OLIVER WYMAN

FINANCIAL ANALYSIS OF A NEW JERSEY BASIC HEALTH PROGRAM

PREPARED FOR RUTGERS CENTER FOR STATE HEALTH POLICY

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Preface

This report was commissioned by the Rutgers Center for State Health Policy (CSHP) under a grant from the Robert Wood Johnson Foundation. We are grateful to members of the New Jersey Interagency Working Group on the Affordable Care Act for comments on earlier versions of this report as well as providing data to inform assumptions made in the report. We also acknowledge the help of Dorothy Gaboda, CSHP associate director for data analysis, who provided data to the Oliver Wyman Actuarial team in support of this effort. This report is intended to inform decisions by New Jersey public officials as they work to craft the State's responses to the requirements of the Patient Protection and Affordable Care Act (ACA). *The contents of this report are the sole responsibility of the authors and is not endorsed by the State of New Jersey*. Additional policy reports addressing other components of New Jersey's response to the ACA are available on CSHP's web site at www.cshp.rutgers.edu.

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Executive Director

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Glossary of Terms

Affordable Care Act (ACA) – For the purposes of this report refers to the PATIENT PROTECTION AND AFFORDABLE CARE ACT and HEALTH-RELATED PORTIONS OF THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010

Affordable Coverage – Within the context of the ACA affordable coverage is defined as that where the premiums, or contribution toward premiums in the case of employer sponsored coverage, exceed 9.5% of one's income

Bronze Plan – Plans in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan

Federal Poverty Level (FPL) – Federal Poverty measure published in the Federal Register, for 2012 48 contiguous states and the District of Columbia are $11,170 for a single person, and $23,050 for a family/household of four (http://aspe.hhs.gov/poverty/12poverty.shtml/12fedreg.shtml)

Managed Care Organization (MCO) – Insurer, HMO, or other entity that manages the delivery of healthcare in exchange for capitation or premium payment

Exchange – Health Benefit Exchange as defined under the ACA

Silver Plan – Plans in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan

Tax Credits – Refundable advance credits provided under the ACA to facilitate the purchase of health coverage in an ACA Exchange; credits vary by income as a percentage of FPL

Federal Cost Sharing Subsidies – Subsidies to lower income individuals that limit their out of pocket costs when enrolling in a Silver plan through an ACA Exchange

Actuarial Value – Percentage of expected allowed charges covered by an insurance plan

NJ FamilyCare – A Federal and State funded health insurance program created to help New Jersey's uninsured children and certain low-income parents and guardians to have access to affordable health coverage

Morbidity – Term that refers to the general health status of an individual or group which in the insurance context has a correlation to the expected medical costs an individual or group might be expected to incur

Risk Adjustment – Mechanism to adjust plan revenues to reflect the underlying risks a plan is covering

Gold Plan – Plans in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan

Platinum Plan – Plans in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan

Loss Ratio – The ratio of plan claims to premiums

Offerors – In this context an insurer or other risk bearing organization offering coverage to individuals under the BHP

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Executive Summary

Background

The Federal requirements and funding for a state to establish a Basic Health Program (BHP) for low-income individuals not eligible for Medicaid are included in Section 1331 of the Patient Protection and Affordable Care Act (ACA). The BHP is an optional program that the State may decide to establish under the requirements of ACA Section 1331, which is included as Appendix 1. In determining whether or not to establish a BHP, the State essentially needs to weigh the advantages of having a program whereby low-income individuals could likely be provided a lower-cost option to Exchange-based coverage, against the risks of incurring certain costs should such a BHP be established.

The Rutgers Center for State Health Policy (CSHP) has contracted with Oliver Wyman to provide necessary financial projections to aid policymakers in determining whether it is in New Jersey's best interest to operate a BHP. In order to meet the goals of the project in the desired timeframe, we have created a financial model to project enrollment, medical costs, administrative costs, and revenues over a multi-year period beginning in 2014. This modeling effort includes varying or sensitizing key parameters in order to develop estimates under a range of assumptions.

Summary of Basic Health Program

Eligibility for the BHP is limited to immigrants below 138% (133% plus 5% disregard) of the Federal poverty level (FPL) but present in the United States less than five years and ineligible for Federal financial participation in Medicaid, and other eligible individuals between 138% (133% with 5% disregard) and 200% FPL. In addition, individuals may not have access to other affordable government or private insurance coverage. The BHP has several requirements related to premiums, cost sharing, benefits, minimum loss ratios, competitive contracting, and coordination with other state plans to maximize efficiency and improve continuity of care.

BHP revenues would primarily consist of Federal subsidies. Federal subsidies are equal to 95% of the premium tax credits and cost-sharing reductions that an eligible individual would have received if enrolled in the Exchange. BHP revenues also take into consideration the health status of the enrollee for purposes of determining risk adjustment and reinsurance payments that would have been made if the enrollee had enrolled in an Exchange plan. The State could also consider charging an additional premium to BHP enrollees, if it would like.

BHP benefits would generally be expected to be fairly rich, possibly near Medicaid levels, and administrative costs could be similar to those associated with administering Medicaid benefits incurred by a state government, as well as Medicaid Managed Care Organizations (MCOs).

BHP Financial Model

Due to the uncertainty associated with exactly how the BHP would operate, as well as who would enroll and what their associated revenues and costs would be, our modeling includes scenario testing. Our general modeling approach follows:

1) Estimate the average second lowest cost Silver plan premiums per member per month (PMPM)
2) Based on the relative demographic and morbidity assumptions, estimate adjusted premiums for BHP plan enrollees, along with the level of Exchange premiums, and Tax Credits for each of the three BHP enrollee segments (new legal residents in the United States less than five years with incomes <138% FPL, Eligibles with incomes 138-150% FPL, and Eligibles with incomes 150%- 200% FPL) as if they would be enrolled in Exchange coverage
3) Develop Federal cost sharing subsidies that the three BHP enrollee segments would have received had they been enrolled in Exchange coverage
4) Determine average Federal subsidy amounts PMPM for each of the three BHP enrollee segments (which equals the total BHP revenue assuming BHP enrollee premiums are $0)
5) Develop average Commercial Exchange plan claims costs PMPM for a 100% Actuarial Value (AV) plan
6) Assume BHP plan benefits are similar to NJ FamilyCare Plan D, and that Plan D benefits have an AV of about 95%
7) Estimate average PMPM claims costs for BHP enrollees by making benefit (or AV), morbidity, and provider reimbursement adjustments to Commercial PMPM claims costs
8) Estimate PMPM administrative costs based on Medicaid expense allowances in State Fiscal Year (SFY) 2012 capitation rates
9) Estimate average PMPM surplus or deficiency for enrollees in each of the three BHP enrollee segments
10) Apply enrollment estimates (based on CSHP analysis) to PMPM amounts estimated per steps (1)-(9) to develop cost estimates in total dollars

Key assumptions in our modeling include:

Enrollment and Enrollment Growth – The number of BHP enrollees is uncertain, as is the timing of when BHP eligibles may enroll in the program. We have varied our projected enrollment to reflect this uncertainty.

Commercial Claim Cost and Premium Trends – Claim costs and premiums for the second lowest cost Silver plan would be expected to increase with medical cost trends. We have varied the trend rates for these premiums and costs since they largely determine the BHP revenues.

BHP Claim Cost Trend Differential – The BHP program could have medical cost trends that are lower than Commercial trends and we have assumed lower trends in the BHP under the more optimistic scenarios.

BHP/ Commercial Reimbursement – We have assumed that the BHP will reimburse providers at lower rates than Commercial plans and have varied this ratio under the modeled scenarios.

Admin % of Premiums to BHP MCOs – Administrative costs as a percentage of Premiums to MCOs who offer BHP coverage vary by scenario.

BHP Enrollee Wage Growth – Enrollees in the BHP would pay premiums based on their actual income as a percentage of FPL if enrolled in the Exchange. The wage growth assumption is 3% annually for all scenarios and it impacts the Federal subsidies paid to the State for the BHP.

BHP/ Commercial Morbidity Adjustment – This adjustment is made to approximate the relative morbidity and claims costs of BHP enrollees relative to Commercial enrollees, all else equal. Our modeling assumes robust risk adjustment program so premiums and claims for BHP enrollees are both adjusted based on this morbidity assumption.

