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A Unit of the Institute for Health, Health Care Policy and Aging Research

The Basic Health Plan Option in New Jersey

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December 2011

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Acknowledgments

Funding for this report was provided by the New Jersey Department of Banking & Insurance under a grant from the US Department of Health & Human Services.

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Executive Summary

The Affordable Care Act (ACA) outlines a process by which states may design a Basic Health Plan (BHP) for low-income residents not eligible for Medicaid. Experts seem to agree that the BHP represents the potential for states to reduce the number of uninsured, and increase continuity and quality of care. Preliminary estimates on a national level, as well as a detailed estimate done in New York, suggest that the BHP could be designed in a way that would not increase state costs, provided that reimbursement levels to providers are lower than in the exchange. However, experts also agree that there are still many unanswered questions about the financial consequences of the BHP for states, including defining essential benefits, anticipating the effects on enrollment and risk pools in the exchange, and operational details of federal compensation to states. Several states are considering the BHP option at this point, though none have yet committed to it.

There are several choices to be made in designing a BHP, including whether to build off of public programs or use a more commercial design. (Residents eligible for the BHP may not use exchange products.) Both approaches offer advantages and disadvantages for consumers. Premiums and copays should be designed with affordability and the chance of adverse selection in mind. Decisions about planned benefit levels, consumer cost-sharing, and provider reimbursement will affect state projections of the financial viability of a BHP.

The BHP provides an opportunity for New Jersey to provide more affordable coverage for low-income individuals who might otherwise choose not to participate in the exchange, even with premium and cost sharing subsidies, and to cover low-income legal immigrants who are not eligible for Medicaid. In the past, New Jersey has demonstrated a commitment to providing comprehensive and affordable care to low-income families by extending NJ FamilyCare to children up to 350% FPL, and parents up to 200% FPL when state finances permit. The state has also experimented with providing health care coverage to low-income single adults above Medicaid levels. Exploring the BHP as a way to cover low-income individuals makes sense as a continuation of New Jersey's efforts to provide affordable health coverage options to state residents, but will require further analysis of the feasibility of alternative program designs.

The option of building a BHP which would be modeled on commercial exchange plans seems challenging in the absence of specific experience with similar designs from other states.

It appears more feasible for New Jersey to design a BHP which takes advantage of the state's experience with NJ FamilyCare. Designing a "Medicaid look-alike" option for BHP benefits and cost-sharing seems inconsistent with the history of NJ FamilyCare, where different benefits and cost sharing have been used for families at different income levels. However, building a BHP as an extension of NJ FamilyCare would be consistent with New Jersey's approach to public coverage, whether or not the BHP is integrated seamlessly with other programs and carries the NJ FamilyCare brand.

The state's ability to implement a BHP is predicated upon using a Medicaid model to control costs by providing reimbursements to providers which are lower than those in the exchange. Along with the 234,000 new Medicaid enrollees expected after the ACA is implemented, adding a projected 65,000-75,000 BHP enrollees to public health plans runs the risk of straining the supply of providers who will find it financially viable to accept lower reimbursement and be able to provide high quality care.

The Basic Health Plan Option in New Jersey

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Introduction

The Affordable Care Act (ACA) outlines a process by which states may design a Basic Health Plan (BHP) for low-income residents under age 65 with income up to 200% of the Federal Poverty Level (FPL) who are not eligible for Medicaid. The BHP may offer a means for New Jersey to improve affordability, service access, and continuity of care for low-income residents using federal dollars that would otherwise have supported tax credits and cost-sharing reductions if these individuals had purchased subsidized coverage through the state American Health Benefit Exchange (exchange).

As an incentive to offer a BHP, the federal government offers states 95% of the premium credits and the cost-sharing reductions which would have applied to individuals eligible for a BHP if they purchased coverage through the exchange. If New Jersey can offer a BHP at lower cost than comparable coverage purchased through the exchange, a BHP can provide a more affordable option which can allow a greater number of low-income individuals to enroll in coverage. However, the ability of the state to do this will depend upon an assessment of the cost of providing a BHP in comparison with the federal payments that the state will receive. In addition, if New Jersey establishes a BHP, those eligible for the program are not permitted to enroll in the exchange, which may limit consumers' choice of health plans. This brief describes the BHP option as outlined in the Affordable Care Act and explores the issues New Jersey should consider in deciding whether to offer a BHP in New Jersey.

