

UCLA CENTER FOR
HEALTH POLICY RESEARCH



UC BERKELEY

**LABOR
CENTER**

CalSIM

California Simulation of Insurance Markets

The California Simulation of Insurance Markets (CalSIM) model is designed to estimate the impacts of various elements of the Affordable Care Act on employer decisions to offer insurance coverage and individual decisions to obtain coverage in California. It was developed by the UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research, with generous funding provided by The California Endowment.

Estimating the Change in Coverage in California with a Basic Health Program

A memorandum prepared at the request of the
California Health Benefit Exchange

by the UC Berkeley Center for Labor Research and Education
and the UCLA Center for Health Policy Research

August 2012

MEMORANDUM

Estimating the Change in Coverage in California with a Basic Health Program

August 10, 2012

The UC Berkeley Labor Center and UCLA Center for Health Policy Research were asked to examine the impact of a Basic Health Program (BHP) on coverage in California. To answer the question we employed the California Simulation of Insurance Markets (CalSIM) Model, version 1.7. Results are provided for two scenarios. The “base” scenario assumes typical responses by individuals and employers to expanded coverage offerings. The “enhanced” scenario is based on a more robust enrollment and retention strategy by state coverage programs.

Executive Summary

- A Basic Health Plan increases overall coverage in California between 60,000 and 120,000 under the base scenario. Under the enhanced scenario, the change in coverage over the no-BHP model ranges from a 20,000 increase to a 70,000 decrease depending on response to the BHP.¹
- We find no negative impact on the risk mix in the overall Exchange/Individual Market as a result of a Basic Health Program.
- A Basic Health Program would reduce the size of the Exchange between 720,000 and 950,000 individuals. This could limit the Exchange’s bargaining power in the individual market, and may affect its ability to generate reforms that would lower the rate of premium cost growth over time.
- These results assume a \$20 per person per month premium in the BHP. A higher premium would reduce the gains in coverage; a lower premium would potentially improve response.

¹ The negative impact in the enhanced model is a result of specifications in CalSIM 1.7 which set Medicaid take-up by the uninsured at 75 percent and Exchange with subsidy take-up at 70% across the entire subsidized population, with 85% and higher take-up rates among individuals from low-income (200% of FPL and below) households. In Model B, which treats the BHP like a Medicaid plan in terms of consumer response, this results in fewer people enrolling under the BHP than would do so in the Exchange with subsidies.

Background

The BHP option would apply to individuals eligible for subsidized insurance coverage through the California Health Benefit Exchange with incomes up to 200 percent of the Federal Poverty Level (FPL). This includes legal permanent residents with less than five years residency with incomes under 138% FPL, but not individuals otherwise eligible for Medi-Cal. Individuals with incomes under 200% FPL account for 41 to 44 percent of those projected to enroll in subsidized coverage through the Exchange and more than 51% of the subsidy dollars.

Exhibit 1: Exchange Subsidy Eligible Californians under Age 65 by Income Category, 2019

Income (Federal Poverty Level)	Eligible	Enrolled Base Scenario	Share of Enrolled with Subsidies, by Income	Enrolled Enhanced Scenario	Share of Enrolled with Subsidies, by Income
138% FPL or less	150,000	90,000	5%	140,000	7%
139-200% FPL	930,000	630,000	36%	790,000	37%
201-250% FPL	660,000	340,000	19%	420,000	20%
251-400% FPL	1,370,000	700,000	40%	800,000	37%
Total	3,100,000	1,750,000	100%	2,150,000	100%