Modeling Results

	Results			
	Low	Middle	High	Pessimistic
2014 Enrollment: Legal Immigrants <138% FPL	20,000	25,000	30,000	50,000
2014 Enrollment: Incomes 138-200% FPL	42,000	46,000	55,000	92,000
Annual Enrollment Growth	0%	1%	2%	3%
Commercial Cost and Premium Trends	6%	7%	8%	10%
BHP Claim Cost Trend Differential	-2%	-1%	0%	0%
BHP/ Commercial Reimbursement	0.65	0.75	0.85	0.95
Admin as % of Premiums to BHP MCOs	10.0%	12.2%	15.0%	15.0%
BHP Enrollee Wage Growth	0.03	3%	3%	3%
BHP/ Commercial Morbidity Adjustment	100%	90%	80%	70%
Yr. 1 Surplus PMPM	$192	$77	-$29	-$97
Yr. 1 Surplus $s	$142,960,459	$65,522,028	-$29,561,488	-$165,293,838
Yr. 1 Fed Subsidy	$560,894,833	$574,985,629	$605,118,008	$871,605,554
Yr. 1 Surplus - % of Yr. 1 Subsidy	25%	11%	-5%	-19%
Yrs. 1-5 Surplus PMPM	$246	$108	-$27	-$109
Yrs. 1-5 Surplus $s	$913,976,467	$469,220,844	-$142,756,111	-$983,329,269
Yrs. 1-5 Fed Subsidy	$3,177,643,846	$3,402,522,700	$3,744,386,708	$5,776,182,696
Yrs. 1-5 Surplus - % of BHP Premium	29%	14%	-4%	-17%

NOTE SURPLUS WILL NEED TO BE ELIMINATED THROUGH RICHER BENEFITS OR BETTER PROVIDER REIMBURSEMENT

More detailed results of our modeling are shown in Appendix 2.

In looking at the model results in more detail, some other noteworthy results emerge, including:

- At higher levels of BHP provider reimbursement relative to Commercial, the plan is not feasible
- Surpluses grow (and deficits shrink) moderately in later projection years which is a by-product of revenues trending at a higher rate than Commercial premium trends, and BHP claims trending lower than Commercial claims (and premiums)
- Because reimbursement varies by the three BHP enrollee segments (legal immigrants <138% FPL, enrollees 138-150% FPL, and enrollees 150%- 200% FPL), the mix of enrollees becomes important under the modeling assumptions. We note under the "High" scenario, the immigrant <138% FPL segment actually shows a slight surplus where as the other enrollees show a deficit.

In addition to our independent modeling, we reviewed publicly available BHP analyses for other states which generally showed similar results. A list of these publicly available analyses is shown in Appendix 3.

BHP Risks and Recommendations

1. State May Incur Unreimbursed Administrative Costs
Whether or not Federal funds can be used to pay state administrative costs for BHP oversight is unclear based on the ACA, and guidance provided to date. Therefore, the State needs to determine and quantify what, if any, unreimbursed BHP administrative costs the State would need to pay should it implement a BHP.

2. Providers May Not Deem BHP Reimbursement Sufficient
In order to be feasible, the BHP provider reimbursement will need to be at levels lower than Commercial levels. Should the BHP reimbursement be deemed to be too low by providers, issues related to provider dissatisfaction with low reimbursement could manifest themselves in many ways, including not participating in BHP networks, which could create access and consumer issues.

3. Consumers Could View BHP as an Inferior Option to Exchange Plans
Consumers would be attracted to a BHP plan with better benefits than an Exchange plan at a lower cost. The BHP may have more restrictive networks, and the cost/access tradeoff needs to be dealt with appropriately so that BHP eligibles do not view their product as inferior to the Exchange products.

4. Health Plans May Not Participate in the BHP Without Adequate Compensation for Their Risks

Assuming that the BHP is administered in a manner similar to a managed Medicaid plan, health plans will need to receive adequate reimbursement to assure that they can set up sufficient networks, and be compensated for their administrative costs, capital investments, and insurance risk, otherwise they may not participate. Should BHP revenues to health plans in addition to the states be risk adjusted, there exists a potential for State revenues to be adjusted downward which is a risk to health plans that would need to be addressed.

5. The State Makes Up Deficit if BHP Costs Exceed Revenues

If Federal funds are not sufficient to pay for BHP administrative and capitation payments to MCOs (assuming a managed model), the State will need to cover the difference. While this scenario seems unlikely under a capitated model to participating offerors, BHP revenues are risk adjusted, and the amount and timing of retrospective (and retroactive) Federal payment adjustments could create some State exposure to losses. Therefore, the timing and amounts of Federal payments and adjustments need to be fully understood once this information is finalized by the Federal government.

6. Exchange Is Impacted by Existence of a BHP

The existence of a BHP certainly would impact Exchange enrollment, since without a BHP, some of those who would have enrolled in a BHP would enroll in the Exchange, and this could have an impact on the risk profile of Exchange enrollees and premiums within the Exchange. Lower enrollment within the Exchange will also increase per member administrative costs since they would be spread over fewer members which might impact the Exchange's sustainability. The impact of a BHP on exchange risks, premiums, and sustainability should be studied by the State, but is beyond the scope of this analysis.

Conclusion

Our financial modeling does indicate the real potential for a BHP to be able to provide a richer level of benefits at a lower cost to low income individuals not eligible for Medicaid than these individuals would be able to obtain through an Exchange plan. In addition, the continuity that could be provided to the transient Medicaid population does have real value to those individuals, and possibly to the State.

However, our analysis also indicates some significant risks associated with a BHP plan as outlined in this section. Some of these risks are related to currently having incomplete information regarding Federal rules for the use of Federal funds for BHP administrative costs, as well as the mechanisms for risk adjustment and reinsurance. This lack of information will be addressed through the passage of time as additional information is disseminated by the Federal government. There will also be ongoing risks to the State since it will essentially become the risk-bearing entity for the BHP as it receives Federal revenues, and must provide medical services directly or indirectly to BHP enrollees. The amount of risk that the State may bear with

a BHP, is also somewhat dependent upon Federal rules regarding the extent to which the State may keep BHP funds in trust as a reserve to stabilize potential loss exposure.

While the BHP has the potential to be a valuable tool to help low income residents of New Jersey obtain and maintain affordable health coverage, we would recommend that the State address the risks outlined in this section as part of its vetting process to determine whether it is prudent to establish a BHP in New Jersey.

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Scope and Limitations

The Rutgers Center for State Health Policy (CSHP) has contracted with Oliver Wyman to provide necessary financial projections to aid policymakers in determining whether it is in New Jersey's interest to operate a Basic Health Program (BHP).

In order to meet the goals of the project in the desired timeframe, we have created a financial model to project enrollment, medical costs, administrative costs, and revenues over a multi-year period beginning in 2014. This modeling effort includes varying or sensitizing key parameters in order to develop estimates under a range of assumptions. The key assumptions and the approach to their development as outlined in the remainder of this report rely heavily on data, work, and analyses prepared by others as agreed upon with CSHP. Completing additional analyses could impact our assumptions and results, and in certain circumstances we have recommended additional work that could be completed to further inform policymakers in their decision-making process regarding the establishment of a BHP.

This report includes proforma projections of revenues and costs for the two required populations: (1) immigrants below 133% of the Federal poverty level (FPL) but present in the US less than five years and ineligible for Medicaid, and (2) other eligible individuals between 133% and 200% FPL. The report also outlines the approaches used to develop key assumptions, and documents sources of data and information.

Oliver Wyman has prepared these projections exclusively for the CSHP, to aid policymakers in determining whether it makes financial sense to establish a Basic Health Program in the State of New Jersey. Our work may not be used or relied upon by any other party or for any purpose other than for which they were issued by Oliver Wyman. Oliver Wyman is not responsible for the consequences of any unauthorized use.

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

Further, the estimates set forth in this report have been prepared prior to the issuance of relevant ACA regulations, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. The State is responsible for all financial and design decisions regarding the BHP. Such decisions should be made only after the State's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

Lastly, Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it, a substitute for legal advice. Accordingly, Oliver Wyman recommends that the CSHP, Rutgers, or any of its State affiliates secure the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

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Background

The Federal requirements and funding for a state to establish a Basic Health Program (BHP) for low-income individuals not eligible for Medicaid are included in Section 1331 of the Patient Protection and Affordable Care Act (ACA). The BHP is an optional program that the State may decide to establish under the requirements of ACA Section 1331. Within the program, an eligible participant could potentially enroll in one of several health benefit plans that might be offered as part of the program. In order to avoid overcomplicating the following discussion, BHP in this report refers alternatively to either the program or coverage under the program.

In determining whether or not to establish a BHP, the State essentially needs to weigh the advantages of having a program whereby low-income individuals could likely be provided a lower-cost option to Exchange-based coverage, against the risks of incurring certain costs should such a BHP be established. While this report focuses upon the financial implications of establishing a BHP, an additional benefit of the BHP could be more continuity of coverage for enrollees who have incomes near Medicaid eligibility levels and, therefore, may alternatively be eligible and ineligible for Medicaid over time.

