

THE URBAN INSTITUTE 2100 M STREET, N.W. / WASHINGTON D.C. 20037

**Testimony of Stan Dorn, Urban Institute Senior
Fellow, concerning HB 6587**

**Before the Joint Committee on Human Services of
the Connecticut General Assembly**

March 15, 2011

Summary

Implementing the Basic Health Program (BH) option as proposed in HB 6587 would save the state of Connecticut more than \$50 million a year by substituting federal BH dollars for state spending on Medicaid. The only other way to realize these savings would make health care substantially less affordable for more than 10,000 low-income residents who qualify for HUSKY and Medicaid under current law.

Introduction

Committee chairs and members, thank you for this opportunity to testify. With support from the Universal Health Care Foundation of Connecticut, the Connecticut Health Foundation, and the Robert Wood Johnson Foundation, colleagues of mine at the Urban Institute and I have worked for several years to help a broad range of Connecticut stakeholders develop what became the SustiNet proposal. Dr. Jonathan Gruber of the Massachusetts Institute of Technology, one of the country's leading health economists, has collaborated in this work by estimating the cost and coverage effects of various policy options. Along with other consultants and literally hundreds of Connecticut volunteer experts, we helped the SustiNet Health Partnership Board of Directors (Board or SustiNet Board) as it worked for more than a year to prepare January's recommendations to the General Assembly.¹

One such recommendation urged Connecticut to implement the Basic Health Program (BH) option established by Section 1331 of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA). That recommendation enjoyed broad support on the SustiNet

¹ Report to the Connecticut General Assembly From the SustiNet Health Partnership Board of Directors, January 2011, http://www.ct.gov/sustinet/lib/sustinet/sn.final_report.appendix.cga.010711.pdf.

Board. Reflected in HB 6587, that policy approach is the subject of my testimony, which covers three topics:

- Federal requirements that apply to BH;
- The proposed approach to BH embodied in HB 6587; and
- The advantages and disadvantages of implementing BH in Connecticut using the approach recommended by the Sustinet Board.

Federal BH legislation

Section 1331 of the ACA allows a state to implement BH with citizens and legally resident adults whose income is at or below 200 percent of the federal poverty level (FPL) and who are ineligible for federally-matched Medicaid.² In Connecticut, BH could thus encompass three groups:

- *Adults who qualify for HUSKY under current law and whose income will exceed 133 percent FPL, as determined under the ACA.*³ This group consists primarily of parents, who now qualify for HUSKY up to 185 percent FPL. If Connecticut ends their Medicaid eligibility, these adults could qualify either for BH or subsidized coverage in the exchange.
- *Uninsured, low-income adults with incomes between 133 percent and 200 percent FPL.*
- *Lawfully resident immigrants with incomes at or below 133 percent FPL who are ineligible for federally-matched Medicaid, typically because they were legalized within the past five*

² Under the ACA, Medicaid will cover adults with incomes up to 133 percent FPL, beginning in 2014.

³ The method for determining income under the ACA will differ from current methods. As a result, some HUSKY parents who are currently classified as having income below 133 percent FPL will be classified as having income above that level beginning in 2014.

years. This group includes roughly 3,400 people now covered through the State Medical Assistance for Non-Citizens (SMANC) program, at state expense.⁴

When a state implements the BH option, beneficiaries do not receive subsidized coverage in the exchange. Rather, the state contracts with health plans or providers to furnish services that meet or exceed minimum standards specified in the ACA. Generally speaking, BH adults may not receive fewer benefits or pay more health care costs than would apply if they received subsidized coverage in the exchange. Nothing in federal law prevents states from going beyond these minimum requirements, however.

To pay for BH contracts, a state receives 95 percent of what the federal government would have spent in subsidies if BH adults had been covered through the exchange. The latter subsidies include federal income tax credits that pay premiums on a sliding scale, based on income; and federal out-of-pocket cost-sharing subsidies that increase the generosity of covered benefits. Federal BH dollars must be placed in a state trust fund and used only to provide BH members with health care.

Connecticut's proposed approach to Basic Health implementation

HB 6587 proposes to implement BH by extending HUSKY A (that is, Medicaid) to all adults who are citizens or legal residents and who have incomes at or below 200 percent FPL. All Medicaid benefits, cost-sharing protections, and consumer safeguards would apply. As required by federal law, the legislation would create a state trust fund for federal BH dollars.