Source: UC Berkeley-UCLA CalSIM version 1.7, Base and Enhanced Scenarios

Assumptions

To model the Basic Health Program we tested two different assumptions by adapting our current CalSIM model. Using our original CalSIM model, people earning 200% of FPL or under who are not eligible for Medi-Cal have four options – remain uninsured, accept an employer offer of coverage (if available), purchase subsidized coverage in the Exchange, or purchase unsubsidized coverage in the Exchange or individual market. To understand the impact of the BHP option, we added a fifth option to our model: enroll in the subsidized BHP. In addition, the individuals eligible for the BHP are no longer eligible for the subsidized Exchange, although they still have an option to purchase coverage on their own in the individual market without subsidies. Under the first model (“Model A”), we treat the BHP like a health insurance plan sold through the Exchange, with similar network, scope and reputation. In the second model (“Model B”), we treat the Basic Health Program more like Medi-Cal, assuming that response will mirror public program take-up decisions rather than private insurance due to welfare stigma, reputation, and plan selection being constrained to Medi-Cal managed care networks. These two models provide upper and lower bounds to understand how coverage might shift if California adopts a Basic Health Program option. In both models, the member premium share was set to \$20 per person per month based on a recent Mercer report on the financial feasibility of the BHP. We used the upper estimate of premium share paid by members up to 200% FPL.¹ Mercer suggested that the average premium would be \$17 per month in 2014 on average if members between 100 to 150% FPL were charged \$10 per month. After projecting a 3% per year premium increase for the BHP program over time

(versus a 6.5% increase per year in the Exchange’s commercial plans), the final 2019 per person premium is \$20 per month. All results are presented for 2019.

In the absence of a Basic Health Plan, families with incomes under 200% FPL would receive subsidies in the Exchange limiting out of pocket premium costs to a share of family income. This would range from 2% of income for a family with an income of 100% FPL to 6.3 percent of income for a family with an income equal to 200% FPL.² A single individual earning \$17,902 a year (134% FPL) would pay \$45 a month in premium costs in 2019 while an individual earning \$26,920 (200% FPL) would pay up to \$141 a month, (exhibit 2).

Exhibit 2. Federal Poverty Level Categories and Predicted Out-of-Pocket Premium Spending for Exchange and Basic Health Program Enrollees in California, 2019

Federal Poverty Level Category	Projected 2019 Federal Poverty Level-based Income Amount for a single individual	Out-of-Pocket Premium Subsidy Threshold as Percent of Income	Maximum Silver Plan Out-of-Pocket Premium (per month)	BHP Individual Premium (per month)	Difference
0 to 100% FPL	\$13,460	2%	\$22	\$20	-\$2
134% FPL	\$17,902	3%	\$45	\$20	-\$25
150% FPL	\$20,190	4%	\$67	\$20	-\$47
200% FPL	\$26,920	6.3%	\$141	\$20	-\$121

A BHP would significantly reduce the size of the Exchange, which will raise the administrative cost per policy. To account for the increased costs, we assume that premiums in the Exchange/Individual market will increase by 0.5%.

This analysis does not speak to the difference in benefits for enrollees and access to care between the two coverage options except to the extent that they affect take-up of coverage.

Enrollment Findings

In Model A we see a significant increase in take-up due to the price reduction from the BHP coupled with the assumptions that the BHP will operate like a commercial plan in terms of reputation and provider networks. An estimated 860,000 people enroll in the BHP in 2019, 80 percent of those who are eligible (Exhibit 3). In comparison, approximately 66% of those eligible for the Exchange with subsidies

² Legal permanent residents with less than 5 years residency in the United States are not eligible for Medicaid under the ACA, but are eligible for subsidies in the Exchange. For those with incomes below 100% FPL, premium costs are limited to 2% of the Federal Poverty Level.

were likely to take-up in previously published work using CalSIM version 1.7.² Coverage in the Exchange with subsidies falls by 720,000, while a small number shift from job-based coverage and out of the individual market or Exchange without subsidies. As a result, 120,000 additional individuals would have coverage under this model when compared to the Exchange with subsidies without a BHP option.

In Model B we adjust the responses to calibrate take-up to the experience of public programs. This takes into account the more limited networks in the BHP and the preference for some individuals to maintain continuity of coverage even in the face of a less expensive insurance option. Under this model 710,000 people take up coverage in the BHP by 2019. Slightly fewer than 60,000 are covered through the Individual Market or Exchange without subsidies in Model B from the BHP eligible income group. This includes 50,000 people with private coverage without the ACA who choose to retain a private insurance plan rather than enroll in the BHP. Overall, the number of people with coverage increases by 60,000 over the base scenario without the BHP.