Individuals Eligible for BHP Coverage

Eligibility for the BHP is limited to immigrants below 138% (133% plus 5% disregard) of the Federal poverty level (FPL) but present in the United States less than five years and ineligible for Federal financial participation in Medicaid, and other eligible individuals between 138% (133% with 5% disregard) and 200% FPL.

In addition, BHP enrollees:

- Must be under age 65
- May not be eligible for another government program- e.g., Medicare, Medicaid, CHIP, TRICARE
- May not have access to affordable employer-sponsored coverage meeting minimum standards

Also, should a BHP be established, eligible individuals may not enroll in coverage and receive premium and cost sharing subsidies through an Exchange.

Outline of BHP Requirements

The BHP and plans offered through it are required to meet certain requirements, summarized as follows:

- **Enrollee premiums** – BHP premiums must not exceed premiums that a BHP enrollee would have been required to pay if the individual would have enrolled in the second lowest cost Silver plan in the Exchange
- **Enrollee cost sharing** – Cannot exceed the level of cost sharing under the Exchange Platinum plan for those with income below 150% FPL, or that under the Gold plan for those with income between 151% to 200% FPL
- **Benefits** – Cover at least the essential health benefits described in Section 1302(b) of ACA
- **Loss Ratio** – Medical loss ratio of at least 85 percent
- **Contracting** – Competitive process is required that considers innovation, enrollee health care needs, differences in local provider access and availability, managed care capabilities of offerors, and performance measures and standards to be met
- There is a preference for multiple plans being available within the BHP
- Regional compacts between states to cover eligible individuals are allowed to enhance availability
- **Coordination with Other State Programs** – A state shall seek to coordinate the administration of the BHP with Medicaid and the Children's Health Insurance Program (CHIP), and any other state plans in order to maximize efficiency and improve the continuity of care for BHP eligibles

BHP Revenues

Federal subsidies consist of 95% of the premium tax credits and cost-sharing reductions that an eligible individual would have received if enrolled in the Exchange. BHP revenues also take into consideration the health status of the enrollee for purposes of determining risk adjustment and reinsurance payments that would have been made if the enrollee had enrolled in an Exchange plan.

These Federal subsidies will be transferred to the State each fiscal year if BHP plan coverage is in place. Federal funds are deposited by the State into a trust and may only be used to reduce premiums and cost sharing or to provide additional benefits for BHP enrollees.

BHP Benefits and Medical Costs

There is some flexibility in designing benefits for the BHP. However, because of the requirements to coordinate with Medicaid and CHIP benefits and the cost-sharing limits, the BHP would have rich benefits (i.e., benefits where the Actuarial Value (AV) is high), and logically would have benefits similar to Medicaid benefits to allow for administrative efficiencies.

Medical costs will be impacted by the actual benefits of the BHP, provider reimbursement of participating carriers in the BHP, enrollee demographics, and enrollee morbidity.

BHP Administrative Costs

BHP administrative costs will include those incurred by the State in order to perform program management functions that would not be part of those that would be delegated to plan offerors who would administer or insure BHP enrollees, and typical insurer functions that would be performed by the offerors.

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BHP Financial Modeling Methodology

Due to the uncertainty associated with exactly how the BHP would operate, as well as who would enroll and what their associated revenues and costs would be, our modeling includes scenario testing that sensitizes key assumptions. In addition, our modeling attempted to develop and utilize reasonable assumptions, but by no means can be considered exhaustive. Additional modeling could be completed, if desired. Some recommendations for additional modeling are included in Section 5 of this report.

General Modeling Approach

The general approach to projecting enrollment, revenues, and costs for 2014 is as follows:

1) Estimate the average second lowest cost Silver plan premiums per member per month (PMPM)
2) Based on the relative demographic and morbidity assumptions, estimate adjusted premiums for BHP plan enrollees, along with the level of Exchange premiums, and Tax Credits for each of the three BHP enrollee segments (new legal residents here less than five years with incomes <138% FPL, Eligibles with incomes 138-150% FPL, and Eligibles with incomes 150%- 200% FPL) as if they would be enrolled in Exchange coverage
3) Develop Federal cost sharing subsidies that the three BHP enrollee segments would have received had they been enrolled in Exchange coverage
4) Determine average Federal subsidy amounts PMPM for each of the three BHP enrollee segments (which equals the total BHP revenue assuming BHP enrollee premiums are $0)
5) Develop average Commercial Exchange plan claims costs PMPM for a 100% AV plan
6) Assume BHP plan benefits are similar to NJ FamilyCare Plan D, and that Plan D benefits have an AV of about 95%
7) Estimate average PMPM claims costs for BHP enrollees by making benefit (or AV), morbidity, and provider reimbursement adjustments to Commercial PMPM claims costs
8) Estimate PMPM administrative costs based on Medicaid expense allowances in State Fiscal Year (SFY) 2012 capitation rates
9) Estimate average PMPM surplus or deficiency for enrollees in each of the three BHP enrollee segments
10) Apply enrollment estimates (based on CSHP analysis) to PMPM amounts estimated per steps (1)-(9) to develop cost estimates in total dollars

2014 amounts are trended for future years, and specific assumptions that vary by scenario as shown in the following table are explained in the remainder of this report.

Table 1
Modeling Assumptions by Scenario

	Assumptions by Scenario			
	Low	Middle	High	Pessimistic
2014 Enrollment: Legal Immigrants <138% FPL	20,000	25,000	30,000	50,000
2014 Enrollment: Incomes 138-200% FPL	42,000	46,000	55,000	92,000
Annual Enrollment Growth	0%	1%	2%	3%
Commercial Cost and Premium Trends	6%	7%	8%	10%
BHP Claim Cost Trend Differential	-2%	-1%	0%	0%
BHP/ Commercial Reimbursement	0.65	0.75	0.85	0.95
Admin as % of Premiums to BHP MCOs	10.0%	12.2%	15.0%	15.0%
BHP Enrollee Wage Growth	3%	3%	3%	3%
BHP/ Commercial Morbidity Adjustment	100%	90%	80%	70%

Plan Design and Benefits

We assume that the benefits covered will be similar to those under NJ FamilyCare Plan D which are substantial, but which also requires the most beneficiary cost sharing: generally through fairly modest copayments for certain services. Plan D is the plan in which NJ FamilyCare eligible adults have most recently enrolled. This is a comprehensive plan with rich benefits and cost sharing that is generally limited to low copayments for certain medical services. Note that we have not made any adjustments for Essential Health Benefits throughout this report, and do not believe adjusting estimates for Essential Health Benefits would significantly impact our financial modeling.

Enrollment

The Rutgers Center for State Health Policy *Health Insurance Status in New Jersey After Implementation of the Affordable Care Act* report included an analysis of how residents were covered in 2009, and how these residents would be covered under the ACA. This report included the following regarding potential enrollment in a BHP: *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.*[1]

[1] Health Insurance Status in New Jersey After Implementation of the Affordable Care Act. http://www.cshp.rutgers.edu/Downloads/8970.pdf (accessed May 2012), Page 10.

Following review of the projected enrollment for general reasonableness, we used these enrollment estimates as the basis for our 2014 legal immigrant and 133-200% FPL enrollment estimates, and varied enrollment around these estimates by scenario. In addition, we assumed varying rates of enrollment growth ranging from 0% to 3% per year in our projections. Based on updated American Community Survey (ACS) data, the 65,000 to 75,000 estimate is probably a bit low. However, it is reasonable for our scenario testing and our higher enrollment scenarios adequately address the impact of assuming higher enrollment, along with more pessimistic plan results.

Estimate of Exchange Silver Plan Premiums

Projecting Exchange premiums in the 2014 New Jersey individual marketplace governed by the Individual Health Coverage Program (IHC) is not a simple task. Currently, the market is somewhat fractured, and marked by some degree of self-selection, in general. Better risks often opt into limited benefit Basic and Essential (B&E) plans while the poorest risks could opt into Standard HMO and Indemnity plans with the richest benefits. Direct Access (DA) plans, based upon our review of premium rates and rate filings, may be reflective of risks that are somewhere near the middle of the continuum of risks currently enrolled in IHC plans, and reasonably good risks relative to other Standard plan risks.