Policy and Legal Context

Provisions of the ACA

Section 1331 of the ACA outlines the requirements of the Basic Health Plan.

- States may offer one or more BHPs providing at least the minimum essential health benefits[1] under ACA to eligible individuals in lieu of offering such individuals coverage

[1] From ACA § 1302(b), these are (A) Ambulatory patient services; (B) Emergency services; (C) Hospitalization; (D) Maternity and newborn care; (E) Mental health and substance use disorder services, including behavioral health treatment; (F) Prescription drugs; (G) Rehabilitative and habilitative services and devices; (H) Laboratory services; (I) Preventive and wellness services and chronic disease management; (J) Pediatric services, including oral and

through an Exchange. The medical loss ratio in the plan cannot be less than 85%. States are directed to maximize choice as much as possible by making available multiple plans if feasible. States may negotiate regional compacts, and should coordinate the BHP with Medicaid and CHIP to promote continuity of coverage.

- Eligible individuals include adults under 65 with incomes between 133% (138% with the five percent disregard) and 200% FPL, and legal immigrants not eligible for Medicaid with incomes below 133%. These individuals must not have access to employer-sponsored coverage which provides the minimum essential benefits, or if they do, it must be unaffordable based on the employee's income level. It is not completely clear whether states have the option to extend the BHP to some but not all of groups described, but the most direct reading of the statute is that states must cover all individuals who meet the criteria (Dorn 2011).
- Premiums charged may not exceed what the eligible individual would pay in the second lowest cost silver plan in the exchange, taking into account premium and cost sharing subsidies. Cost sharing cannot exceed that of the exchange platinum level plan for those with household income of 133% to 150% FPL, or that of the gold level plan for those with income of 151% to 200% FPL.

States are required to establish a competitive contracting process, including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits. Negotiations must take into account:

- All minimum essential benefits under the ACA must be covered.
- The plan implements innovative features, including (i) care coordination and care management, especially for those with chronic health conditions; (ii) incentives for use of preventive services; and (iii) the establishment of relationships that maximize patient involvement in health care decision-making, including incentives for appropriate utilization.
- Differences in health care needs of enrollees and differences in local availability of health care providers must be considered. No discrimination based on pre-existing conditions or other health status-related factors is allowed.
- The plan is either a managed care system or a system that offers "as many of the attributes of managed care as are feasible in the local health care market." It is not clear how feasibility is to be measured.

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vision care. The detailed list of essential benefits has not yet been released–The Institute of Medicine Board of Health Care Services is expected to issue a report in September 2011 on the topic (*See* http://www8.nationalacademies.org/cp/projectview.aspx?key=IOM-HCS-10-04).

Those eligible to offer plans "include a licensed health maintenance organization, a licensed health insurer, or a network of health care providers established to offer services under the program." If the BHP is operated by an inssuer: The plan must report on state-selected specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, and establish a process to make performance and quality information available to enrollees in a useful form.

- The plan's medical loss ratio may not fall below 85%.

At this point, it has not been specified how states will demonstrate that they have an adequate negotiation process, including how states will be expected to demonstrate that they have negotiated around premium pricing, the introduction of innovations, adjustments for health and resource differences, the use of managed care arrangements, and performance measurement (Rosenbaum 2011).

Federal payments to states for the BHP will be 95% of the premium tax credits "and the cost-sharing reductions" that would have been given to the enrollee in an exchange. It is uncertain at this point whether the federal government will pay 95% or 100% of the cost sharing reductions. The methodology for determining the amount of BHP funds a state will receive relies upon experience in the state's exchange, and it is not yet clear how the methodology will operate if a state seeks to establish a BHP prior to amassing experience with its exchange (Rosenbaum 2011). There is also uncertainty about how federal regulators will project a silver-plan premium for BHP financing (Benjamin and Slagle 2011a).

The U.S. Department of Health and Human Services (HHS) will make one BHP payment to a state before the federal fiscal year begins, based on best available projections (Dorn 2011). If silver-level premiums in the exchange exceed anticipated levels, federal BHP payments to the state will be higher than expected, but if plans offered in the exchange have premiums lower than expected, then federal BHP funding also will be lower than expected. If the federal payment made to a state is too high or too low, HHS will make an offsetting correction in the next year's payment (Dorn 2011). However, the specifics of the fund transfer system have not yet been established (Rosenbaum 2011), and states are concerned that federal regulators establish a reliable method of annual reconciliation to minimize fiscal uncertainties of financing the BHP. States must establish a trust for the deposit of the amounts received, and funds can be used only to reduce the premiums and cost-sharing or to provide additional benefits.