In the enhanced versions of Model A, we estimate 950,000 fewer individuals in the Exchange with subsidies. These changes are partially explained by 1.01 million enrolling in BHP. In this model, 20,000 more people have coverage than would have without the BHP. BHP enrollment increases by 850,000 in the enhanced version of Model B. Under model B, the number of remaining uninsured increases in the enhanced model over the no-BHP option by 70,000, due to the lower projected take-up rate.

Exhibit 3: Estimated Change in Source of Coverage, 2019 (millions)

Source of Coverage	Base			Enhanced		
	Without BHP	Change in Coverage MODEL A	Change in Coverage MODEL B	Without BHP	Change in Coverage MODEL A	Change in Coverage MODEL B
Employer Sponsored Insurance	19.07	(0.01)	0.01	19.08	(0.02)	0.01
Public	8.92	-	-	9.38	-	-
Subsidized Exchange Exchange without Subsidies / Individual Market	1.75	(0.72)	(0.72)	2.15	(0.95)	(0.95)
Basic Health Plan	-	0.86	0.71	-	1.01	0.85
Uninsured	3.96	(0.12)	(0.06)	3.04	(0.02)	0.07

Note: Based on Assumption that BHP enrollees will pay \$20 per person per month
Source: UC Berkeley-UCLA CalSIM Model version 1.7

Risk Mix Findings

The Affordable Care Act includes measures to adjust risk across plans in the Exchange and outside individual market. The BHP would not be included in risk adjustment. If California adopts the BHP, it could potentially affect the risk mix in the Exchange, which could in turn have important impacts on premium costs and enrollment.

In order to understand the impact of a BHP on the risk mix in the remaining Exchange/Individual Market we looked at three factors:

- prevalence of one or more of four chronic conditions: asthma, diabetes, heart disease and high blood pressure;
- self-reported health status; and
- age category.

A BHP could be expected to affect the risk mix in conflicting ways. There is a high correlation between health status and income. The BHP population as a whole is less likely to report “Excellent” or “Very Good” health status than those in the Exchange/Individual Market with incomes over 200 percent FPL. Prevalence of one or more of the four chronic conditions is similar between the two groups. Given the difference in health status, removing the BHP population from the pool has the potential to improve the risk mix. At the same time, lower income individuals receive the largest subsidies and a greater share is predicted to enroll in coverage due to the ACA. As a result, we would expect a broader mix of individuals within that market segment to obtain coverage. These two dynamics appear to counter act each other, leaving a slight improvement in the risk mix.

We find little change in the share of individuals with chronic conditions or self-reported health status among those with coverage in the Exchange or Individual market with or without a Basic Health Plan (Exhibit 4). Without the BHP, 28 percent of the individuals predicted to enroll in the Exchange/Individual have one or more chronic illnesses; with the BHP it is 27 percent. Without a BHP, we predict that 56 percent of the individuals that enroll in the Exchange have self-reported health status of “Excellent or Very Good,” without a BHP, 58 percent. With more adults leaving the Subsidized Exchange for the BHP, children make up a slightly larger share of the combined Exchange/Individual Market with the BHP (16%) than without it (13%). The highest cost age group, those between 45 and 65, makes up a similar share of the pool (33%) across all three models.