It is generally accepted that there is anti-selection into the Standard plans within the New Jersey IHC market. It is logical to think that the risk profile of the new enrollees entering the market in 2014 via the Exchanges might actually be better than those currently enrolled in Standard products. However, it is difficult to project how carriers will price in the Exchange and the cost of the second lowest cost Exchange Silver plan. As a starting point, we assume that enrollees within the Exchange will be healthier, on average, than those currently enrolled in Standard plans, and believe that trended Direct Access plan premiums with necessary adjustments could represent a reasonable approximation of Silver plan premiums in the Exchange. It is also reasonable to assume that based on its current market position, Horizon Blue Cross Blue Shield of New Jersey may be have the lowest cost Silver premiums in the Exchange.

Using this as our starting premise, we developed the 2014 estimated average Horizon DA PMPM premium as follows:

Table 2
Estimated 2014 Horizon Direct Access PMPM Premium

Base Period (11/1/2011 to 10/31/2012) Claims Estimate PMPM:	$498	Horizon DA Rate Filing Eff. 11/1/2011
Midpoint of Base Period:	5/1/2012	
Midpoint of Initial BHP Coverage Period	7/1/2014	
Annual Trend Assumption	7.0%	
2014 Claims Costs- DA Plans and Enrollees PMPM:	$577	
Assumed Initial Loss Ratio	82.7%	
Projected 2014 Average DA Premiums with Current Enrollees PMPM:	$698	

From this 2014 Horizon DA premium estimate, we made demographic, benefit (AV), and a market adjustment to estimate the average second lowest cost Silver plan premiums (prior to subsidy) for BHP enrollees if they had been enrolled in the Exchange, as follows:

Table 3
2014 2nd Lowest Silver Plan Premium Estimate

Projected 2014 Average DA Premiums with Current Enrollees PMPM	$698
Demographic Adjustment: DA to BHP population	98%
Market Adjustment : 2nd Lowest Equals Horizon +	5%
Actuarial Value Adj: Silver (70%AV) to DA AV Estimate	97%
2nd Lowest Silver Premium Estimate	$693

The demographic adjustment is based on our developed demographic factors being applied to the enrollment by age in non-group coverage during the CSHP study period[2] to the enrollment by age in the BHP projected post-ACA. The adjustment is fairly close to 100% (or 1.0) due to enrollment estimates showing that the adults in the BHP are expected to be considerably younger than those currently enrolled in non-group coverage, which is offset by the expectation that very few children will enroll in the BHP.

The Market Adjustment is an approximation of the additional cost of the second lowest cost Silver plan relative to the assumed Horizon lowest cost plan. We have no way of knowing what this relationship will actually be since pricing strategies in the Exchange are uncertain. This is a risk factor in assessing the financial feasibility of a BHP. The Actuarial Value adjustment was developed based on our review of the benefits and enrollment in the Horizon DA plans, and was calculated using a combination of DA plan benefits run through our pricing models and plan relativities provided in Horizon's public rate filing for rates effective 11/1/2011.

[2] Ibid.

Federal Subsidy Revenues Calculation

The table below shows the calculation of the Federal subsidies for the three BHP enrollee segments under the "Middle" scenario:

Table 4
Federal Subsidy Estimates for BHP Enrollee Segments

	Legal Immigrants <138% FPL	138-150% FPL	150-200% FPL
2nd Lowest Silver Premium	$693	$693	$693
Estimated Avg FPL	119%	144%	175%
Morbidity Adjustment	90%	90%	90%
Premium With Morbidity Adjustment	$624	$624	$624
Estimated Avg Enrollee Premium Contribution	$32	$51	$88
Silver Premium Tax Credit if Enrolled in Silver Plan	$592	$573	$536
Estimated Premium Tax Credit for BHP (95% of Exchange Amt.)	$562	$544	$509
Estimated Loss Ratio- Silver Plan	82.7%	82.7%	82.7%
Estimated PMPM Claims- Silver Plan (100% Morbidity)	$573	$573	$573
Morbidity Adjustment	90%	90%	90%
Estimated Claims - 100% AV w/ Morbidity Adj	$737	$737	$737
AV for Cost Sharing Subsidy	94%	94%	87%
Maximum Cost Sharing (% of Claims)	6%	6%	13%
Maximum Cost Sharing for Enrollee($Dollars)	$44	$44	$96
Value of 70% to 100% AV Corridor w/ Morbidity Adjustment	$221	$221	$221
Cost Sharing Subidy Assuming Exchange Enrollment	$177	$177	$125
Cost Sharing Subsidy in BHP ($Dollars) = 95% x Exchange Amt.	$168	$168	$119
Total 2014 Estimated Federal Subsidy	$730	$712	$628

Once the Silver plan premium is developed, the subsidy estimate is a generally a mechanical calculation, other than an assumption needs to be made for the relative morbidity between the Commercial Exchange enrollees and the BHP enrollees. Of significance in the calculation is that the Federal subsidies do vary fairly widely between the three enrollee segments which does highlight that if the mix of actual enrollees by income level is not consistent with expectations, a certain amount of risk is introduced into the BHP.

Enrollee Premiums

We have assumed enrollees would not make a premium contribution. Note for NJ FamilyCare, when enrollment was opened to those with incomes of 150-200% FPL, contributions were $43

per month for the first parent and $21.50 for the second parent[3]. There is an opportunity to increase modeled BHP revenues by requiring premium contributions from enrollees subject to ACA limits.

Revenue Trends

Premiums for Silver plans are assumed to increase at a rate between 6% and 8% that varies by scenario. Revenues to the BHP are assumed to trend at a slightly higher rate since incomes are assumed to trend at 3% (a rate lower than premium trends for all scenarios) meaning the tax credits would increase at a higher rate than premiums since tax credits are based on the actual premiums less the income based enrollee premium contribution calculated as if enrollee had Exchange coverage.

2014 BHP Medical Costs

The BHP medical costs are assumed to equal the Commercial medical costs with AV, morbidity and provider reimbursement adjustments. The 2014 PMPM medical cost estimate for all BHP enrollees is illustrated below for the "Middle" scenario. Note that the morbidity and BHP/Commercial provider reimbursement assumptions vary by scenario in our modeling.

Table 5
2014 PMPM BHP Medical Cost Estimate

Estimated 2014 Commercial 100% AV Claim Cost PMPM	$819
BHP AV	95%
BHP Morbidity Adj	90%
BHP/Commercial Reimbursement	0.75
Estimated 2014 BHP PMPM Claims Cost	$525

BHP/Commercial Reimbursement

The relationship between the BHP and Commercial provider reimbursement is critical. At a very basic level, the economics of a BHP (as modeled) are feasible only if provider reimbursement is at lower levels than reimbursement for Commercial programs. The lower provider reimbursement is the mechanism that compensates for the fact that the Federal subsidies are lower (95% of Exchange levels), premium contributions (as modeled) are lower, and benefits are richer due to lower cost sharing than would exist if BHP enrollees were enrolled in an Exchange plan.

[3] NJ FamilyCare Income Eligibility and Cost.. http://www.njfamilycare.org/pages/whatItCosts.html (Accessed May 2012)

Reimbursement will likely need to be higher than Medicaid levels to build a sufficient provider network that will also satisfy consumers. It is important to note that in the absence of a BHP many consumers would likely enroll in an Exchange plan with higher reimbursement to providers, as well as higher costs to consumers. Without a BHP, we would also expect fewer lower income individuals to have insurance coverage, and that those without coverage would have less of a capacity to utilize medical services or pay medical providers.
It is difficult to determine the current relationship between Medicaid and Commercial reimbursement, primarily because detailed provider contracting information is proprietary for both the Commercial and Medicaid markets, and there is not a practical mechanism to allow us to calculate this Medicaid/ Commercial relationship at a carrier or market level. Based on Horizon's direct access rate filing claims data and adult Medicaid claims cost information for similar periods of time (around 12 months ending June 30, 2011 or SFY11), after adjusting for estimated benefit, demographic, and morbidity differences, we developed a rough estimate that Medicaid reimbursement is currently a little more than half of Commercial reimbursement as shown below.

Table 6
Estimate of Ratio of Average Medicaid to Commercial Reimbursement

Midpt of SFY11	1/1/2011	Horizon	Adult
Hzn Base Period Experience midpt.	11/1/2010	DA PPO Plans	Medicaid
	Base Period-	5/1/2010 to 4/30/2011	7/1/2010 to 6/30/2011
	Base Period Claims	$412.98	$202.98
	Base Period Trend Adj	1.011	1.000
	SFY 11 Claims Costs	$417.68	$202.98
	Estimated AV	72%	95%
	AV Adjustment to Medicaid	1.31	
	Demographic Adj	0.99	
	Morbidity Adj (Commercial to Adult Medicaid)	0.70	
	Implied Medicaid to Commercial Reimbursement Adjustment	0.53	
	Cost of Adult Medicaid Benefits at Medicaid Reimbursement	$202.98	

We have assumed that a Medicaid/ Commercial reimbursement ratio of 0.5 is the starting point, and floor for our analysis. As we noted, it is unlikely providers would be willing to accept BHP reimbursement at Medicaid levels, and ACA changes increasing Medicaid primary care reimbursement to Medicare levels for two years would also increase the current Medicaid/Commercial reimbursement ratio. In our modeling, we have assumed that the Medicaid/Commercial reimbursement ratio is between 0.65 and 0.95 in the modeled scenarios.

