New York's Exchange should be large enough to have adequate purchasing power with a parallel BHP program. A commonly cited rule of thumb is that a threshold enrollment of 100,000 people in the Exchange should ensure adequate purchasing power.[48] Estimates indicate that as many as 650,000 to 1.4 million New Yorkers may enroll in the Exchange.[49] As described above, we estimate that 466,700 people will be eligible for BHP.

Therefore, BHP would represent a significant portion, roughly one-third, of potential Exchange enrollment.[50]

The potential transfer of a large population group out of the Exchange into a BHP might be cause for concern in smaller states. But this is not necessarily a concern for a large state, like New York. Even if New York were to adopt a standalone BHP program outside the Exchange, there would be anywhere from 400,000 to 900,000 New Yorkers left in the Exchange.

Accordingly, while a BHP would not necessarily compromise the viability of New York's Exchange, the issue of the impact the adoption of BHP would have on the Exchange's purchasing power needs further study by State policymakers.

BHP's Impact on Health Risk of the Exchange Population

A second important question raised by policymakers relates to whether the adoption of a BHP will adversely affect the medical underwriting risk of the enrollees left in New York's Exchange. The answer to this question can only be resolved once we know whether the BHP population is sicker or healthier than their Exchange counterparts. If the BHP enrollees are healthier than their Exchange counterparts, than their removal from the Exchange into a separately rated BHP program, would drive up the cost of coverage in the Exchange. Conversely, if BHP members are sicker than the remaining Exchange population, it is possible that the addition of a BHP could lead to lower costs in the Exchange by removing the relatively higher-costing BHP population. In either event, the adoption of a BHP leads to increased uncertainty about costs in the Exchange.

But, a close reading of the ACA indicates that the BHP population does not necessarily have to be separated from the Exchange's risk pool.[51] Instead, some experts argue that it is both possible and potentially desirable for states, like New York, to pool the risk by including the BHP in a risk adjustment program between BHP and Exchange members.[52] While pooling risk in this way could resolve concerns about the BHP's adverse impact on Exchange premiums, the actual mechanics of this shared pooling are unknown at this time and require further study by State and federal policymakers.

Assuming that it is possible to combine these two risk pools, this option could improve the overall risk in the Exchange. Most notably, enrollees in a free or very low-cost BHP would experience higher take-up and less adverse selection than the Exchange, with its relatively expensive co-premiums and substantially higher out of pocket costs. As discussed above, under a pooled risk scenario, the Exchange would additionally benefit because another 57,600 to 126,600 more people will opt for BHP coverage. These individuals would both increase the size of the risk pool, and would also represent healthier risk than the Exchange population overall, since absent a BHP, only sicker individuals among this low-income population are likely to pay the relatively expensive co-premiums required in the Exchange.

Accordingly, if pooled with the Exchange, a BHP would both increase the size of the risk pool overall, and would to a significant extent mitigate adverse selection among the large low-income uninsured population with incomes below 200 percent of FPL in the Exchange.

Additional Factors to Consider about Adopting a BHP in New York

The opportunity presented by adopting a BHP is not without costs. Low-income New Yorkers would have fewer choices amongst subsidized coverage and would not be able to access the subsidized commercial products in the Exchange. Commercial products are thought to have more comprehensive networks. To increase these concerns about inadequate provider capacity, we recommend that the State strengthen the program through increasing provider reimbursements by 10 percent, for an additional cost of $255 million. Some of the costs of improving provider networks through reimbursement increases could be offset by offering a BHP plan with a 94 percent actuarial value, instead of the full FHP benefit (with a 98 percent actuarial value). This would engender $104 million in savings (see Table 16).

In addition, adopting a BHP has risks. As described throughout this report, several key questions have yet to be addressed by the federal regulators (see sidebar). Guidance from federal regulators is urgently needed on key financing questions related to how valuations will be set for the Silver-level premiums and cost-sharing subsidies. Additional questions arise about what type of benefit plans will be acceptable to federal regulators in state-run BHP programs. Most

importantly, states need guidance about how to administer the risk pool for BHP: namely, can and should the BHP risk pool be combined with a state's Exchange risk pool? To do so would alleviate the concern that adopting a BHP would undermine the viability of a state's individual market.