Exhibit 4. Risk Mix Exchange and Individual Market 2019 with and without BHP

	Without BHP		Model A Base		Model B Base	
	N	%	N	%	N	%
Chronic Conditions						
None	2,789,000	72%	2,288,000	73%	2,325,000	73%
1 or More	1,071,000	28%	841,000	27%	867,000	27%
Health Status						
Excellent	914,000	24%	787,000	25%	812,000	25%
Very Good	1,230,000	32%	1,040,000	33%	1,060,000	33%
Good	1,102,000	29%	863,000	28%	876,000	27%
Fair	526,000	14%	377,000	12%	381,000	12%
Poor	88,000	2%	62,000	2%	63,000	2%
Age						
0-18	512,000	13%	506,000	16%	507,000	16%
19-29	1,200,000	31%	953,000	30%	996,000	31%
30-44	878,000	23%	630,000	20%	638,000	20%
45-64	1,270,000	33%	1,041,000	33%	1,050,000	33%
Total	3,860,000		3,129,000		3,191,000	

Source: UC Berkeley-UCLA CalSIM version 1.7

Note: Based on assumption that BHP enrollees will pay \$20 per person per month;

Model A = "Exchange"-like take-up decisions, Model B = "Medicaid"-like take-up decisions

Discussion

The BHP has the potential to increase coverage in California by 60,000 to 120,000 people by 2019 compared to the Exchange with subsidies on its own. This is consistent with findings in an analysis of a BHP in California by the Urban Institute.³ Under the enhanced CalSIM scenario, which assumes stronger outreach and enrollment strategies by the Exchange, the benefits to coverage from a BHP decrease significantly.

As noted above, this analysis assumes a \$20 per person per month premium cost, which may be lower than the real premium in 2019. To the degree the premium cost is higher, the increase in coverage would be smaller; if a BHP is able to offer a lower premium, the impact on coverage would be greater. Federal law allows the BHP premium to be as high as the second lowest silver plan offered in the Exchange, which provides a wide range of values that would potentially affect take-up as the price increased. While subsidies available to lower-income people would not change in that pricing scenario, the differences in cost of the BHP versus an Exchange plan would be reduced substantially. To ensure

the high levels of take-up in the BHP estimated here, the actual out-of-pocket premium would need to remain low relative to the silver plan premium options available in the Exchange.

Another important factor that could impact coverage under the BHP is increased churn between the programs. An analysis by John Graves for the Institute for Health Policy Solutions suggests that this would be significant.⁴ Using the Survey of Income and Program Participation, he estimates that only 30 percent of those who qualify for the Basic Health Plan at the beginning of the year will still qualify at the end of the year. If individuals are required to re-enroll as their income changes between BHP coverage and Medi-Cal on the one side and BHP coverage and the Exchange on the other, it could create an additional administrative barrier to continuous coverage. This can be minimized if churn between Medicaid and the BHP is made seamless for enrolled individuals; how seamless this process can be is dependent on the federal rules on Basic Health Plans, which have not been issued.

Finally, a smaller Exchange (720,000 to 950,000 fewer enrollees by 2019) would have reduced market power. This could affect the bargaining power of the Exchange in the insurance market and reduce its ability to drive reforms in the delivery system that can serve to reduce costs over time. To the degree that premium in the BHP and administrative costs in the Exchange are higher than projected, increases in coverage would be correspondingly reduced.

¹ Mercer, *State of California Financial Feasibility of a Basic Health Program*, June 28, 2011 (accessed on July 22, 2012 from <http://www.mercer-government.mercer.com/basic-health-program/feasibility>). Funded by The California HealthCare Foundation.

² Jacobs K, Watson G, Kominski GF, Roby DH, Graham-Squire D, Kinane CM, Gans D, and Needleman J. *Nine out of Ten Non-Elderly Californians Will Be Insured When the Affordable Care Act is Fully Implemented*. UC Berkeley Center for Labor Research and Education, Research Brief, June 2012. Accessed on July 22, 2012 from http://www.healthpolicy.ucla.edu/pubs/files/calsim_Exchange1.pdf.

³ Dorn, Stan, "Basic Health Program: Issues for California," webinar, August, 2011. <http://www.urban.org/uploadedpdf/412370-basic-health-program-california.pdf>

⁴ Curtis, Rick and Ed Neuschler, "Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program (BHP) in California, September, 2011. http://www.ihps.org/pubs/Income_Volatility_Creates_BHP_Uncertainty_2Sep2011.pdf