With regard to setting the "right" level of BHP reimbursement, the State will need to put significant thought into what is a sensitive issue. We would recommend that this thought include serious discussions with the provider community, consumers, and potential BHP offerors.

Medical Cost Trends

After 2014, we have assumed that BHP medical costs will trend at rates that are between 0% and 2% lower than the second lowest cost Silver plan premiums, consistent with how government programs generally have slightly lower trends than Commercial plans. This assumption improves the financial viability over time of a BHP since it results in trending claims at a lower rate than Commercial premiums under some of the scenarios modeled.

Administrative Costs

Included in the SFY 2012 Capitation Rates for adult Medicaid/NJ FamilyCare enrollees, there is an expense allowance of approximately 12% which includes 2% for premium taxes and 2% for carrier profit. For the purposes of our modeling, we have assumed that the total expenses for the BHP will be 10% to 15% varying by scenario. With regard to expenses, there are certain offeror expenses that would be part of the capitation or premiums paid from the State to the offeror, as well as State costs for administration and oversight of the program.

Our modeling assumes that the Federal subsidies can be used to pay for the State's costs of administering the program which should properly be thought of as the incremental costs of administering the BHP, or costs in excess of those associated with administering coverage in the Exchange, and perhaps other social programs (i.e., for those who would not elect Exchange coverage, but would elect BHP coverage) for BHP eligible enrollees in the absence of a BHP.

As noted later in the report, whether or not State administrative costs for a BHP could be paid out of Federal subsidies is unclear, but language in the ACA states: "USE OF FUNDS.—A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals…"[4] Therefore, we believe that it is reasonable to assume that BHP administrative costs incurred by the State could be paid out of Federal subsidies under our modeling where no premiums are charged for the BHP, or alternatively they could be recovered through a premium charge to BHP enrollees.

[4] ACA Section 1331(d)(2)

5

BHP Modeling Results and Discussion

As previously noted, to account for the significant uncertainty in BHP revenues and costs, we have used a scenario approach to test the sensitivity of results to changes in assumptions. The assumptions that we varied are explained briefly below:

Enrollment and Enrollment Growth – The number of BHP enrollees is uncertain, as is the timing of when BHP eligibles may enroll in the program. We have varied our projected enrollment to reflect this uncertainty.

Commercial Claim Cost and Premium Trends – Claim Costs and Premiums for the second lowest cost Silver plan would be expected to increase with medical cost trends. We have varied the trend rates for these premiums and costs since they largely determine the BHP revenues.

BHP Claim Cost Trend Differential – The BHP program could have medical cost trends that are lower than Commercial trends and we have assumed lower trends in the BHP under the more optimistic scenarios

BHP/ Commercial Reimbursement – We have assumed that the BHP will reimburse providers at lower rates than Commercial plans and have varied this ratio under the modeled scenarios.

Admin % of Premiums to BHP MCOs – Administrative costs as a percentage of premiums to MCOs who offer BHP coverage vary by scenario, the actual admin costs is calculated as the [(Claim Costs)/(1-Admin %) - Claim Costs], and this amount is assumed to include any State costs in administering the plan in our modeling.

BHP Enrollee Wage Growth – Enrollees in the BHP would pay premiums based on their actual income as a percentage of FPL if enrolled in the Exchange. The wage growth assumption is 3% annually for all scenarios and it impacts the Federal subsidies paid to the State for the BHP.

BHP / Commercial Morbidity Adjustment – This adjustment is made to approximate the relative morbidity and claims costs of BHP enrollees relative to Commercial enrollees, all else equal. Our modeling assumes robust risk adjustment program so premiums and claims for BHP enrollees are both adjusted based on this morbidity assumption.

Modeling Results and Discussion

The assumptions and results of our modeling are shown in the table below and discussed in the remainder of this section.

Table 7
Modeling Results and Assumptions

	Results			
	Low	Middle	High	Pessimistic
2014 Enrollment: Legal Immigrants <138% FPL	20,000	25,000	30,000	50,000
2014 Enrollment: Incomes 138-200% FPL	42,000	46,000	55,000	92,000
Annual Enrollment Growth	0%	1%	2%	3%
Commercial Cost and Premium Trends	6%	7%	8%	10%
BHP Claim Cost Trend Differential	-2%	-1%	0%	0%
BHP/ Commercial Reimbursement	0.65	0.75	0.85	0.95
Admin as % of Premiums to BHP MCOs	10.0%	12.2%	15.0%	15.0%
BHP Enrollee Wage Growth	0.03	3%	3%	3%
BHP/ Commercial Morbidity Adjustment	100%	90%	80%	70%
Yr. 1 Surplus PMPM	$192	$77	-$29	-$97
Yr. 1 Surplus $s	$142,960,459	$65,522,028	-$29,561,488	-$165,293,838
Yr. 1 Fed Subsidy	$560,894,833	$574,985,629	$605,118,008	$871,605,554
Yr. 1 Surplus - % of Yr. 1 Subsidy	25%	11%	-5%	-19%
Yrs. 1-5 Surplus PMPM	$246	$108	-$27	-$109
Yrs. 1-5 Surplus $s	$913,976,467	$469,220,844	-$142,756,111	-$983,329,269
Yrs. 1-5 Fed Subsidy	$3,177,643,846	$3,402,522,700	$3,744,386,708	$5,776,182,696
Yrs. 1-5 Surplus - % of BHP Premium	29%	14%	-4%	-17%

NOTE SURPLUS WILL NEED TO BE ELIMINATED THROUGH RICHER BENEFITS OR BETTER PROVIDER REIMBURSEMENT

In reviewing the chart above, note that the “Surplus” shown is simply the result of modeling revenues, claims, and expenses as described in the following section. Federal BHP funds are actually held in trust for the BHP use only, so any “Surplus” would need to be used to pay plan expenses, enhance benefits through reduced cost sharing, or be returned to the Federal government, though it is unclear what level of and how long “Surplus” funds may be held in the BHP trust prior to being returned to the Federal government.

The obvious takeaway of the summarized results is that BHP reimbursement needs to be limited to somewhere between 75% and 85% of Commercial reimbursement in order for the BHP to break even.

In looking at the model results in more detail, some other noteworthy results emerge, including:

- At higher levels of BHP provider reimbursement relative to Commercial, the plan is not feasible
- Surpluses grow (and deficits shrink) moderately in later projection years which is a by-product of revenues trending at a higher rate than Commercial premium trends, and BHP claims trending lower than Commercial claims (and premiums)
- Because reimbursement varies by the three BHP enrollee segments (legal immigrants <138% FPL, enrollees 138 - 150% FPL, and enrollees 150% - 200% FPL), the mix of enrollees becomes important under the modeling assumptions. We note under the "High" scenario, the immigrant <138% FPL segment actually shows a slight surplus where as the other enrollees show a deficit.

Some additional observations from our modeling and follow-up recommendations are shown in the following section.

6

BHP Risks, Recommendations, and Conclusion

Key Risks and Recommendations

Key BHP Risks that have been identified and should be further explored, and mitigated prior to implementing a BHP include the following:

1. State May Incur Unreimbursed Administrative Costs

As noted previously, whether Federal funds can be used to pay State administrative costs for BHP oversight is unclear based on the ACA, and guidance provided to date. Therefore, the State needs to determine and quantify what, if any, unreimbursed BHP administrative costs the State would need to pay should it implement a BHP.

2. Providers May Not Deem BHP Reimbursement Sufficient

In order to be feasible, the BHP provider reimbursement will need to be at levels lower than Commercial levels. Should the BHP reimbursement be deemed to be too low by providers, issues related to provider dissatisfaction with low reimbursement could manifest themselves in many ways, including not participating in BHP networks, which could create access and consumer issues. In order to address this issue, we would recommend discussing the likely operation and reimbursement under a potential BHP with providers, so that providers will understand the impact of BHP enrollment on their revenues relative to the alternative of individuals who may have been eligible for a BHP enrolling in an Exchange plan, or possibly being uninsured.

