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Crossing 138: Two Approaches to Churn under the Affordable Care Act

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— Articles —

CROSSING 138: TWO APPROACHES TO CHURN UNDER THE AFFORDABLE CARE ACT

Gabriel Ravel & J. Angelo DeSantis[†]

ABSTRACT

A predicted side effect of the Medicaid expansion and state-based Exchanges under the Affordable Care Act is churn. Churn is the shifting into and out of eligibility for insurance affordability programs due to income changes. Because the line between Medicaid and Exchange eligibility is fine –138% of the federal poverty level –millions of Americans are expected to gain and lose eligibility. Frequently, this churning undermines continuity of care, raises costs, and frustrates those affected. This article explores two proposed programs to mitigate the effects of churn: the Basic Health Program and the Bridge Program. This article evaluates both programs’ ability to mitigate the effects of churn, the likely side effects to states’ implementing them, and legal and practical obstacles to their implementation. It concludes that the Bridge Program is the better approach.

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INTRODUCTION

A. The Churn Problem

The Affordable Care Act follows a circuitous path to cover most Americans. Rather than creating a streamlined single payer system, the Act employs an array of public and public–private programs to expand coverage: Medicare for the elderly; Medicaid for the poor; and for most others, either employer-sponsored coverage or Exchange-bought coverage. This intricate system inevitably creates problems. One such problem stems from how eligibility is determined.

For many insurance affordability programs,¹ eligibility turns on an individual or family’s income, measured as a percentage of the federal poverty level (FPL).² In Medicaid expansion states,³ individuals and families are Medicaid-eligible if their income does not exceed 138% FPL.⁴ Above that level, those earning up to 400% FPL are eligible, on a sliding scale, for subsidized Exchange coverage.⁵

But income as a percentage of FPL is a volatile factor; income shifts are common. This leads to “churning,” the frequent shifting into and

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1. The insurance affordability programs are “Medicaid, the Children’s Health Insurance Program (CHIP), or premium and cost-sharing assistance for purchasing private health insurance through state insurance Exchanges.” ROBERT WOOD JOHNSON FOUND., DETERMINING ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS 2 (2013), *available at* http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2013/rwjf404380.
 2. *See id.* at 2-4.
 3. *See* Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012) (holding that Congress may offer States grants to expand Medicaid eligibility, but “states must have a genuine choice whether to accept the offer”). As of this writing, twenty-six states will expand Medicaid eligibility. *Status of State Action on the Medicaid Expansion Decision*, HENRY J. KAISER FAM. FOUND. (2014), <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (last visited Mar. 11, 2014).
 4. *See* 42 U.S.C. § 1396a(a)(7)(B)(i) (2012).
 5. *See* 26 U.S.C. § 36B (2012).

out-of coverage eligibility.⁶ Under the Act, churning is expected between Medicaid eligibility and Exchange subsidy eligibility because of the many factors that affect income as a percentage of FPL.⁷

For example, Ben earned \$15,500 a year in 2012, when the poverty line for an individual was \$11,170. Ben was ineligible for Medicaid because his income exceeds 138% FPL, or \$15,414.60 (138% of \$11,170).⁸ But the next year, with the same income, Ben is Medicaid eligible because the poverty line for 2013 grew to \$11,490, placing Ben's income just above the 138% threshold of \$15,856.20.

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia ⁹	
Persons in family/household	Poverty guideline
1	\$11,170
2	\$15,130
3	\$19,090
4	\$23,050
5	\$27,010
6	\$30,970
7	\$34,930
8	\$38,890
For families/households with more than 8 persons, add \$3,960 for each additional person.	

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6. Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFFS. 228, 228 (2011).
 7. *See id.* at 228-29; COVERED CAL., BRIDGE PLAN: A STRATEGY TO PROMOTE CONTINUITY OF CARE & AFFORDABILITY THROUGH CONTRACTS WITH MEDICAL MANAGED CARE PLANS 2 (2013) [hereinafter COVERED CAL.], available at [http://www.healthexchange.ca.gov/BoardMeetings/Documents/February26_2013/VI_BRB_Bridge_Plan_\(Update\).pdf](http://www.healthexchange.ca.gov/BoardMeetings/Documents/February26_2013/VI_BRB_Bridge_Plan_(Update).pdf).
 8. State Exchanges are directed to use 2013 Federal Poverty figures to calculate eligibility for 2014. BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41137, HEALTH INSURANCE PREMIUM CREDITS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) 4 n. 20 (2014), available at <https://www.fas.org/sgp/crs/misc/R41137.pdf>.
 9. Annual Update of the HHS Poverty Guidelines, 77 Fed. Reg. 4034, 4035 (Jan. 26, 2012).