The legislation would use a combination of Medicaid and BH to maximize the amount of federal funding received by Connecticut, as follows:

⁴ Jack Hoadley, *Policy Brief: Consequences Of Eliminating Health Benefits For Lawfully Residing Immigrants*, prepared by Georgetown University Health Policy Institute for the Connecticut Health Foundation, April 2009.

- Most childless adults with incomes at or below 133 percent FPL would receive enhanced Medicaid match as “newly eligible adults.” For 2014-2016, the federal government would pay 100 percent of their health care costs. The applicable Federal Medical Assistance Percentage (FMAP) would gradually decline from 100 percent to 90 percent, reaching the latter level in 2020 and remaining at 90 percent thereafter.
- Most parents with incomes at or below 133 percent FPL would receive standard Medicaid match, which is slated to return to 50 percent once federal fiscal relief ends later this year.
- Adults with incomes between 133 and 200 percent FPL would have all of their health care costs paid by federal funding through BH. Dr. Gruber has estimated that federal funding under BH will exceed baseline Medicaid costs for Connecticut adults by at least 6 to 13 percent, and probably by a larger margin. This is consistent with national estimates suggesting that, mainly because provider payment rates tend to exceed Medicaid levels in the private insurance plans on which federal subsidies (hence BH payments) will be based, federal BH dollars will exceed baseline Medicaid costs by an average of 29 percent.⁵
- Legally resident immigrants with incomes below 133 percent FPL who are ineligible for federally-matched Medicaid would likewise have all of their health care costs paid by federal BH funds. Today, many are covered entirely at state expense.

HB 6587 would use any excess of federal BH payment over baseline Medicaid costs to raise payment levels for Medicaid providers who care for BH members. As noted above, this is likely to result in a reimbursement rate increase of at least 6 to 13 percent.

⁵ Stan Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States*, prepared by the Urban Institute for the State Coverage Initiatives program of AcademyHealth, Robert Wood Johnson Foundation, March 2011, <http://www.statecoverage.org/files/TheBasicHealthProgramOptionUnderHealthReform.pdf>.

Advantages and disadvantages of this approach

The remainder of my testimony compares the approach taken by HB 6587 to three alternative policies:

1. Retaining current HUSKY/Medicaid eligibility while implementing federal health care reform for uninsured adults;
2. Using subsidized coverage through the exchange, rather than HUSKY/Medicaid funded through federal BH dollars, to cover low-income adults with incomes above 133 percent FPL and poor immigrants ineligible for federal Medicaid dollars; and
3. Using subsidized coverage through the exchange to cover such adults and providing state dollars to supplement federal subsidies and achieve the same level of benefits and cost-sharing protections formerly provided by Medicaid/HUSKY.

BH vs. retaining current Medicaid/HUSKY coverage

Implementing BH, as proposed in HB 6587, would substitute federal BH dollars for approximately \$50 million a year the state of Connecticut spends to provide HUSKY to parents with incomes above 133 percent FPL, according to Dr. Gruber's estimates. In addition, the legislation would substitute federal BH dollars for roughly \$10 million a year in state spending for legally present immigrants who are ineligible for Medicaid matching funds because they were granted favorable immigration status within the past five years.⁶

BH vs. moving low-income adults into the exchange

As a general rule, the above savings could be realized by moving adults with incomes above 133 percent FPL out of Medicaid and into the exchange, where they would qualify for

⁶ Connecticut Department of Social Services, *Testimony before the Appropriations Committee, Claudette J. Beaulieu, Deputy Commissioner for Programs*, November 15, 2010. Ms Beaulieu estimated such costs as equaling \$9.3 million in SFY 2010 and \$9.75 million in SFY 2011.

federal tax credits and out-of-pocket cost-sharing subsidies.⁷ **But moving HUSKY parents with incomes above 133 percent into the exchange rather than continuing their Medicaid/HUSKY coverage though BH would significantly increase these parents' health care costs without achieving any additional savings for state taxpayers.**

In addition to approximately 12,000 HUSKY-eligible parents, 32,000 other adults with incomes between 133 and 200 percent FPL would pay more for health care in the exchange than under the approach to BH reflected by HB 6587. On the other hand, many providers are likely to be paid more by private insurance in the exchange than by Medicaid, so plans in the exchange will probably have much broader provider networks. These and other trade-offs are described in the following analysis.