Other Issues Requiring Resolution

In addition to the open issues mentioned above, a number of other issues remain to be clarified regarding the BHP, including the timeline and process for a state to secure federal approval and certification of a BHP and what information will be required of states during the approval

process. It is also not clear to what extent evidence will be required of public involvement in the decision to establish a BHP.

If a state BHP includes the offering of plans by networks of health care providers that are not health insurance issuers, it is not clear what federal standards will be set for these entities. It has yet to be determined what test will be used for measuring whether it is feasible for the state to offer more than one basic health plan.

Another open question is the definition of essential benefits. The Institute of Medicine Board of Health Care Services issued a report on the topic.[2] Until those benefits have been determined, it is difficult to estimate what the cost of administering a BHP will be. Benefits mandated by states beyond the essential health benefits will not be reimbursed by the federal government.[3] In addition to affecting the costs of the BHP, this may affect prices of commercial plans in the exchange.

Adopting a BHP has risks, but several questions have yet to be addressed by federal regulators before these risks can be evaluated. In addition to the question of how silver-level premiums and cost-sharing subsidies will be valued, states need guidance about how to administer the risk pool for a BHP (Benjamin and Slagle 2011a). Will states be able to combine the BHP and exchange risk pools to alleviate the concern that adopting a BHP would undermine the viability of a state's exchange? The recommended method for risk adjustment between carriers must be established. The Association for Community Affiliated Plans (ACAP), a national trade association representing 58 nonprofit safety net health plans in 28 states (including Horizon NJ Health), directed a detailed letter on May 5, 2011 to CMS regarding suggestions and items to be clarified.[4] Among other issues, ACAP asked that states be provided with risk pool flexibility to determine whether the BHP market should be merged with the exchange market or the Medicaid program. Finally, there is a question as to whether states will be able to offer BHP plans at the lower 90/80% actuarial values (AVs), or if federal regulators will recommend the 94/87% AVs, consistent with the exchange (Benjamin and Slagle 2011a).

The New Jersey Context

New Jersey does not currently offer coverage through Medicaid or CHIP (NJ FamilyCare) to most of the population that potentially would be covered by the BHP. However, New Jersey currently offers some state-funded coverage to immigrants ineligible for Medicaid, subject to funding availability, in its Supplemental Prenatal Care program and the Medical Emergency Payment Program for Aliens. The BHP offers the opportunity to capture federal dollars for these efforts. The foreign born population in New Jersey is growing and is now at 20 percent, behind

[2] *See* http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.
[3] ACA § 1311(d)(3).
[4] *See* "ACAP Comments to CMS on Basic Health Program," available at http://communityplans.net.dnnmax.com/PolicySupport/CommentsandRegulations/tabid/351/Default.aspx.

only California and New York, and this population was the largest source of population growth in the state between 2000 and 2008 (Kelly et al. 2011).

The NJ FamilyCare program currently covers children up to 350% FPL and has covered parents below 200% of poverty as state financing has permitted. For both children and parents with income above eligibility for Medicaid, NJ FamilyCare has successfully designed and administered plans with benefits, premiums, and copayments that varied for families by income levels. The state also has designed a buy-in program for children in families with income over 350% FPL. The NJ FamilyCare Advantage program, which is offered by a commercial insurer, is available for children above the income cutoff for NJ FamilyCare who have been uninsured for at least six months, although the six-month period is waived for children who have lost coverage in Medicaid and NJ FamilyCare, or in the event of a parent's job loss. These programs, along with efforts to provide premium support for low-income individuals to purchase insurance from their employers, demonstrate New Jersey's recognition that affordability often constrains the ability of low-income families to obtain health insurance and assistance is needed for individuals and families above Medicaid cutoffs.