3. Consumers Could View BHP as an Inferior Option to Exchange Plans

Consumers would be attracted to a BHP plan with better benefits than an Exchange plan at a lower cost. The BHP may have more restrictive networks, and the cost/access tradeoff needs to be dealt with appropriately so that BHP eligibles do not view their product as inferior to the Exchange products. This is especially important since the existence of the BHP, would exclude a BHP eligible individual from enrolling in an Exchange plan even if enrollment in an Exchange plan would be the eligible individual's preference.

4. Health Plans May Not Participate in the BHP Without Adequate Compensation for Their Risks

Assuming that the BHP is administered in a manner similar to a managed Medicaid plan, health plans will need to receive adequate reimbursement to assure that they can set up sufficient networks, and be compensated for their administrative costs, capital investments, and insurance

risk, otherwise they may not participate. Should BHP revenues to health plans in addition to the states be risk adjusted, there exists a potential for State revenues to be adjusted downward which is a risk to health plans that would need to be addressed.

5. The State Makes Up Deficit if BHP Costs Exceed Revenues

If Federal funds are not sufficient to pay for BHP administrative and capitation payments to MCOs (assuming a managed model), the State will need to cover the difference. While this scenario seems unlikely under a capitated model to participating offerors, BHP revenues are risk adjusted, and the amount and timing of retrospective (and retroactive) Federal payment adjustments could create some State exposure to losses. Therefore, the timing and amounts of Federal payments and adjustments needs to be fully understood once this information is finalized by the Federal government.

Assuming a managed model, capitation rates to participating carriers may need to include a provision to pass through revenue adjustments to offerors, which may also need to be passed through to participating providers. The relatively high individual premiums for IHC Standard plans create the real possibility that initial Exchange premiums may reflect a risk profile of expected insureds that is actually worse than the risk profile of BHP enrollees, and risk adjustments that may actually reduce BHP revenues.

6. Exchange Is Impacted by Existence of a BHP

The existence of a BHP certainly would impact Exchange enrollment, since without a BHP, some of those who would have enrolled in a BHP would enroll in the Exchange, and this could have an impact on the risk profile of Exchange enrollees and premiums within the Exchange. Lower enrollment within the Exchange will also increase per member administrative costs since they would be spread over fewer members which might impact the Exchange's sustainability. The impact of a BHP on exchange risks, premiums, and sustainability should be studied by the State, but is beyond the scope of this analysis.

Conclusion

Our financial modeling does indicate the real potential for a BHP to be able to provide a richer level of benefits at a lower cost to low income individuals not eligible for Medicaid than these individuals would be able to obtain through an Exchange plan. In addition, the continuity that could be provided to the transient Medicaid population does have real value to those individuals, and possibly to the State.

However, our analysis also indicates some significant risks associated with a BHP plan as outlined in this section. Some of these risks are related to currently having incomplete information regarding Federal rules for the use of Federal funds for BHP administrative costs, as well as the mechanisms for risk adjustment and reinsurance. This lack of information will be addressed through the passage of time as additional information is disseminated by the Federal government. There will also be ongoing risks to the State since it will essentially become the

risk-bearing entity for the BHP as it receives Federal revenues, and must provide medical services directly or indirectly to BHP enrollees. The amount of risk that the State may bear with a BHP, is also somewhat dependent upon Federal rules regarding the extent to which the State may keep BHP funds in trust as a reserve to stabilize potential loss exposure.

While the BHP has the potential to be a valuable tool to help low income residents of New Jersey obtain and maintain affordable health coverage, we would recommend that the State address the risks outlined in this section as part of its vetting process to determine whether it is prudent to establish a BHP in New Jersey.

Appendix 1

ACA Text

able during the period beginning with 2014 and ending with 2019.

(2) ALLOCATION.—The Secretary shall allocate the amount appropriated under paragraph (1) among the territories for purposes of carrying out this section as follows:

(A) For Puerto Rico, $925,000,000.

(B) For another territory, the portion of $75,000,000 specified by the Secretary.

SEC. 1324 [42 U.S.C. 18044]. LEVEL PLAYING FIELD.

(a) IN GENERAL.—**[***As revised by section 10104(n)***]** Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, or a multi-State qualified health plan under section 1334, is not subject to such law.

(b) LAWS DESCRIBED.—The Federal and State laws described in this subsection are those Federal and State laws relating to—

(1) guaranteed renewal;
(2) rating;
(3) preexisting conditions;
(4) non-discrimination;
(5) quality improvement and reporting;
(6) fraud and abuse;
(7) solvency and financial requirements;
(8) market conduct;
(9) prompt payment;
(10) appeals and grievances;
(11) privacy and confidentiality;
(12) licensure; and
(13) benefit plan material or information.

PART 4—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

SEC. 1331 [42 U.S.C. 18051]. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 1302(b).

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan.

(b) STANDARD HEALTH PLAN.—In this section, the term "standard heath plan" means a health benefits plan that the State contracts with under this section—

(1) under which the only individuals eligible to enroll are eligible individuals;

(2) that provides at least the essential health benefits described in section 1302(b); and

(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(c) CONTRACTING PROCESS.—

(1) IN GENERAL.—A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 1302(b).

(2) SPECIFIC ITEMS TO BE CONSIDERED.—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) INNOVATION.—Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including—

(i) care coordination and care management for enrollees, especially for those with chronic health conditions;

(ii) incentives for use of preventive services; and

(iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.

(B) HEALTH AND RESOURCE DIFFERENCES.—Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.

(C) MANAGED CARE.—Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.

(D) PERFORMANCE MEASURES.—Establishing specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.

(3) ENHANCED AVAILABILITY.—

(A) MULTIPLE PLANS.—A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(4) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

(d) TRANSFER OF FUNDS TO STATES.—

(1) IN GENERAL.—If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined under paragraph (3).

(2) USE OF FUNDS.—A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits

for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

(3) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—[*As revised by section 10104(o)(1)*] The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is 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.

(ii) SPECIFIC REQUIREMENTS.—The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified 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. This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty.

(iii) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(B) CORRECTIONS.—The Secretary shall adjust the payment for any fiscal year to reflect any error in the de-

terminations under subparagraph (A) for any preceding fiscal year.

(4) APPLICATION OF SPECIAL RULES.—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) ELIGIBLE INDIVIDUAL.—

(1) IN GENERAL.—In this section, the term "eligible individual" means, with respect to any State, an individual—

(A) who a resident of the State who is not eligible to enroll in the State's medicaid program under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b);

(B) ⟦*As revised by section 10104(o)(2)*⟧ whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved, or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2) of such Code); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE.—An eligible individual shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.

(f) SECRETARIAL OVERSIGHT.—The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

(1) eligibility verification requirements for participation in the program;

(2) the requirements for use of Federal funds received by the program; and

(3) the quality and performance standards under this section.

(g) STANDARD HEALTH PLAN OFFERORS.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.

(h) DEFINITIONS.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

SEC. 1332 [42 U.S.C. 18052]. WAIVER FOR STATE INNOVATION.

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promul-

Appendix 2

Other Basic Health Program Analyses

Mercer. "State of California Financial Feasibility of a Basic Health Program." Prepared with finding from the California HealthCare Foundation. June 28, 2011.

Mercer, Oliver Wyman and Health Management Associates. "Health Insurance Exchange Planning Report, The State of Connecticut." January 19, 2012.

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Appendix 3

Additional Scenario Results

Immigrants < 138% FPL **Low Scenario**

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$ 195,549,851	$ 121,335,786	$ 13,481,754	$ 60,732,311
2015	$ 207,511,949	$ 126,189,217	$ 14,021,024	$ 67,301,707
2016	$ 220,198,646	$ 131,236,786	$ 14,581,865	$ 74,379,995
2017	$ 233,653,624	$ 136,486,258	$ 15,165,140	$ 82,002,227
2018	$ 247,923,193	$ 141,945,708	$ 15,771,745	$ 90,205,740
2019	$ 263,056,447	$ 147,623,536	$ 16,402,615	$ 99,030,295
2020	$ 279,105,431	$ 153,528,478	$ 17,058,720	$ 108,518,234
2021	$ 296,125,323	$ 159,669,617	$ 17,741,069	$ 118,714,637
2022	$ 314,174,615	$ 166,056,401	$ 18,450,711	$ 129,667,502
2023	$ 333,315,318	$ 172,698,657	$ 19,188,740	$ 141,427,920