Affordability

Without BH, low-income adults could be covered through the exchange, where they would be asked to pay substantial amounts for premiums and out-of-pocket cost-sharing. Table 1 illustrates the premium costs that will apply, as well as the actuarial value of the coverage these adults will receive.

Table 1. Minimum premium costs and the actuarial value of coverage for a single, uninsured adult at various income levels qualifying for subsidies under ACA

Percentage of FPL	Monthly Pre-Tax Income	Minimum Monthly Premium	Actuarial Value
150	\$1,354	\$54.15	94%
175	\$1,579	\$81.34	87%
200	\$1,805	\$113.72	87%

Notes: Dollar amounts assume 2010 FPL levels. Actuarial value represents the average percentage of covered health care services paid by the insurer, taking into account deductibles, copayments, and co-insurance.

⁷ One possible exception involves Medicaid for lawfully present immigrants. It is not clear whether state policymakers have the legal authority to move these immigrants from Medicaid to the exchange, since terminating their Medicaid benefits has already been struck down by the courts as unconstitutional discrimination based on alienage. *Hong Pham V. Commissioner of Social Services*, SC 18582 (2009) is now pending before the Connecticut Supreme Court.

Actuarial value (AV) refers to the percentage of health care costs that an insurer pays for an average population by offering specific covered benefits, copayments, deductibles, co-insurance, and limits on OOP costs. Many combinations of cost-sharing rules and benefits fit each AV, complicating efforts to analyze the affordability of out-of-pocket costs for low-income consumers under ACA.

One potentially fruitful approach looks at examples of coverage at applicable AV levels. According to the Congressional Research Service (CRS),⁸ the typical, employer-sponsored Health Maintenance Organization has an AV of 93 percent, which is approximately the AV for adults in the exchange with incomes at or below 150 percent FPL. Such a plan has:

- No annual deductible;
- \$20 office visit co-payments;
- A \$250 co-payment for inpatient hospitalization; and
- Prescription drug co-payments of \$10, \$25, and \$45 for generic, preferred name-brand, and non-preferred name-brand drugs, respectively.

At the AV level for consumers with incomes between 150 and 200 percent FPL, the federal Blue Cross/Blue Shield plan has an AV of 87 percent, according to CRS, with coverage that involves:

- A \$250 annual deductible;
- \$15 office visit co-payments;
- A \$100 co-payment for inpatient hospitalization, plus a requirement to pay 10 percent of all remaining hospital costs;

⁸ Chris L. Peterson, *Setting and Valuing Health Insurance Benefits*, Congressional Research Service, April 6, 2009. The description in the text does not include out-of-pocket cost-sharing limits because the discussion focuses on the initial deterrent effect of cost-sharing on utilization of care, not on the cumulative financial burden of cost-sharing.

- A requirement to pay 10 percent of all laboratory and X-ray costs; and
- A requirement to pay 25 percent of all prescription drug costs.

Considerable evidence suggests that many low-income consumers will find these costs unaffordable. Many who do not foresee an immediate need for health insurance will be deterred from enrolling into coverage; and when low-income consumers do enroll, the amounts charged for using non-preventive services will delay and deter utilization of necessary care, sometimes with adverse health outcomes.⁹

HB 6587's implementation of the Basic Health option would avoid these problems. Consumers would be charged no more than whatever premiums and copayments apply under the Medicaid program, which federal law limits to nominal amounts.

Risk of adverse tax consequences

One other factor is likely to deter enrollment into subsidized coverage in the exchange. Premium subsidies in the exchange are provided in the form of tax credits advanced to insurers when monthly premiums are due. If credits provided during the year turn out to be too low, based on annual income reflected on federal tax returns, consumers receive a refund. But if tax credits are too high, beneficiaries must repay the excess, up to a “safe harbor” maximum that varies by income—\$600 for a family at or below 200 percent FPL, \$1,000 between 200 and 250 percent FPL, and so forth. Safe harbor amounts have already increased since the initial