2013 Poverty Guidelines for the 48 Contiguous States and the District of Columbia ¹⁰	
Persons in family/household	Poverty guideline
1	\$11,490
2	\$15,510
3	\$19,530
4	\$23,550
5	\$27,570
6	\$31,590
7	\$35,610
8	\$39,630
For families/households with more than 8 persons, add \$4,020 for each additional person.	

But if Ben marries Linh who also earns \$15,500, neither Ben nor Linh will be Medicaid eligible in 2013 because the poverty line for a family of two is \$15,510, placing the Medicaid eligibility threshold at \$21,403.80 — well below Ben and Linh’s combined income of \$31,000.

But if Linh gives birth to twins, Kyle and Kevin, all four family members will be eligible for Medicaid because Linh and Ben’s combined income of \$31,000 is less than the Medicaid threshold for a family of four: \$32,499 (138% of \$23,550). Moreover, while Linh is pregnant, she may be Medicaid eligible as most states cover pregnant women with income up to or above 185% FPL.¹¹

Those dizzying back-and-forths occurred without Ben’s income changing by a dime. But realistically, Ben and Linh’s income will fluctuate. Their work hours may be cut;¹² they could lose or change jobs; they might take unpaid leave to care for Kyle and Kevin; or they could divorce (changing the size of the family, and thus the threshold FPL).

And if Linh and Ben’s income passes 138% FPL, their children may be covered by CHIP while Linh and Ben are covered by Exchange plans. The same family could be covered by different insurance plans with different provider networks.¹³

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10. Annual Update of the HHS Poverty Guidelines, 78 Fed. Reg. 5182, 5183 (Jan. 24, 2013).
 11. 42 U.S.C. § 1396a(1)(2)(A)(i) (2012).
 12. See Lisa Myers & Carroll Ann Mears, *Businesses Claim Obamacare Has Forced Them to Cut Employee Hours*, NBC NEWS (Aug. 13, 2013, 6:17 PM), http://investigations.nbcnews.com/_news/2013/08/13/20010062-businesses-claim-obamacare-has-forced-them-to-cut-employee-hours.
 13. See TENN. INS. EXCH. PLANNING INITIATIVE, BRIDGE OPTION: ONE FAMILY, ONE CARD ACROSS TIME (2011), available at <http://www.tn.gov/nationalhealthreform/forms/onefamily.pdf>.

The many variables affecting eligibility multiplied by the 21.3 million Americans expected to enroll in Medicaid by 2022,¹⁴ along with the existing 66 million enrollees,¹⁵ make frequent churning inevitable.¹⁶ Indeed, 35% of adults with income below 200% FPL will experience an income change affecting their Medicaid eligibility within six months; 50% will experience a change within a year.¹⁷ Further, 24% will churn at least twice within a year; 39% will churn twice in two years; and in all, 38% will churn at least four times in as many years.¹⁸

Churning creates many problems. Switching between Medicaid and Exchange coverage undermines continuity of care when it forces enrollees to change provider networks. And improving continuity of care is a major objective of the Affordable Care Act.¹⁹ But churn works against that goal. When patients switch providers, records transfer and may be lost.²⁰ Providers must familiarize themselves with a new patient. Things