A BHP could provide an affordable, comprehensive coverage option for parents under 200% FPL who have been unable to enroll in NJ FamilyCare because of State budget constraints and who will not be eligible for Medicaid/NJ FamilyCare under the ACA. These parents have children covered by or eligible for NJ FamilyCare. If a BHP can be structured in a manner that provides parents with health plans and benefits similar to what their children are eligible for through NJ FamilyCare, the BHP may be especially helpful in filling the gap for these parents. In addition, a BHP could benefit childless adults who do not have access to affordable employer-based insurance and legal immigrant adults not eligible for Medicaid because of the length of their residency in the U.S. At a point in time 65,000-75,000 adults may be eligible for the BHP (Cantor et al. 2011), a number which includes 25,000 legal immigrant adults and 42,000 - 50,000 additional uninsured adults between 133 and 200% FPL who will not have an affordable employer-sponsored insurance option.

Research and Experience

A BHP has the potential to mitigate concerns about maintaining continuity of health insurance coverage for low-income residents whose incomes are likely to fluctuate above and below the 133% FPL limit for Medicaid coverage, thus requiring these people to move between Medicaid and purchasing coverage in the exchange, where benefit designs, cost-sharing requirements, and networks are expected to vary more significantly from Medicaid than they would under the BHP. The number of individuals affected may be substantial. Sommers and Rosenbaum (2011) calculated that in the US "within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from

Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will."

Those whose incomes are only somewhat above Medicaid levels still have very limited incomes, which are more strained in high cost states like New Jersey. These individuals may have difficulty affording coverage in the exchange, even with premium and cost-sharing support. In addition, low-income individuals whose income fluctuates around the Medicaid threshold may find the administrative requirements of enrolling in first one program and then another too onerous and drop out of coverage. If the state can create a more affordable product in the BHP and improve continuity of coverage, this could improve outcomes for low-income people and, ultimately, save the state money in terms of reduced charity care and social service or criminal justice costs.

Research has shown that loss of Medicaid coverage results in increased rates of uninsurance and suboptimal utilization (i.e., higher cost emergency care resulting in unpaid medical debt that may be shifted to government relief in some fashion), as well as in declining health for the uninsured. This is true for both adults (Sommers 2009) and children (Rimsza, Butler and Johnson 2007). Loss of coverage can result from loss of eligibility or administrative barriers. Similar findings exist regarding continuity of insurance generally–i.e., not just among current or former Medicaid recipients (Christakis et al. 2001; Hadley 2002). However, disruptions in insurance are more likely for low-income people (Ku and Ross 2002).

A number of states are considering how to move forward with the BHP as part of their post-ACA health coverage structure. California, Connecticut and Illinois have introduced bills,[5] and Rhode Island is considering the BHP as part of its system design.[6] A report on New York argues that a BHP would offer nearly half a million low-income New Yorkers "more affordable and comprehensive coverage than they would receive in the Exchange," and projects that about 100,000 of them would gain coverage. It calculates that federal funding would be adequate to cover the costs of the BHP if the state uses a design which provides provider reimbursement which is 10% above Medicaid levels, generating more than $500 million in savings from the difference between federal funding and the cost of the plan that could be used to enhance services (Benjamin and Slagle 2011a).

Other analysts have projected savings for states by assuming a design based on provider reimbursement levels similar to Medicaid or CHIP programs. Dorn (2011) notes that "according to the Urban Institute's microsimulation modeling of ACA, average federal BHP payments, based on the cost of subsidies for private insurance in the exchange, will exceed by 29 percent what it would cost Medicaid to cover BHP-eligible individuals." This works out to about $1,000

[5] CA and CT as reported by *Inside Health Reform*, May 9, 2011, "States Move to Create Health Reform's Lesser-Known Basic Health Plans." On IL, *see* HB1685, 97th General Assembly, available at http://www.ilga.gov/legislation/BillStatus.asp?DocNum=1685&GAID=11&DocTypeID=HB&LegId=58849&SessionID=84.

[6] *See* http://www.healthcare.ri.gov/documents/Exchange%20Work%20Group%206.27%20Ppt.pdf.

per enrollee per year. Uncertainties about how the federal government will design further details and state-specific factors could cause this estimate to vary. For example, if a state is successful in designing a plan which incents a large proportion of those eligible for the BHP to enroll, participation in the BHP may be higher than the enrollment which would be expected for this group in the state exchange. In this case, the federal government might experience an aggregate cost increase rather than the savings expected by giving the state 95% of the premium credits rather than paying 100% of the credits used in the exchange (Palmer 2011). An analysis by Milliman also concludes that states can design BHPs that are less costly than the exchange for consumers and states, and that the financial advantages of BHPs which are Medicaid "look-alike" programs will likely grow over time because commercial premiums and cost sharing requirements have tended to grow faster than those in public programs (Palmer 2011). This analysis assumed that Medicaid costs will grow at a rate of 6% per year and that commercial market costs will grow at a rate of 8%, so that the growth of federal subsidies will increase faster than costs of the BHP.