⁹ See, e.g., Katherine Swartz, *Cost-sharing: Effects on Spending and Outcomes*, Research Synthesis Report No. 20, Robert Wood Johnson Foundation, December 2010; Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, March 2003; Bill J. Wright, Matthew J. Carlson, Heidi Allen, Alyssa L. Holmgren, and D. Leif Rustvold, “Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out,” *Health Affairs*, December 2010; 29(12):2311–2316; Dana P. Goldman, Geoffrey F. Joyce, and Yuhui Zheng, “Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health,” *Journal of the American Medical Association*, July 4, 2007; 298(1):61–69; Becky A. Briesacher, Jerry H. Gurwitz, and Stephen B. Soumerai, “Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature,” *Journal of General Internal Medicine*, June 2007; 22(6):864–871; Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences*, Kaiser Commission on Medicaid and the Uninsured, May 2005.

enactment of the ACA, and the House has recently passed legislation that would further increase such limits on low-income taxpayers' potential liability to the Internal Revenue Service (IRS).

Some low-income consumers may be deterred from seeking tax credits during the year because year-end reconciliation could endanger anticipated tax refunds or require payments to IRS that many low-income people might view as unaffordable. Such reconciliation is one reason why no more than 3 percent of low-income workers who receive Earned Income Tax Credits claim those credits during the year, in advance of filing year-end returns.¹⁰

HB 6587 avoids these problems. Because they would not receive tax credits, BH consumers would not face the danger of owing money to IRS at the end of the year.

Continuity of coverage

Compared to a policy that would cover low-income adults through the Exchange, HB 6587 would increase continuity of coverage and care, since changes in household income that move adults above and below 133 percent FPL would not force a transition between Medicaid and the exchange.

With the income threshold for transitioning between Medicaid and the exchange set at 133 percent FPL, more than 35 percent of all low-income adults will need to change health programs at least once every six months.¹¹ For two reasons, raising the income threshold to 200 percent FPL, as proposed by HB 6587, would reduce the number of subsidy recipients moving between programs. First, many more people will qualify for subsidies at lower income levels,

¹⁰ Joanna Stamatziades and James Cook, Government Accountability Office, Eric Larson, Internal Revenue Service, *Demographic and Noncompliance Study of the Advance EITC (AEITC)*, Presented at the 2008 IRS Research Conference, June 11, 2008; Government Accountability Office, *Advance Earned Income Tax Credit: Low Use and Small Dollars Paid Impede IRS's Efforts to Reduce High Noncompliance*, GAO-07-1110, August 2007.

¹¹ Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges," *Health Affairs*, February 2011; 30(2):228–236.

where ESI offers are less frequent.¹² Second, significant income volatility is more widespread at lower income levels,¹³ where unstable and shifting employment arrangements are more common.

Fewer transitions between public coverage and the exchange will mean reduced administrative costs for Medicaid, the exchange, and insurers; fewer disruptions in coverage for families; increased incentives for plans to invest in members' long-term (and even medium-term) wellness, since today's health plan is more likely to reap any eventual gains; and the clinical benefits of continuity of care.

Provider payment levels and networks

One important factor involves provider reimbursement levels and the breadth of provider networks. Medicaid/HUSKY payments generally fall far below private levels, as indicated above. As a result, many providers are unwilling to serve many Medicaid patients (and in some cases, providers will not see any Medicaid patients). Providing low-income adults with private insurance would thus furnish access to a broader network of providers.

As noted earlier, HB 6587 would increase Medicaid payments for BH consumers by at least 7 to 13 percent, reflecting the margin by which federal BH funds are expected to exceed baseline Medicaid costs. But that will still leave a significant shortfall, relative to private reimbursement. Nevertheless, the clear judgment of the Sustinet Board was that, for this particular low-income population, affordability is a much more important factor in shaping access to care than is the limitation on provider participation that results from low Medicaid payment levels.

¹²Lisa Clemans-Cope and Bowen Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005*, prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, December 2006.