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14. KAISER FAM. FOUND., THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS I (2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384_es.pdf.
 15. See MACPAC, MACSTATS: MEDICAID AND CHIP PROGRAM STATISTICS 40 (2013), *available at* <http://www.macpac.gov/macstats> (indicating that enrollment data is for 2010 and includes 9.7 million dual-eligibles).
 16. See Sommers & Rosenbaum, *supra* note 6, at 230.
 17. MD. DEP'T OF HEALTH AND MENTAL HYGIENE: MEDICAID OFFICE OF PLANNING & THE HILLTOP INST., ANALYSIS OF THE BASIC HEALTH PROGRAM 1, 9 (2009) [hereinafter MDHMH & HILLTOP INST.], *available at* <http://dnhm.maryland.gov/docs/BHP%2001%2018%2012%20Report%20Analysis%20FINAL.pdf>.
 18. *Id.* See also MIRANDA DIETZ ET AL., U.C. BERKELEY CTR. FOR LABOR RES. & EDUC., THE ONGOING IMPORTANCE OF ENROLLMENT: CHURN IN COVERED CALIFORNIA AND MEDI-CAL 2 (2014), *available at* http://laborcenter.berkeley.edu/healthcare/churn_enrollment.pdf (noting that 16.5% of California Medi-Cal enrollees are expected to earn out of Medicaid within twelve months); Benjamin D. Sommers et al., *Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact*, 33 HEALTH AFFS. 700, 704 (2014).
 19. See 42 U.S.C. § 18051(c)(4) (2012) (“A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section . . . to improve the continuity of care.”); § 1315b (c)(6) (“The goals of the Federal Coordinated Health Care Office are as follows: . . . (6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals”); § 1395w-5 (a)(2)(C) (directing the secretary to develop a public reporting program for consumers that will, among other measures, report on “an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use”).
 20. See R.A. Clay, *The Advantages of Electronic Health Records: Electronic Records Can Improve Patient Care. Here's How*, MONITOR ON PSYCHOL. (2012), <http://www.apa.org/monitor/2012/05/electronic-records.aspx> (“With electronic health records, the transfer of complete records from

may be overlooked; symptoms communicated to one provider may not be communicated to the next.²¹

Further, not all patients dutifully reenroll every time their eligibility changes. A patient earning out of Medicaid may let coverage lapse before enrolling in an Exchange plan. And though she may risk an individual mandate penalty, the penalty is only triggered when the individual is owed a tax refund –not the case for all individuals close to 138% FPL. And if different members of the same household are enrolled in different networks and plans due to different eligibility statuses, it further increases the likelihood that one will not be reenrolled when eligibility changes.

B. Two Approaches to Churn Consequences

This article evaluates two approaches to mitigate the consequences of churn under the Affordable Care Act.²² The first is the Basic Health Program. Authorized by the Act, it offers states an alternative means for covering citizens earning between 138% and 200% FPL.²³ Under Basic Health, states can provide similar coverage to Medicaid for enrollees earning above 138% FPL but below 200% FPL. Enrollees would incur some premium contributions and cost sharing.²⁴ Basic Health would mitigate many harmful effects of churn at 138%, though churn would occur at 200% FPL. Still, shifting churn to a population better able to weather coverage changes may be an improvement.

The other approach is the Bridge Program. Under the Bridge Program, Medicaid-managed care issuers would offer “Bridge plans”: Medicaid plans on the Exchange. These plans would let Medicaid enrollees passing 138% FPL purchase identical coverage, benefits, and

provider to provider or facility to facility happens electronically. That also means records don’t get lost or delayed when patients change providers or providers make referrals.”).

21. See Sommers & Rosenbaum, *supra* note 6, at 234-35.
22. At least one other solution has been proposed. Sara Rosenbaum and Benjamin D. Sommers suggested as a mitigation measure “a subsidy structure utilizing annual enrollment periods.” Sara Rosenbaum & Benjamin D. Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U. J. HEALTH L. & POL’Y 127, 146 (2011). Subsidy and Medicaid eligibility would be determined for a plan year. “Individuals would sign up for coverage, say, on November 1, their incomes as of November 1 would have been compared to the subsidy scale as of that date, and the subsidy would have been locked in for the next twelve months.” Using an annual enrollment process and a twelve-month projected income approach, the law could have offered far more stability in enrollment. *Id.*
23. 42 U.S.C. § 18051 (2012); DEBORAH BACHRACH ET AL., THE ROLE OF THE BASIC HEALTH PROGRAM IN THE COVERAGE CONTINUUM: OPPORTUNITIES, RISKS, AND CONSIDERATIONS FOR STATES 4 (2012), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8283.pdf>.
24. BACHRACH ET AL., *supra* note 23, at 5.

provider network access at a highly subsidized rate. Access to Bridge plans may not be perpetual. At the states' discretion, enrollees may eventually earn or time-out of eligibility, but when they do, they could simply buy comparable coverage on the Exchange.