Since the ACA gives states flexibility in the design of a BHP, characteristics of each state will be important to determining the impact of the BHP on consumers and state finances. State decisions about designing a BHP will also be affected by guidance which has not yet been issued by the federal government. However, states must do their own cost and enrollment projections to determine the impact a BHP would have on the exchange and how much it could be expected to reduce the rate of uninsurance by making coverage more attractive and affordable for low-income individuals and families than it would be in the exchange.

Policy Options

The ACA gives New Jersey and other states considerable flexibility to design coverage for low-income residents in innovative ways. If New Jersey does not offer a BHP, all adults who do not qualify for Medicaid under the provisions of the ACA would have only exchange products available, with premium and cost sharing subsidies based on their income level. This might have some advantages for consumers who could afford exchange products, since it is commonly assumed that provider networks for commercial plans will provide more access to timely care, particularly specialist care, than public provider networks. However, previous research has shown that premium and out-of-pocket costs such as those likely to be offered in the exchange have deterred many low-income consumers from enrolling in care (Wright et al. 2010). In addition, individuals who use premium and cost sharing credits to purchase insurance through the exchange run the risk that credits will be adjusted after year-end reconciliation with the Internal Revenue Service (IRS). Some low-income consumers may be deterred from seeking tax credits to purchase coverage in the exchange for fear that year-end reconciliation might require IRS payments which they would view as unaffordable. It is unclear what recoupment of tax

credits exchange participants can be expected to experience, for both individuals with incomes above Medicaid eligibility levels or those who become eligible for Medicaid during an enrollment year (Rosenbaum 2011). This issue is even more complicated for individuals who move between Medicaid and the Basic Health Program more than once during an enrollment year.

The Department of Treasury issued proposed regulations in August providing additional guidance on implementation of the health insurance premium tax credits, including how Treasury will calculate the premium tax credit amount.[7] The proposed regulations indicate a reconciliation process that taxpayers must complete as part of their tax returns for years in which they receive advance premium tax credits. The taxpayers' premium contribution amount is based on household income and size at the end of the taxable year, and the proposed rule includes provisions that address calculations based on changes in filing status (Jett Hayes 2011). While an attempt is made to mitigate the financial impact of repayment of excess tax advances at the lower income levels, the complexity of the calculations of the tax credit/liability for those who move in and out of credit status is significant.

From the state perspective, deciding to offer a BHP will require the state to devote resources to designing a BHP option which accords with state objectives and which can attract health plans to offer it, at a time when many states face serious budget problems and are facing many other challenges in implementing the ACA. Offering a BHP will increase the administrative burden for states. However, many individuals in the low-income population are likely to qualify for Medicaid at some point (particularly if health problems cause a decline in income) and the state would then be paying for care in the public system at a later (and perhaps more expensive) point.[8] Sending parents between 133% and 200% FPL whose children are covered by NJ FamilyCare to the exchange for coverage would reverse New Jersey's long-standing policy of covering these parents in a system as consistent with that of their children as possible to promote continuity of care for families and retention of children in the program.

The BHP will remove the lowest-income members from the exchange's individual market—between 11% and 13% of the individual market (Cantor et al. 2011). National analyses suggest that this will probably have little effect on the risk pool in the individual market, particularly if a state shifts all non-elderly adults above 133% FPL out of Medicaid. The BHP would include some pregnant women and people with disabilities who formerly qualified for Medicaid, so that the average cost of adults receiving individual coverage in the exchange would be unchanged or slightly reduced from what it would be if these individuals moved to the exchange (Dorn 2011). Any effect on the exchange risk pool will be mitigated by the ACA requirement that each insurer pool all individual market enrollees both inside and outside the

[7] 76 Fed. Reg. 50931, (August 17, 2011).