Enrollees 138%-200% FPL **Low Scenario**

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$ 365,344,982	$ 254,805,151	$ 28,311,683	$ 82,228,148
2015	$ 388,484,403	$ 264,997,357	$ 29,444,151	$ 94,042,896
2016	$ 413,048,752	$ 275,597,251	$ 30,621,917	$ 106,829,584
2017	$ 439,124,619	$ 286,621,141	$ 31,846,793	$ 120,656,685
2018	$ 466,803,827	$ 298,085,987	$ 33,120,665	$ 135,597,176
2019	$ 496,183,740	$ 310,009,426	$ 34,445,492	$ 151,728,822
2020	$ 527,367,597	$ 322,409,803	$ 35,823,311	$ 169,134,483
2021	$ 560,464,872	$ 335,306,195	$ 37,256,244	$ 187,902,432
2022	$ 595,591,639	$ 348,718,443	$ 38,746,494	$ 208,126,702
2023	$ 632,870,978	$ 362,667,181	$ 40,296,353	$ 229,907,444

Immigrants < 138% FPL - PMPM

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$814.79	$505.57	$56.17	$253.05
2015	$864.63	$525.79	$58.42	$280.42
2016	$917.49	$546.82	$60.76	$309.92
2017	$973.56	$568.69	$63.19	$341.68
2018	$1,033.01	$591.44	$65.72	$375.86
2019	$1,096.07	$615.10	$68.34	$412.63
2020	$1,162.94	$639.70	$71.08	$452.16
2021	$1,233.86	$665.29	$73.92	$494.64
2022	$1,309.06	$691.90	$76.88	$540.28
2023	$1,388.81	$719.58	$79.95	$589.28

Enrollees 138%-200% FPL - PMPM

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$724.89	$505.57	$56.17	$163.15
2015	$770.80	$525.79	$58.42	$186.59
2016	$819.54	$546.82	$60.76	$211.96
2017	$871.28	$568.69	$63.19	$239.40
2018	$926.20	$591.44	$65.72	$269.04
2019	$984.49	$615.10	$68.34	$301.05
2020	$1,046.36	$639.70	$71.08	$335.58
2021	$1,112.03	$665.29	$73.92	$372.82
2022	$1,181.73	$691.90	$76.88	$412.95
2023	$1,255.70	$719.58	$79.95	$456.17

Immigrants <138% FPL - % of Federal Subsidy

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	100.0%	62.0%	6.9%	31.1%
2015	100.0%	60.8%	6.8%	32.4%
2016	100.0%	59.6%	6.6%	33.8%
2017	100.0%	58.4%	6.5%	35.1%
2018	100.0%	57.3%	6.4%	36.4%
2019	100.0%	56.1%	6.2%	37.6%
2020	100.0%	55.0%	6.1%	38.9%
2021	100.0%	53.9%	6.0%	40.1%
2022	100.0%	52.9%	5.9%	41.3%
2023	100.0%	51.8%	5.8%	42.4%

Enrollees 138%-200% FPL - % of Federal Subsidy

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	100.0%	69.7%	7.7%	22.5%
2015	100.0%	68.2%	7.6%	24.2%
2016	100.0%	66.7%	7.4%	25.9%
2017	100.0%	65.3%	7.3%	27.5%
2018	100.0%	63.9%	7.1%	29.0%
2019	100.0%	62.5%	6.9%	30.6%
2020	100.0%	61.1%	6.8%	32.1%
2021	100.0%	59.8%	6.6%	33.5%
2022	100.0%	58.5%	6.5%	34.9%
2023	100.0%	57.3%	6.4%	36.3%

Immigrants < 138% FPL **Middle Scenario**

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$ 219,086,700	$ 157,503,184	$ 21,885,408	$ 39,698,108
2015	$ 237,152,660	$ 168,622,909	$ 23,430,518	$ 45,099,234
2016	$ 256,692,086	$ 180,527,686	$ 25,084,713	$ 51,079,687
2017	$ 277,824,511	$ 193,272,940	$ 26,855,693	$ 57,695,877
2018	$ 300,679,144	$ 206,918,010	$ 28,751,705	$ 65,009,428
2019	$ 325,395,643	$ 221,526,422	$ 30,781,576	$ 73,087,646
2020	$ 352,124,967	$ 237,166,187	$ 32,954,755	$ 82,004,025
2021	$ 381,030,284	$ 253,910,120	$ 35,281,361	$ 91,838,804
2022	$ 412,287,961	$ 271,836,174	$ 37,772,225	$ 102,679,562
2023	$ 446,088,626	$ 291,027,808	$ 40,438,944	$ 114,621,874

Enrollees 138%-200% FPL **Middle Scenario**

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$ 355,898,929	$ 289,805,858	$ 40,269,151	$ 25,823,920
2015	$ 386,417,492	$ 310,266,152	$ 43,112,153	$ 33,039,187
2016	$ 419,471,342	$ 332,170,942	$ 46,155,871	$ 41,144,529
2017	$ 455,267,997	$ 355,622,210	$ 49,414,476	$ 50,231,311
2018	$ 494,031,839	$ 380,729,139	$ 52,903,138	$ 60,399,563
2019	$ 536,005,479	$ 407,608,616	$ 56,638,099	$ 71,758,764
2020	$ 581,451,234	$ 436,385,784	$ 60,636,749	$ 84,428,701
2021	$ 630,652,722	$ 467,194,620	$ 64,917,704	$ 98,540,398
2022	$ 683,916,590	$ 500,178,561	$ 69,500,893	$ 114,237,136
2023	$ 741,574,370	$ 535,491,167	$ 74,407,656	$ 131,675,546

Immigrants < 138% FPL - PMPM

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$730.29	$525.01	$72.95	$132.33
2015	$782.68	$556.51	$77.33	$148.84
2016	$838.78	$589.90	$81.97	$166.91
2017	$898.85	$625.30	$86.89	$186.66
2018	$963.16	$662.81	$92.10	$208.24
2019	$1,032.01	$702.58	$97.63	$231.80
2020	$1,105.73	$744.74	$103.48	$257.51
2021	$1,184.65	$789.42	$109.69	$285.53
2022	$1,269.14	$836.79	$116.27	$316.08
2023	$1,359.59	$886.99	$123.25	$349.34

Enrollees 138%-200% FPL - PMPM

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$644.74	$525.01	$72.95	$46.78
2015	$693.10	$556.51	$77.33	$59.26
2016	$744.94	$589.90	$81.97	$73.07
2017	$800.50	$625.30	$86.89	$88.32
2018	$860.06	$662.81	$92.10	$105.15
2019	$923.90	$702.58	$97.63	$123.69
2020	$992.31	$744.74	$103.48	$144.09
2021	$1,065.62	$789.42	$109.69	$166.50
2022	$1,144.18	$836.79	$116.27	$191.12
2023	$1,228.35	$886.99	$123.25	$218.11

Immigrants <138% FPL - % of Federal Subsidy

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	100.0%	71.9%	10.0%	18.1%
2015	100.0%	71.1%	9.9%	19.0%
2016	100.0%	70.3%	9.8%	19.9%
2017	100.0%	69.6%	9.7%	20.8%
2018	100.0%	68.8%	9.6%	21.6%
2019	100.0%	68.1%	9.5%	22.5%
2020	100.0%	67.4%	9.4%	23.3%
2021	100.0%	66.6%	9.3%	24.1%
2022	100.0%	65.9%	9.2%	24.9%
2023	100.0%	65.2%	9.1%	25.7%

Enrollees 138%-200% FPL - % of Federal Subsidy

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	100.0%	81.4%	11.3%	7.3%
2015	100.0%	80.3%	11.2%	8.6%
2016	100.0%	79.2%	11.0%	9.8%
2017	100.0%	78.1%	10.9%	11.0%
2018	100.0%	77.1%	10.7%	12.2%
2019	100.0%	76.0%	10.6%	13.4%
2020	100.0%	75.1%	10.4%	14.5%
2021	100.0%	74.1%	10.3%	15.6%
2022	100.0%	73.1%	10.2%	16.7%
2023	100.0%	72.2%	10.0%	17.8%

Immigrants < 138% FPL **High Scenario**

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$ 232,483,304	$ 190,403,849	$ 33,600,679	$ 8,478,776
2015	$ 256,687,831	$ 209,748,880	$ 37,014,508	$ 9,924,443
2016	$ 283,381,099	$ 231,059,366	$ 40,775,182	$ 11,546,551
2017	$ 312,817,461	$ 254,534,998	$ 44,917,941	$ 13,364,522
2018	$ 345,277,186	$ 280,395,753	$ 49,481,604	$ 15,399,829
2019	$ 381,069,099	$ 308,883,962	$ 54,508,934	$ 17,676,202
2020	$ 420,533,485	$ 340,266,572	$ 60,047,042	$ 20,219,870
2021	$ 464,045,289	$ 374,837,656	$ 66,147,822	$ 23,059,812
2022	$ 512,017,645	$ 412,921,162	$ 72,868,440	$ 26,228,043
2023	$ 564,905,755	$ 454,873,952	$ 80,271,874	$ 29,759,929