This article evaluates both programs' ability to mitigate the churn consequences, the likely side effects to states' implementing them, and legal and practical obstacles to implementation. We conclude the Bridge Program is the better approach. Although both programs place some Affordable Care Act values in tension with others, the Bridge Program provides multiple benefits over the Basic Health Program for enrollees and states.

I. THE BASIC HEALTH PROGRAM

A. *An Overview of the Basic Health Program*

1. Washington State's Basic Health Program

The Affordable Care Act's Basic Health Program is modeled after Washington State's Basic Health Program.²⁵ In the mid-1980s, Washington State explored ways of expanding coverage to residents.²⁶ A major barrier to that expansion was the growing cost of care. Managed care offered a solution.²⁷ But implementing that solution involved many false starts.

In 1983 the legislature created a committee to study the problem of uncompensated charity care, estimated to cost \$60 million a year. The committee saw expanding coverage as the solution and proposed expanding Medicaid eligibility, made affordable, by adopting a managed care system. The committee also recommended a statewide charity pool, funded by state hospital contributions. The legislature ultimately rejected legislation implementing the committee's plan, following hospital opposition.²⁸

Washington's governor then ordered a study of options for controlling state-purchased health care costs.²⁹ The study recommended a six-year plan to increase managed care.³⁰ A second study (ordered by the legislature) examined means of encouraging the use of managed care.

25. Press Release, Office of Sen. Maria Cantwell, Cantwell Announces Federal Basic Health Plan Timeline (Apr. 18, 2013), *available at* <http://www.cantwell.senate.gov/public/index.cfm/press-releases?ID=381378e5-d2d4-4be2-8827-82a14cf6852f>.

26. Carolyn W. Madden et al., *Washington State's Basic Health Plan: Choices and Challenges*, 13 J. PUB. HEALTH POL'Y. 81, 82 (1992).

27. *Id.*

28. *Id.*

29. *Id.* at 82-83.

30. *Id.* at 83.

That study's final report focused on using managed care to increase access to low-income residents, rather than to simply reduce costs. It concluded that expanding managed care could increase Medicaid eligibility.³¹

These twin studies led to two bills (one in 1985, one in 1986) to implement what was called a "Basic Health Plan."³² The plans would increase access to care while controlling expenditures. They would cover non-elderly uninsured with income below 200% FPL. Coverage would be basic but comprehensive, with an emphasis on prevention. Coverage would be through a managed care system under contract with the state.³³

Both bills failed. Legislators disagreed about the magnitude of funds required and the appropriate funding source. The 1985 bill would have taxed hospitals and physicians, angering providers. The 1986 bill would have imposed a "sin tax," largely on cigarettes, angering groups wanting cigarette tax revenue to go elsewhere. Legislators also worried that Basic Health would become a fiscal "black hole." Indeed, no one knew how many eligible residents there were, how many would enroll, or whether employers would drop coverage in favor of Basic Health. For answers, the legislature created a new commission.³⁴

The McPhaden Commission formed in 1986.³⁵ Composed of legislators from both parties, care providers, businesses, and constituent groups, it was tasked with fleshing out the details of a workable Basic Health Plan.³⁶ The Commission surveyed statewide to determine the number of Basic Health eligible persons in Washington and their characteristics. The Commission "generated actuarial estimates of various program designs . . . [and] . . . considered the governance and administration of the program."³⁷

The result was that Basic Health Plan legislation passed in 1987.³⁸ Basic Health would cover individuals under 65 with income below 200 percent FPL. Enrollees would make premium and co-payments on a sliding scale.³⁹

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.* at 83-84.

36. *Id.* at 84.

37. *Id.*

38. *Id.*

39. *Id.* at 85, 89.