Finally, state policymakers continue to express an uncomfortable level of uncertainty related to the concern that federal regulators could significantly revise the financing of a BHP after its adoption. This uncertainty, and the other issues raised above, should be addressed by federal regulators through the rapid promulgation of BHP regulations.

Conclusions & Recommendations

In 2008, the New York State Legislature authorized the State to seek federal financing in order to offer our popular, high quality and affordable FHP program to all New Yorkers with incomes below 200 percent of FPL. The passage of time and the historic enactment of the ACA have overtaken that effort. But now the ACA provides New Yorkers the proverbial "second bite at the apple" to cover these same families with federal funding.

Adopting a BHP would provide significant fiscal relief to those low-income New York families who otherwise would face substantial co-premiums for coverage purchased through the Exchange. If adopted, a BHP could offer coverage to around 466,700 New Yorkers. It would also result in approximately 92,100 fewer uninsured New Yorkers than if there were only an Exchange—in other words, 92,100 more New Yorkers would find the cost of insurance within reach if given the option of enrolling in a BHP Plan.

Financially, the State is also likely to benefit should it adopt a BHP. Table 16 on the next page describes three possible financing scenarios if New York adopts a BHP: (1) a Best Case scenario; (2) a Worst Case scenario; and (3) CSS's Best Estimate. In all three scenarios, the program costs are the same—approximately $2.5 billion.

Federal financing for the program could range from a Best Case scenario of $3.8 billion. In the Best Case scenario, federal officials would use of PPO small group rates as a proxy for an individual market rate in 2014. The Worst Case scenario, there would be federal financing in the amount of $2.6 billion, which assumes the use of less expensive HMO small group rates to generate financing estimates (see Table 16).

As for State savings, in the Best Case scenario, the State is also able to use its $511 million in savings to fund its BHP. In the Worst Case scenario, the State uses the $511 million in savings for purposes unrelated to providing affordable health care to low-income families.

Our Best Estimate assumes that the HMO small group rate is adopted as a proxy for financing BHP. This leaves BHP with a program operating margin of $27 million. CSS also assumes that the State savings of $511 million will be used to increase provider reimbursement rates by 10 percent, for a cost of

Issues Requiring Federal Regulatory Resolution

Several issues requiring resolution by federal regulators before a state can proceed with a BHP are identified by this Issue Brief:

- How will federal regulators project a Silver-plan premium for BHP financing in the states?

  What products and markets will regulators use as a premium basis for states, like New York, where individual market premiums are inflated?

- How will federal regulators value the cost-sharing subsidies?

  Will they be pegged at 100% or 95% level?

  What method will be used for delivering them?

  What utilization and cost basis will be used for calculating them?

- Will states be able to offer BHP plans at the lower 90/80 percent AVs; or will federal regulators recommend the 94/87 percent AVs, consistent with the Exchange?
- Can states opt to combine the BHP and Exchange risk pools? If so, what is the recommended method for risk adjustment between carriers?
- Can federal regulators propose a reliable method of annual financing reconciliation to address states' anxieties about the fiscal uncertainty of the BHP program?

TABLE 16
Best and Worst Case Scenarios Financing Estimates Should New York Adopt a BHP

	Best Case	Worst Case	Best Estimate
Federal Financing Available	$3,815,881,000	$2,580,299,000	**$2,580,299,000**
BHP Program Costs	$2,553,619,000	$2,553,619,000	**$2,553,619,000**
Sub-Total: BHP Net Operating Margin	$1,262,262,000	$26,680,000	**$26,680,000**
State Cost Savings Offsets	$510,752,000	n/a	**$510,752,000**
Increase in Provider Reimbursement (10%)			**($255,362,000)**
Plan Design Scenario 1 (AV for all beneficiaries would be 94%)			**$ 104,229,000**
Net Financial Impact of BHP for New York State	$1,773,014,000	$26,680,000	**$386,299,000**

$255 million. We then assume that the State adopts a 94 percent actuarial value plan for BHP instead of the baseline FHP product, which has a 98 percent actuarial value. Using Plan Design Scenario 1 would generate an addition $104 million in savings. Accordingly, in our Best Estimate scenario, we find that the total net impact of adopting a BHP would result in an additional $386 million in State revenue.