Enrollees 138%-200% FPL **High Scenario**

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$ 372,634,704	$ 349,073,723	$ 61,601,245	$ (38,040,264)
2015	$ 413,207,498	$ 384,539,613	$ 67,859,932	$ (39,192,046)
2016	$ 458,039,772	$ 423,608,838	$ 74,754,501	$ (40,323,567)
2017	$ 507,571,234	$ 466,647,496	$ 82,349,558	$ (41,425,820)
2018	$ 562,286,620	$ 514,058,881	$ 90,716,273	$ (42,488,534)
2019	$ 622,720,285	$ 566,287,264	$ 99,933,047	$ (43,500,025)
2020	$ 689,461,261	$ 623,822,049	$ 110,086,244	$ (44,447,033)
2021	$ 763,158,833	$ 687,202,370	$ 121,271,006	$ (45,314,544)
2022	$ 844,528,682	$ 757,022,130	$ 133,592,141	$ (46,085,589)
2023	$ 934,359,654	$ 833,935,579	$ 147,165,102	$ (46,741,027)

Immigrants < 138% FPL - PMPM

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$645.79	$528.90	$93.34	$23.55
2015	$699.04	$571.21	$100.80	$27.03
2016	$756.60	$616.91	$108.87	$30.83
2017	$818.82	$666.26	$117.58	$34.98
2018	$886.06	$719.56	$126.98	$39.52
2019	$958.74	$777.13	$137.14	$44.47
2020	$1,037.28	$839.30	$148.11	$49.87
2021	$1,122.16	$906.44	$159.96	$55.76
2022	$1,213.89	$978.96	$172.76	$62.18
2023	$1,313.02	$1,057.27	$186.58	$69.17

Enrollees 138%-200% FPL - PMPM

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$564.60	$528.90	$93.34	-$57.64
2015	$613.80	$571.21	$100.80	-$58.22
2016	$667.05	$616.91	$108.87	-$58.72
2017	$724.69	$666.26	$117.58	-$59.15
2018	$787.07	$719.56	$126.98	-$59.47
2019	$854.57	$777.13	$137.14	-$59.70
2020	$927.61	$839.30	$148.11	-$59.80
2021	$1,006.63	$906.44	$159.96	-$59.77
2022	$1,092.12	$978.96	$172.76	-$59.60
2023	$1,184.59	$1,057.27	$186.58	-$59.26

Immigrants <138% FPL - % of Federal Subsidy

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	100.0%	81.9%	14.5%	3.6%
2015	100.0%	81.7%	14.4%	3.9%
2016	100.0%	81.5%	14.4%	4.1%
2017	100.0%	81.4%	14.4%	4.3%
2018	100.0%	81.2%	14.3%	4.5%
2019	100.0%	81.1%	14.3%	4.6%
2020	100.0%	80.9%	14.3%	4.8%
2021	100.0%	80.8%	14.3%	5.0%
2022	100.0%	80.6%	14.2%	5.1%
2023	100.0%	80.5%	14.2%	5.3%

Enrollees 138%-200% FPL - % of Federal Subsidy

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	100.0%	93.7%	16.5%	-10.2%
2015	100.0%	93.1%	16.4%	-9.5%
2016	100.0%	92.5%	16.3%	-8.8%
2017	100.0%	91.9%	16.2%	-8.2%
2018	100.0%	91.4%	16.1%	-7.6%
2019	100.0%	90.9%	16.0%	-7.0%
2020	100.0%	90.5%	16.0%	-6.4%
2021	100.0%	90.0%	15.9%	-5.9%
2022	100.0%	89.6%	15.8%	-5.5%
2023	100.0%	89.3%	15.8%	-5.0%

Immigrants < 138% FPL **Pessimistic Scenario**

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$ 336,770,947	$ 310,339,607	$ 54,765,813	$ (28,334,472)
2015	$ 382,938,035	$ 351,614,774	$ 62,049,666	$ (30,726,406)
2016	$ 435,329,176	$ 398,379,539	$ 70,302,272	$ (33,352,634)
2017	$ 494,777,277	$ 451,364,018	$ 79,652,474	$ (36,239,214)
2018	$ 562,226,329	$ 511,395,432	$ 90,246,253	$ (39,415,356)
2019	$ 638,746,205	$ 579,411,025	$ 102,249,004	$ (42,913,824)
2020	$ 725,549,420	$ 656,472,691	$ 115,848,122	$ (46,771,393)
2021	$ 824,010,126	$ 743,783,559	$ 131,255,922	$ (51,029,355)
2022	$ 935,685,630	$ 842,706,772	$ 148,712,960	$ (55,734,102)
2023	$ 1,062,340,779	$ 954,786,773	$ 168,491,783	$ (60,937,777)

Enrollees 138%-200% FPL **Pessimistic Scenario**

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$ 534,834,606	$ 571,024,876	$ 100,769,096	$ (136,959,365)
2015	$ 612,383,505	$ 646,971,184	$ 114,171,385	$ (148,759,065)
2016	$ 700,637,136	$ 733,018,352	$ 129,356,180	$ (161,737,396)
2017	$ 801,043,023	$ 830,509,793	$ 146,560,552	$ (176,027,322)
2018	$ 915,242,661	$ 940,967,595	$ 166,053,105	$ (191,778,040)
2019	$ 1,045,097,400	$ 1,066,116,285	$ 188,138,168	$ (209,157,053)
2020	$ 1,192,717,783	$ 1,207,909,751	$ 213,160,544	$ (228,352,513)
2021	$ 1,360,496,782	$ 1,368,561,748	$ 241,510,897	$ (249,575,863)
2022	$ 1,551,147,473	$ 1,550,580,461	$ 273,631,846	$ (273,064,834)
2023	$ 1,767,745,717	$ 1,756,807,662	$ 310,024,882	$ (299,086,827)

Immigrants < 138% FPL - PMPM

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$561.28	$517.23	$91.28	-$47.22
2015	$619.64	$568.96	$100.40	-$49.72
2016	$683.90	$625.85	$110.44	-$52.40
2017	$754.65	$688.44	$121.49	-$55.27
2018	$832.55	$757.28	$133.64	-$58.37
2019	$918.31	$833.01	$147.00	-$61.70
2020	$1,012.73	$916.31	$161.70	-$65.28
2021	$1,116.66	$1,007.94	$177.87	-$69.15
2022	$1,231.06	$1,108.73	$195.66	-$73.33
2023	$1,356.99	$1,219.61	$215.22	-$77.84

Enrollees 138%-200% FPL - PMPM

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	$484.45	$517.23	$91.28	-$124.06
2015	$538.54	$568.96	$100.40	-$130.82
2016	$598.20	$625.85	$110.44	-$138.09
2017	$664.01	$688.44	$121.49	-$145.91
2018	$736.58	$757.28	$133.64	-$154.34
2019	$816.59	$833.01	$147.00	-$163.42
2020	$904.78	$916.31	$161.70	-$173.23
2021	$1,002.00	$1,007.94	$177.87	-$183.81
2022	$1,109.14	$1,108.73	$195.66	-$195.25
2023	$1,227.20	$1,219.61	$215.22	-$207.63

Immigrants <138% FPL - % of Federal Subsidy

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	100.0%	92.2%	16.3%	-8.4%
2015	100.0%	91.8%	16.2%	-8.0%
2016	100.0%	91.5%	16.1%	-7.7%
2017	100.0%	91.2%	16.1%	-7.3%
2018	100.0%	91.0%	16.1%	-7.0%
2019	100.0%	90.7%	16.0%	-6.7%
2020	100.0%	90.5%	16.0%	-6.4%
2021	100.0%	90.3%	15.9%	-6.2%
2022	100.0%	90.1%	15.9%	-6.0%
2023	100.0%	89.9%	15.9%	-5.7%

Enrollees 138%-200% FPL - % of Federal Subsidy

	Federal Subsidy	Medical Costs	Admin Cost	Surplus/Deficit
2014	100.0%	106.8%	18.8%	-25.6%
2015	100.0%	105.6%	18.6%	-24.3%
2016	100.0%	104.6%	18.5%	-23.1%
2017	100.0%	103.7%	18.3%	-22.0%
2018	100.0%	102.8%	18.1%	-21.0%
2019	100.0%	102.0%	18.0%	-20.0%
2020	100.0%	101.3%	17.9%	-19.1%
2021	100.0%	100.6%	17.8%	-18.3%
2022	100.0%	100.0%	17.6%	-17.6%
2023	100.0%	99.4%	17.5%	-16.9%

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