The Basic Health Plan was temporary, limited to a five-year demonstration.⁴⁰ That limit created implementation problems, as providers were leery of investing in a program that might be short-lived.⁴¹ The plan also limited enrollees. Only 30,000 residents from at least five congressional districts could enroll in the demonstration.⁴² This further dampened provider enthusiasm.⁴³

Although the plan covered the poor, it did not use Medicaid funds, in part because Basic Health covered some swaths of the population not eligible for Medicaid.⁴⁴ But there was also a desire to avoid the stigma of Medicaid welfare funding.⁴⁵ Care under Basic Health was provided by managed care systems under contract with the State. The care was basic but comprehensive: it emphasized preventive benefits but included hospital, physician, ER, and ambulance services.⁴⁶ But it “did not cover prescription drugs [or] mental health, vision, or dental care and included a 12-month waiting period” for coverage of pre-existing conditions.⁴⁷

Basic Health signed its first service contract in late 1988.⁴⁸ The next year, Basic Health expanded to two more counties and capacity was added to existing counties.⁴⁹ By 1991 fifteen managed care providers enrolled 20,700 residents in fourteen counties.⁵⁰ In 1993 the legislature made Basic Health permanent, and enrollees doubled in 1994.⁵¹ That year prescription drug benefits were also added.⁵² Soon after, Basic Health Plus was created to cover women and children who churned into and out of Medicaid eligibility.⁵³ The result was, from the perspective of enrollees, seamless coverage: “To the member, it’s all Basic Health.”⁵⁴

40. *Id.* at 85.

41. *Id.* at 86.

42. *Id.* at 85.

43. *Id.* at 86.

44. *Id.*

45. *Id.*

46. *Id.* at 83, 85.

47. STATE OF WASH. HEALTH CARE AUTH., A STUDY OF WASHINGTON STATE BASIC HEALTH PROGRAM 4 (2002) [hereinafter WASH. HEALTH CARE AUTH.].

48. Madden et al., *supra* note 26, at 91.

49. *See* WASH. HEALTH CARE AUTH., *supra* note 47, at 3.

50. Madden et al., *supra* note 26, at 91.

51. *See* WASH. HEALTH CARE AUTH., *supra* note 47, at 3.

52. *Id.* at 4.

53. *Id.* at 2.

54. *Id.*

A little over twenty years after Basic Health took effect, Washington Senator Maria Cantwell included an amendment to the Affordable Care Act bill to give states the option of following Washington State's lead.⁵⁵

2. The Basic Health Program under the Affordable Care Act

Section 1331 of the Affordable Care Act establishes a "Basic Health Program" for states to provide "standard health plans."⁵⁶ The plans are in lieu of Exchange plans for individuals and families earning between 138% and 200% FPL.⁵⁷ Plans offered under the Basic Health Program must provide, at a minimum, essential health benefits.⁵⁸ Premiums may not exceed what an eligible individual would pay for the benchmark plan—the second-lowest cost silver plan—in their rating area.⁵⁹ And cost-sharing may not exceed that of a platinum plan (90%) but only for individuals with a household income of 150% FPL or lower. For individuals above 150% FPL, cost sharing may not exceed that of a gold plan (80%).⁶⁰

While the Basic Health Program has been called a "quasi-public option" or "single-payer lite," it does not involve a public health insurer; Basic Health is implemented through contracts with private insurers.⁶¹

55. See JANET VARON, NW. HEALTH LAW ADVOCATES & NHELP CONTRACT ATT'Y, THE BASIC HEALTH OPTION: CONSIDERATIONS FOR STATES IMPLEMENTING FEDERAL HEALTH REFORM 1-2 (2010), *available at* <http://www.familiesusa.org/conference/health-action-2011/speaker-materials/NHELP-Paper-Basic-Health-Option.pdf>.

56. 42 U.S.C. § 18051(a)(1) (2012).

57. § 18051(e)(1)(B).

58. § 18051(e)(1)(A).

59. § 18051(a)(2)(A)(i). Marketplace insurance plans are divided into five categories based on premium and out-of-pockets costs: "bronze," "silver," "platinum," "gold," and "catastrophic." See also *How Do I Choose Marketplace Insurance?*, HEALTHCARE.GOV, <https://www.healthcare.gov/how-do-i-choose-marketplace-insurance> (last visited Mar. 10, 2014).

60. § 18051(a)(2)(ii) (2012).