[8] McWilliams et al. (2007) found that Medicare enrollees who had been previously uninsured had higher costs once enrolled than did those who had been previously insured.

exchange. If HHS interprets the ACA to allow states to use their regulatory authority to require an insurer which operates a BHP to pool BHP enrollees with other individual market customers, this can also potentially distribute the risk over more covered lives. In addition, it is possible that a state may be able to include the BHP plan in its risk-adjustment and reinsurance systems (Dorn 2011). If such a policy is allowed by HHS, the BHP would simply move consumers between plans which share risk together.

New Jersey and other states have considerable latitude in designing BHPs. While the BHP cannot be a Medicaid program, most of the existing analyses of the BHP assume that plan designs will have some Medicaid-like benefits and reimbursement systems (Dorn 2011; Benjamin and Slagle 2011a). However, as an alternative to offering a plan designed on a public program model, states may decide to negotiate with private insurers to offer a BHP with benefits like those offered in other exchange plans but with lower premiums and cost sharing than other exchange products (Dorn 2011). Such a plan might include design features such as incentives for members to join health promotion programs, addressing such issues as smoking or obesity. A commercial BHP plan could potentially provide participants with broader networks of providers, deeper network capacity for absorbing new participants, and more carriers offering plans (Benjamin and Slagle 2011b). When the income of BHP consumers rises above 200% FPL, they may be able to transition into other exchange products more smoothly from a commercial BHP, particularly if the same carriers offer the BHP and other exchange products. On the other hand, a commercial design would not ease the transition for consumers cycling back and forth from Medicaid. However, developing a commercial BHP model which will be affordable for low-income participants and attractive to providers in the absence of experience with similar programs will be a challenge while states are juggling so many other responsibilities for ACA implementation. It may be more feasible for most states interested in offering a BHP to build on existing public programs.

Dorn (2011) details three examples of BHP designs which build on public programs.

- Use the BHP to provide “Medicaid look-alike” coverage. This design builds on the approach used by some states for CHIP children in which these children received Medicaid benefits and cost-sharing and enrolled in the same health plans which enrolled Medicaid children, although using CHIP rather than Medicaid funds and without an individual entitlement. Under this approach, BHP enrollees would receive the same benefits and cost-sharing protections that apply to Medicaid.
- Use the BHP funds for a “CHIP for adults” program for low-income parents and other adults. Under this design, premiums and cost sharing would be above Medicaid levels, but lower than in the exchange. The ACA does not require that all BHP members receive the same benefits or cost sharing protections, so the program might be designed to offer different features at different income levels. Such a program might have benefits more similar to commercial plans, but could also include innovations such as value-

based design and cost sharing that incents consumers to use more efficient providers.[9] Provider payments could also be higher than those for Medicaid.

- Combine funding from Medicaid, CHIP, and BHP into a single program which would serve all low-income residents. A single set of health plans would provide coverage to all members, but benefits and cost sharing could vary for incomes above 133% FPL. From the consumer's perspective, a single program would serve all residents with incomes up to 200% FPL.

Designing a BHP based on public insurance has the advantages of building off insurer relationships from other public contracting work and providing better coordination between Medicaid and the BHP, particularly if the same health plans offer Medicaid, CHIP, and the BHP. This could have the advantage of improving care continuity for members of the same family, even if their benefits are somewhat different, and for enrollees cycling between programs. Lower costs for consumers should increase enrollment into health coverage. If federal payments exceed costs, the difference could be used to fund additional services and/or provide increased provider payment levels, although these would likely remain below payments from exchange plans.

On the other hand, covering those eligible for the BHP in a public program would increase the population using public plan provider networks. It has been estimated that 234,000 new enrollees will participate in NJ FamilyCare after ACA implementation, if eligible individuals take up coverage at expected rates (Cantor et al. 2011). While these new enrollees may not have poorer health status than current NJ FamilyCare beneficiaries, many are likely to have chronic conditions, mental health problems, or substance abuse problems which will require specialized services and care management. Integrating these individuals into the existing service systems is likely to pose significant challenges for health plans. While these individuals may be able to enroll in a health plan, finding participating providers who can meet their health care needs in a coordinated manner may be difficult. Absorbing another 65,000-75,000 BHP consumers into public program health plans will place additional demands upon the state and the carriers who offer public health plans to negotiate arrangements which will provide high quality care for these additional enrollees. The lower reimbursement rates paid by public programs may contribute to fiscal distress of providers serving large numbers of low-income patients.[10]

Under an alternative design combining public and commercial BHP plans, New Jersey could also offer BHP consumers a choice between Medicaid look-alike coverage and subsidized plans in the exchange. Under this alternative, the state would need to require plans in the

[9] ACA § 1331(c)(2)(A).