Despite the considerations and unknowns identified in the prior section, we recommend that New York adopt a BHP. Our Best Estimate indicates that there would be approximately $2.6 billion in federal financing, with costs on the order of $2.5 billion, for a net operating margin of $27 million. Importantly, some experts have argued that a state's operating margin will improve over time because federal financing for BHP is pegged to commercial Silver-tier plan costs which are likely to increase at a faster rate than increases in Medicaid (or a publically modeled BHP) costs.[53] The State's savings of $511 million is not included in this positive net operating margin.

Besides saving the State money, offering a BHP ensures that low-income families would not face extreme eligibility cliffs between the federal Medicaid baseline and the relatively cost-prohibitive coverage in the Exchange. Building off of public coverage would ensure that fewer low-income families would face coverage disruptions than they would if they were moving between Medicaid and the Exchange.

In summary, the adoption of BHP could generate significant savings for the State annually. In addition, offering a BHP would ensure that New York maintains its tradition of offering high quality, affordable coverage to its low-income families. It would also ensure that these families have greater continuity of care due to their fluctuating incomes, thereby avoiding inevitable disruptions in coverage as they migrate between Medicaid and the Exchange. Finally, offering a BHP ensures that roughly 92,000 more New Yorkers are likely to enroll in coverage than would have it they were only offered relatively expensive products in the Exchange.

In summary, the adoption of BHP could generate significant savings for the State annually. In addition, offering a BHP would ensure that New York maintains its tradition of offering high quality, affordable coverage to its low-income families.

Adopting a BHP offers New York an important opportunity to continue its leadership in offering quality, affordable coverage to its low- and moderate-income families while generating State savings. It is an opportunity worth seriously exploring.