61. See BACHRACH ET AL., *supra* note 23, at 8; Ryan Grim, *Senate Committee Passes Quasi-Public Option*, HUFFINGTON POST (Dec 1, 2009, 5:12 AM), http://www.huffingtonpost.com/2009/10/01/senate-committee-passes-q_n_306831.html. Cf. Igor Volsky, *Media Mischaracterizes Cantwell's Basic Health Plan Amendment as "Quasi Public Option,"* CTR. FOR AM. PROGRESS (Oct. 2, 2009), <http://thinkprogress.org/politics/2009/10/02/62618/cantwell-not-public-plan/> ("Under Cantwell's proposal, states would use their purchasing power to negotiate for more affordable coverage options, improve efficiencies, and even lower the health care costs within the Exchange (by shifting lower income and disproportionately sicker individuals into the Basic Health Plan), but they would have to contract with private insurers. Cantwell herself 'declined to liken her proposal to a controversial public option,' which has become a major sticking point in health care reform." I

Under Basic Health, states may select plans from HMOs, licensed health insurers, and networks of care providers established to offer services under the program.⁶² In negotiating contracts, states are to consider “innovation” including: 1) care coordination and care management (especially for enrollees with chronic health conditions); 2) incentives for using preventative services; and 3) provider-patient relationships that maximize patient involvement in care decision-making, including providing incentives for appropriate use of care.⁶³ In turn, providers should use managed care or as many attributes of managed care as possible.⁶⁴

To fund Basic Health, the federal government will pay states 95% of what the enrollee would have received under the Exchange in premium tax credits and cost-sharing reductions. But the Act limits states’ use of those funds to enrollee premium and cost-sharing reductions or providing enrollees additional benefits.⁶⁵

Individuals are eligible for Basic Health Plans if: (1) they are not enrolled in Medicaid; (2) they earn between 133% and 200% FPL; (3) they are not eligible for minimum essential coverage from an employer-sponsored plan; and (4) they are under 65.⁶⁶ Eligible individuals may not purchase coverage from the Exchange.⁶⁷ Thus, no effort is needed to encourage eligible consumers to choose Basic Health Plans over Exchange plans.⁶⁸ Also, lawful permanent resident aliens who earn below 138% FPL and who have lived in the U.S. for less than five years are eligible for a Basic Health Plan, though they are ineligible for Medicaid.⁶⁹

But the Affordable Care Act provides only a broad sketch of Basic Health. Regulations implementing the specifics are needed. And as of this writing, such regulations exist only in draft form and do not fully

think we’ve hit the sweet spot’ (sic) she said. ‘Everybody says they want to have private providers (sic) and we’re saying fine.’”)

62. *Id.*; BACHRACH ET AL., *supra* note 23, at 4.

63. BACHRACH ET AL., *supra* note 23, at 4.

64. *Id.* (explaining that states may also negotiate regional compacts with other states and may agree to have the same issuers provide standard health plans to eligible residents in all compact states).

65. *Id.*

66. *Id.*

67. *Id.*

68. Something not true of the Bridge plan. *See infra* Part II.

69. ALISON SISKIN, CONG. RESEARCH SERV., R 41714, TREATMENT OF NONCITIZENS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 30 (2011), *available at* <http://www.nafsa.org/uploadedFiles/CRS%20analysis%20re%20noncitizens.pdf> (explaining that lawful permanent resident aliens are eligible for the Exchange at the highest level of subsidies, whether or not there is a Bridge or Basic Health Program).

answer many questions regarding a state's implementation of Basic Health.⁷⁰

3. How the Basic Health Plan May Mitigate the Effects of Churn

Unlike the Bridge Program, Basic Health was not created to reduce the effects of churn. Yet, it may be used for that purpose. States might mitigate churn effects by offering Basic Health Plans with coverage similar to Medicaid – “Medicaid-look-alike” plans.⁷¹ Eligible individuals passing 138% FPL could enroll in plans similar to their Medicaid coverage.⁷²

Offering comparable coverage will reduce churn consequences by allowing individuals who transfer out of Medicaid to keep their provider network and benefits until they reach 200% FPL.⁷³ And enrollees need not contend with premium sharing and subsidies under the Exchange. There would be no requirement to estimate income for the following year under the threat of an end-of-year reconciliation.