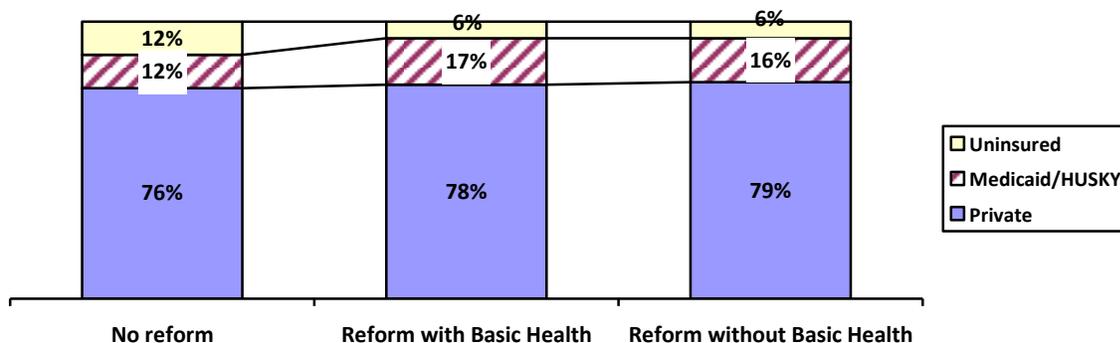
¹³Neil Bania and Laura Leete, *Income Volatility and Food Insufficiency in U.S. Low-Income Households, 1991-2003*, draft paper prepared for presentation at the USDA/National Poverty Center Conference: Income Volatility and Implications for Food Assistance Programs–II, November 16–17, 2006, Economic Research Service, U.S. Department of Agriculture, October 2006.

BH vs. moving low-income adults into the exchange and using state General Fund dollars to supplement federal subsidies

As the final alternative to HB 6587, policymakers could: (a) place low-income adults in the exchange, rather than keep them in HUSKY/Medicaid; and (b) use state dollars to supplement federal subsidies. Such state supplements would seek to raise covered benefits and lower cost-sharing to Medicaid/HUSKY levels. The goal of this particular approach is to achieve “the best of both worlds:” the provider networks that result from private payment rates in the exchange, plus the kind of affordable, comprehensive coverage currently furnished by Medicaid.

In addition to broadening provider networks that serve low-income adults, this approach would increase revenue for hospitals, doctors, and other providers. Reform itself will cause the much larger effect, reducing uncompensated care by a significant amount, with or without Basic Health. Whether this particular group of adults goes into HUSKY or the exchange, the number of state residents without coverage will decline greatly, the number with public coverage will rise significantly, and the number with private coverage will increase modestly. Under HB 6587’s approach to Basic Health, the proportion of residents with private and public coverage will exceed current levels by 2 and 5 percentage points, respectively; without Basic Health, those increases will be 3 and 4 percentage points, according to Dr. Gruber’s estimates (Figure 1). Put differently, the proportion of state residents with private coverage would be 1 percentage point higher without BH, which would have a modest effect on total provider revenue.

Figure 1. Estimated proportion of state residents under age 65 with various types of coverage, status quo vs. reform with and without Basic Health: 2017



Source: Gruber Microsimulation Model. Notes: Totals may not add to 100 percent because of rounding.

On the other hand, even if the state supplements federal subsidies in the exchange to fully replicate Medicaid benefits and cost-sharing protections, low-income consumers will still face two problems: the risk of owing money to IRS at the end of the year if family income turns out to exceed expectations; and frequent changes between Medicaid and the exchange when family income moves above or below 133 percent FPL.

From a state budget perspective, this approach would be problematic, compared to BHP. With BHP, the state General Fund saves money; but if the state supplements federal subsidies in the exchange, the state General Fund will spend more, not less, on this population. The cost of state supplements would begin at \$61 million a year in 2014, according to Dr. Gruber’s research, exceeding \$100 million in 2017 and beyond (Table 2).

Table 2. State costs of supplementing federal subsidies for HUSKY parents and other adults with incomes between 133 and 200 percent of FPL: 2014-2019 (millions)

2014	2015	2016	2017	2018	2019
\$63	\$87	\$99	\$112	\$120	\$129

Source: Gruber Microsimulation Model. *Notes:* This projection assumes the absence of cost-savings through delivery system and payment reform, as proposed by pending SustiNet legislation. Amounts shown are in 2010 dollars.

Conclusion

Other states face important questions about the wisdom of implementing the Basic Health Program option contained in the Affordable Care Act. But in Connecticut, the case for BH seems particularly strong, because of what the state is currently spending to cover low-income adults. As a result, implementing BH would save money for Connecticut taxpayers while improving affordability and continuity of coverage for low-income state residents and shielding such residents from increased health care costs.