Notes

1. T.S. Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues," The Commonwealth Fund, July 2010.
2. Congressional Budget Office, "Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)," March 2011.
3. P. Boozang, M. Dutton, A. Lam and D. Bachrach, "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010.
4. The BHP option was modeled and named after Washington State's Basic Health, a state-sponsored program which provides low-cost health insurance options for low-income people using private health plans.
5. Section 1331(d) of the Affordable Care Act (ACA) lays out the available funding for a BHP as: "…equal to 95 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle." There is a lively debate as to whether this provision should be interpreted as 95% of the premium tax credits and 95% of the cost-sharing, or if the comma separating the two means that the cost-sharing credits are not subject to the 95% rule and, in fact, will be paid in full. *Compare*, R. Carey, "Health Insurance Exchanges: Key Issues for State Implementation," RWJF State Coverage Initiatives, September 2010 *with* Milliman, "Planning Washington's Health Benefit Exchange, The potential impact of three key decisions," January 2011, *and* S. Dorn, "The Basic Health Program Option Under Federal Health Reform: Issues for Consumers and States," RWJF State Coverage Initiatives, March 2011.
6. ACA §1331(b).
7. The statute requires that the State-based "competitive process" for procuring plans to consider: innovation; health and resource differences of enrollees and access to local health providers; encouragement to contract with managed care plans; and performance measures to encourage the provision of quality of care and improved health outcomes. ACA § 1331(c).
8. Community Service Society of New York, The Unheard Third Survey, "Hardships and Personal Worries for Low-Income New Yorkers," December 2010, *available at* http://www.cssny.org/userimages/downloads/UnheardThird2010HardshipsandPersonalWorries.pdf.
9. B. Sommers & S. Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," 30 HEALTH AFFAIRS 238-36, February 2011.
10. Eight states offer Medicaid-like products above the federal Medicaid floor: CT, DC, ME, MN, NY, RI, VT, WI. Eighteen others offer something other than Medicaid: CA, CT, DC, HI, IN, IA, ME, MA, MN, NJ, NM, OR, PA, UT, VT, VA, WA, WI. Still more states have disease- or service-specific programs that are state-only funded. Kaiser Family Foundation, "Income Eligibility – Low Income Adults," *available at* www.statehealthfacts.org, January 2011.
11. In addition, New York's State Children's Insurance Program (SCHIP)—Child Health Plus—offers subsidized coverage to children in families who earn up to 400 percent of FPL. This program is subject to maintenance of effort requirements through 2019, and thus does not face the same risks, at least not during the first five years following implementation of the ACA. See Children Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-13, § 2113, 123 Stat. 37.
12. Thirty-three states provide state-only funding for varying classes of legal immigrants: AL, AR, CA, CO, CT, DE, FL, HI, IL, IO, LA, ME, MD, MA, MI, MN, MO, NE, NJ, NM, NY, NC, OH, OR, PA, RI, TN, TX, VA, WA, WI, WY. National Immigration Law Center, "Guide to Immigrant Eligibility for Federal Programs: Medical Assistance Program for Immigrants in Various States," July 2010, *available at* www.nilc.org.
13. As a result of *Aliessa v. Novella*, New York offers public coverage to legal immigrants who are ineligible for federal Medicaid matching funds, including recent Green Card holders and people who are permanently residing under color of law (PRUCOL immigrants). *Aliessa v. Novello*, 730 N.Y.S.2d 1 (2001).
14. In implementing the ACA, the U.S. Department of Health and Human Services has determined that the term "lawful immigrants" covers a broad category of immigrants, including: Lawful Permanent Residents ("green card holders") during their first five years, people who are permanently residing under of color of law (PRUCOLs) and, more broadly than what is currently deemed eligible for public coverage in New York State, some additional non-immigrant visa holders. See 75 Fed. Reg. 45930 (July 30, 2010) (to be codified at 45 C.F.R. pt. 152.2).
15. *Supra* n. 11.
16. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (CPS ASEC), 2008-2010 three-year blend adjusted to 2010 uninsurance levels, controlling for immigrant status. Estimates include legal immigrants but exclude undocumented immigrants. The size and characteristics of these immigrant populations are estimated based on the work of Jeffrey Passel. *See*, e.g., J. Passel and C. D'Vera Cohn, "A Portrait of Unauthorized Immigrants in the United States," Pew Hispanic Center, April 2009.
17. In developing this take-up function, Gorman referred to papers written by Ku/Coughlin and Gruber. See: L. Ku and T.A. Coughlin, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," Inquiry, Volume 36, Number 4 (2000): pp 471-490; J. Gruber, "Tax Policy for Health Insurance," National Bureau of Economic Research, Working Paper 10977, December 2004. In addition, Gorman engaged in direct discussions with Dr. John Gruber to clarify his modeling techniques. However, the final model was not reviewed by Dr. Gruber, and Gorman Actuarial takes full responsibility for the resulting analysis. These results are supported by the recent Kaiser Family Foundation report. See: J. Holahan and I. Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults Below 133% of FPL," Kaiser Commission on Medicaid and the Uninsured, May 2010.
18. Data tabulation provided by New York State Department of Health, February 2011. FHP parent membership distributed by income based on analysis of Medicaid enrollee demographic data from a three-year blend of data from the 2008-2010 Current Population Survey, Annual Social and Economic Supplement.
19. *Supra*, n. 13.
20. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193, 8 U.S.C. 1601-22 (Title IV).
21. Data tabulation provided by New York State Department of Health, February 2011.
22. The New York State Department of Insurance estimates that roughly 15% of sole proprietors and individuals enrolled in Healthy NY have

incomes below 200 percent of FPL (personal communication with the authors). We also removed children (roughly 20% of the Healthy NY individual and sole proprietor enrollment) from our calculations. Burns & Associates, "Independent Report on the Healthy NY Program for Calendar Year 2009," January 2010.