Depending on the plans' cost, enrollees may be responsible for a portion of the premiums and cost-sharing. But states may not require enrollees to pay more in premiums than they would for the silver plan they would otherwise have been eligible for. And cost sharing may not exceed that of a platinum plan (90% actuarial value) for individuals earning up to 150% or a gold plan (80% actuarial value) for all others.⁷⁴

Basic Health may be characterized as simply kicking the problem down the road by shifting the Exchange threshold to 200% FPL. But churn may be less prevalent at 200% FPL. One study found that churn is likely to decrease at 200%.⁷⁵ The study followed individuals ages 19 to 62, with income below 400% FPL and without employer-sponsored

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70. Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity, 78 Fed. Reg. 59,122 (Sept. 25, 2013) (to be codified at 42 C.F.R. pt. 600 & 45 C.F.R. pt. 144).
71. 78 Fed. Reg. at 59,138.
72. Ann Hwang et al., *Creation Of State Basic Health Programs Would Lead To 4 Percent Fewer People Churning between Medicaid And Exchanges*, 31 HEALTH AFFAIRS 1314, 1318-19 (2012) (indicating that “if states designed Basic Health Programs that were not compatible with Medicaid in terms of benefits and providers, they would simply be adding another layer of churning at both 138% and 200% of the federal poverty level”).
73. BACHRACH ET AL., *supra* note 23, at 6.
74. The proposed rules provide that cost sharing must be reduced even further: 94% actuarial value for those up to 150% FPL and 87% for those up to 200% FPL. 78 Fed. Reg. at 59,133.
75. Hwang et al., *supra* note 72, at 1317.

insurance. After twenty-four months, 39.5% of the population experienced two eligibility changes at the 138% level. At the 200% level, 36.1% experienced two eligibility changes. Population members experiencing one change were 17.3% and 15.8% respectively.⁷⁶

And beyond raw numbers, the study authors noted that at 200% FPL, individuals are more able to weather brief coverage gaps, provider changes, and cost sharing changes.⁷⁷ Shifting Exchange eligibility up would also protect lower income individuals from potential tax credit recoupment.

4. Practical Issues with the Basic Health Program

The complexity of some states' Medicaid systems complicates providing Medicaid-comparable coverage. For example, California's Medi-Cal system is county-focused and divided between two delivery systems: fee-for-service and managed care.⁷⁸ The managed care system has three models, each offering a different type of managed care.⁷⁹ And sixteen not-for-profit health plans and four commercial for-profit plans provide Medi-Cal managed care services to approximately 4.5 million members.⁸⁰ Among managed care plans, there remain carve-outs where

76. *Id.*

77. *Id.*

78. CAL. DEP'T OF HEALTHCARE SERVS., MEDI-CAL MANAGED CARE PROGRAM: BASELINE QUALITY REPORT 3 (Apr. 2012), *available at* http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_QualRpts/Studies/QualityReport_April2012.pdf. *See also* HEALTH RESEARCH FOR ACTION, UNIV. OF CAL. BERKELEY, THE MEDI-CAL MANAGED CARE PROJECT: INCREASING AWARENESS ABOUT MEDI-CAL MANAGED CARE AND PROMOTING VOLUNTARY ENROLLMENT FOR SENIORS AND PERSONS WITH DISABILITIES 1, *available at* http://www.dhcs.ca.gov/provgovpart/Documents/MMCDExpansion/Outreach%20Education_Project_Overview.pdf.

79. The three are County Organized Health Systems (COHS), the two-plan model, and geographic managed care. CAL. HEALTHCARE FOUND., MEDI-CAL FACTS & FIGURES: A PROGRAM TRANSFORMS 27 (2013), *available at* <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFactsAndFigures2013.pdf>. In COHS counties, all beneficiaries share the same managed health care plan. *Id.* The two-plan model supports two different health plans in the county: a "Local Initiative," where the community gives input in the development of the plan, and a "Commercial Plan," a private health plan that provides benefits to Medi-Cal enrollees. *Id.* The state contracts with both plans in counties with this model. *Id.* The third managed health care model is geographic managed care. Under that model, the State contracts with multiple commercial plans to provide benefits. *Id.*

80. *Id.*

the state assumes responsibility for certain care on a fee-for-service basis.⁸¹

Still, California is unifying and simplifying its Medicaid system to coincide with Medicaid expansion. By 2014 managed care will be available in every county, and most members will be mandatorily enrolled into a managed care plan.⁸² But 1 to 1.5 million Californians are expected to continue to receive Medi-Cal services through a fee-for-service system.⁸³

Simplifying Medicaid systems and moving away from fee-for-service in particular, makes providing comparable coverage more feasible. Patients receiving fee-for-service care will not find identical coverage under a managed care Basic Health Plan. In those instances, it is possible — but unlikely — that a Basic Health Plan may include the same provider network.