[10] *See* Amerigroup Public Policy Institute's suggestions on increasing provider participation, available at http://hcr.amerigroupcorp.com/wp-content/uploads/2011/07/Option-16-Increase-Provider-Participation-in-Medicaid-and-Improve-Access-to-Care.pdf.

exchange to offer identical coverage in the BHP (Dorn 2011). This would allow each BHP consumer to decide between the greater affordability of Medicaid or the broader provider networks likely to be available in exchange plans. Such a design might allow people whose income fluctuates around 133% FPL to move more easily between public programs and the BHP, while those whose income fluctuates around 200% FPL could move more easily between the commercial BHP and other exchange products.

However, this would require a more complicated design for the BHP and more administrative complexity for the state in qualifying and managing multiple plans. While offering a broad range of choices to consumers, this design might be more difficult for consumers and Navigators who need to sort through a wide variety of plans and subsidy options. Too many choices may be confusing or paralyzing for individuals who are not accustomed to choosing health care plans, and this confusion might lower enrollment or increase the likelihood that individuals pick a plan which is not optimal for their needs. For those who are able to choose plans which best meet their needs, those who need more specialist care may gravitate to plans with better specialist networks, resulting in adverse selection for some plans.

Conclusions

Research has documented many problems that occur with being uninsured, including suboptimal utilization patterns and declining health, which can increase government expenditures in the short term and over the long run. Experts seem to agree that the BHP represents the potential for states to reduce the number of uninsured, and increase continuity and quality of care for low-income residents. They also agree, however, that there are still many unanswered questions about the financial consequences for states, including what benefits will be declared as essential, what the effects on enrollment and risk pools in the exchange will be, and how federal compensation to states will work. Several states are considering the option at this point, though none have yet committed to it.

There are several choices to be made in designing a BHP, including whether to build off of public programs or use a more commercial design. Both approaches offer advantages and disadvantages for consumers. Premiums and copayments should be designed with affordability and the chance of adverse selection in mind. Decisions about planned benefit levels, consumer cost-sharing, and provider reimbursement will affect state projections of the financial viability of a BHP.

New Jersey currently offers some state-funded coverage to immigrants ineligible for Medicaid, although state budget constraints have limited coverage for this population. The BHP offers the opportunity to capture federal dollars for these efforts. New Jersey also has experience with creating public coverage with different benefit and cost sharing levels and a

buy-in program based on its NJ FamilyCare program, potentially reducing the learning curve required in implementing a BHP.

The BHP provides an opportunity for New Jersey to provide more affordable coverage for low-income individuals who might otherwise choose not to participate in the exchange, even with premium and cost sharing subsidies, and to provide coverage for low-income immigrants who are not eligible for Medicaid. In the past, New Jersey has demonstrated a commitment to providing comprehensive and affordable care to low-income families by extending NJ FamilyCare to children up to 350% FPL, and parents up to 200% FPL when state finances permit. The state has also experimented with providing care to low-income single adults above Medicaid levels. Exploring the BHP as a way to cover low-income individuals makes sense as a continuation of New Jersey's concern to provide affordable health coverage options to state residents, but will require further analysis of the feasibility of alternative program designs.

The option of building a BHP which would use a commercial model seems challenging in the absence of specific experience with similar models from other states. It appears more feasible for New Jersey to design a BHP which takes advantage of the state's experience with NJ FamilyCare. Designing a "Medicaid look-alike" option seems inconsistent with the history of NJ FamilyCare, where different benefits and cost sharing have been used for families at different income levels. However, building a BHP as an extension of NJ FamilyCare would be consistent with the New Jersey's approach to public coverage, whether or not the BHP is integrated seamlessly with other programs and carries the NJ FamilyCare brand. However, the state's ability to do this is predicated upon using a Medicaid model to control costs by reimbursing providers at rates which are lower than those in the exchange. Along with the 234,000 new Medicaid enrollees expected after the ACA is implemented, adding a projected 65,000-75,000 BHP enrollees to public health plans runs the risk of straining the supply of providers who will find it financially viable to accept lower reimbursement and be able to provide high quality care.

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