23. ACA §1302.
24. As of January 2011, there were approximately 24,450 HMO/POS Direct Pay members, according data provided to the authors by the New York State Department of Insurance. We have estimated 19,250 "Other" Direct Pay members as of January 2011 using the HMO/POS trends. We have estimated that total Direct Pay membership is approximately 44,000. These direct pay members were then distributed by income and age using demographic data on direct pay members from the Current Population Survey, Annual Social and Economic Supplement, 2008-2010 three-year blend.
25. CSS analysis of New York State Department of Insurance data, "Premium Rates for HMO Standard Individual Health Plans – May 2011," available online at: http://www.ins.state.ny.us/ihmoindx.htm.
26. The presence of a BHP may be detrimental to the very sickest individuals in the Direct Pay market, an issue policymakers should consider in advance of adopting a BHP.
27. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010.
28. ACA §1331(e). An estimated 80% of people with employer-sponsored insurance with incomes between 139 and 200 percent of FPL pay some co-premiums for their insurance coverage, and an estimated 30 percent pay co-premiums of more than 8 percent of their family income. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Household Component, 2004-2006 blend, Northeast Region.
29. Section 1402 of the ACA states that individuals with incomes between 100 and 400 percent of FPL who enroll in a Silver-level plan on the Exchange will get a reduction in the out-of-pocket cap on spending outlined in §1302 (c)(1). ACA §1402(c)(1). It further states that those individuals with incomes between 100 and 250 percent of FPL will receive an additional reduction in their cost-sharing by having the actuarial value of their plans increased from 70 percent to between 73, 87 or 94 percent, depending on income. ACA §1402(c)(2).
30. *See* ACA §1331(d)(3).
31. *Supra* n. 24.
32. ACA §1311(d)(3).
33. Section 1401 of the ACA amends the Internal Revenue Code of 1986 by setting a cap on how much a household will be required to pay in health insurance premiums in any given year. The difference between this cap and the actual premium cost for insurance on the Exchange will be allowed as a credit against taxes imposed. For people with incomes below 139 percent of FPL, the premium cost is capped at 2 percent of household income. For people with incomes between 139 and 150 percent of FPL, the premium cap is 3 to 4 percent of income. For those between 150 and 200 percent of FPL, the premium cap is 4 to 6.3 percent. For those between 200 and 250 percent, the cap is 6.3 to 8.05 percent of income. For those between 250 and 300 percent, the cap is 8.05 to 9.5 percent. For those between 300 and 400 percent FPL, the cap is at 9.5 percent.
34. There is no federal guidance about how the cost sharing subsidy will work. Accordingly, we have identified three methods, described in order of increasing complexity. First, the simplest approach would be to enroll eligible individuals in richer plan designs and then the cost sharing subsidy would be the premium difference between the second lowest costing Silver plan and the 94 percent (or 87 percent) AV plan. But this approach may overstate the subsidy as insurers may overstate the premiums for the higher AV plans. Second, insurers could adjudicate claims for these members twice (e.g., first for a 70 percent AV plan and second for 94 percent AV plan) with the federal government paying the difference in claims costs. CSS estimated cost-sharing subsidies using this second approach. Third, the consumer could receive funds directly from the federal government to pay for the cost-sharing difference. However, this would seem to contradict §1402(c)(3), which states that payments will be made directly to the health plan. Moreover, this would be a burdensome process for consumers and insurers alike. All of these approaches might need to be supplemented with some sort of risk adjustment to ensure consistency and fairness in financing for insurance carriers.
35. Kaiser Family Foundation, "A Profile of Health Insurance Exchange Enrollees," Focus on Health Reform series, March 2011.
36. The State's share of 2009 capitation rate for FHP was $229 per member per month. We assumed a 5 percent annual trend rate. We assumed that FHP members are only enrolled for 10.5 months, despite the fact that beginning in 2012 enrollees will have guaranteed continuous enrollment for 12 months, generating a savings of $192 million annually, beginning calendar year 2014. Capitation rate and enrollment data provided to authors by New York State Department of Health, March 2011.
37. In 2009, medical expenses for legal immigrants enrolled in public coverage was $327 per member per month. Assuming an annual trend of 5 percent and a shift of 86,400 legal immigrants currently on public coverage, results in a savings of $378 million beginning in calendar year 2014. Capitation figures and enrollment data provided to authors by New York State Department of Health, March 2011.
38. In 2009, the State funding for the Healthy NY stop loss subsidy was $86 per member per month. See Healthy NY 2010 Annual Report at page 94. Using this subsidy for 12,200 members with a five percent annual trend, we estimate a savings of approximately $14 million in calendar year 2014.
39. ACA §1331(d)(2).
40. Based upon Fourth Quarter 2009 Medicaid Managed Care Operating Reports, provided to CSS by the New York State Coalition of Public Health Plans.
41. This method was used by Milliman in a recent analysis issued for Washington State, "Planning Washington's Health Benefit Exchange: The Potential Impact of Three Key Decisions," January 2011.
42. Age adjustments analysis performed by Gorman Actuarial.
43. This estimate is based on an analysis on the FHP population over a three year period.
44. To be conservative, CSS overstated these costs as 15 percent annually, the maximum amount allowed under the BHP statute. The current (2009) MMCOR report indicates administration costs in the FHP program are running between 11 and 13 percent annually.
45. It is unclear if it was the intention of lawmakers to allow states to offer higher cost-sharing to the same population under the BHP than they would face otherwise in the Exchange. The original ACA bill defined the required cost-sharing subsidies for this population on the Exchange as increases in actuarial value from the 70 percent Silver level to the 90 percent Platinum and 80 percent Gold levels, corresponding with that which was required for the same population under a BHP. ACA §1302(d). It was only through the Health Care and Education Reconciliation Act that the cost-sharing subsides were revised to the higher values and a discrepancy was established. Health Care and Education Reconciliation Act of 2010, Pub. L. 111-52, §1323, 124 Stat. 1029.
46. This analysis does not account for potential employer-sponsored insurance take up.

47. Once these two threshold questions are addressed, the State would have to address a host of administrative and administrative cost questions relevant to the nexus between BHP and the Exchange.
48. A. Enthoven, et al, "Making Exchanges Work in Health-Care Reform," Committee for Economic Development, December 14, 2009, *available at* http://www.ced.org/images/library/reports/health_care/exchangememohc09.pdf. *See also*, T. Jost, *supra* n. 1; S. Dorn, *supra* n. 5.
49. *Compare*, P. Boozang, M. Dutton, A. Lam, D. Bachrach, "Implementing Federal Health Care Reform: A Roadmap for New York State," New York State Health Foundation, August 2010, *with* M. Buettgens, J. Holahan, C. Carroll, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," prepared for the Robert Wood Johnson Foundation State Coverage Initiatives by the Urban Institute, March 2011.
50. The Kaiser Family Foundation and Robert Wood Johnson Foundation have generated similar estimates as to the size of New York's BHP-eligible population. *See* E. Trish, et al., "A Profile of Health Insurance Exchange Enrollees," Kaiser Family Foundation, March 2011, *available at* http://www.kff.org/healthreform/upload/8147.pdf and Buettgens et al, March 2011.
51. The section of the ACA that describes how much the federal government shall pay the states says: "The Secretary shall make the determination … on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and the cost-sharing reduction that would have been provided to eligible individuals…including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for the health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payment and reinsurance payments that would have been made if the enrollee had enrolled in a quality health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled." ACA §1331(d)(3)(ii). Rather than affirmatively stating BHP risk is to be separately rated, as is required under the "actuarial soundness" provision in the federal Medicaid regulations, it strongly implies that risk between BHP and the Exchange is expected to be pooled and adjusted for an establish list of factors. *See* 42 C.F.R. §438.6 (actuarial soundness regulation for Medicaid).
52. S. Dorn, "The Basic Health Program Option under Federal Health Reform: Issues for Consumer and States," Academy Health/Robert Wood Johnson Foundation, March 2011.
53. Milliman, "Healthcare Reform and the Basic Health Program Option, Modeling Financial Feasibility," April 2011.

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