B. Potential Downsides of the Basic Health Program

1. Only Partial Federal Government Funding

The Basic Health Program is not without risk to the state. One significant challenge is funding. While Basic Health might give consumers more affordable coverage, it could leave states — already in a tenuous financial position — with substantial financial liabilities.

The Affordable Care Act leaves states to cover the administrative costs of the program.⁸⁴ It prohibits states from using Basic Health funds for administrative costs.⁸⁵ Government funding (the 95% of what an individual would have received in premium tax credits and cost sharing on the Exchange) covers only the cost of coverage.⁸⁶

And administrative costs in implementing and operating Basic Health may be substantial. Indeed, federal Medicare administrative

81. *Id.* at 26. *See also* Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 45 (2001) (“As states have begun to purchase managed care products, it is clear that virtually no vendors sell products as broad as Medicaid coverages either requires or permit. States have pursued a logical tactic of effectively breaking up their state plans into two components: one consisting of the managed care contract and the other consisting of residual benefits that remain directly administered by the state. The result has been a hodgepodge of state managed care agreements that vary enormously in what lies ‘inside’ the agreement and what lies ‘outside’ the scope of the contract and, thus remains a direct responsibility of the state agency.”).

82. E-mail from Anthony Cava, Spokesman, Cal. Dep’t of Health Care Servs. to Angelo DeSantis (Aug. 9, 2013) (on file with author).

83. *Id.*

84. 42 U.S.C. § 18051 (2012). *See also* BACHRACH ET AL., *supra* note 23, at 17.

85. § 18051(d)(2).

86. § 18051 (d)(3)(A)(i); MDHMH & HILLTOP INST., *supra* note 17, at 4.

expenses total \$2 billion a year.⁸⁷ Even if the Basic Health Program is housed in an existing state agency, creating a new program always incurs administrative expenses. These include: assessing the quality of care, managing a trust fund for federal payments, collecting and distributing enrollee premiums, and liaising with the federal government.⁸⁸

Collecting and distributing premiums in particular can be an expensive undertaking for states. Because the plans are not likely to be fully funded by the federal government, states will collect premium contributions from enrollees, combine that with federal subsidies, and pay the issuers.⁸⁹ This fund collection and channeling is not required for either Medicaid programs or Exchange plans. Thus, this new duty would require increasing personnel or contracting out to third parties.⁹⁰

And this is not the only potential cost arising out of Basic Health. The federal government's 95% contribution may guarantee a low or zero premium for Basic Health enrollees, but it may not cover all an enrollee's claims during the plan year. If the premiums and federal contributions fail to cover claims, states are liable for the shortfall.⁹¹

Moreover, the lack of final federal regulations for Basic Health creates financial uncertainty for states. How the federal government will reconcile under- and over-payments of state subsidies is unknown.⁹² Also unknown is how precisely federal payments will be calculated.⁹³ The federal government could alleviate some of the financially difficult aspects of Basic Health through regulations, although the proposed rules do not elaborate on this topic.⁹⁴ Indeed, the Act's language that federal contributions can "only be used to reduce the premiums and cost-sharing of, or to provide additional benefits" suggests that regulations alone cannot lift the state's administrative burden.⁹⁵

87. CONG. BUDGET OFFICE, CBO'S MAY 2013 MEDICARE BASELINE 1 (May 14, 2013), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf (noting though this is a small fraction of the over \$500 billion annual Medicare expenditures).

88. MDHMH & HILLTOP INST., *supra* note 17.

89. *Id.* at 11.

90. *Id.* at 4.

91. *Id.* at 5. *See also* TENN. INS. EXCH. PLANNING INITIATIVE, *supra* note 13, at 3.

92. MDHMH & HILLTOP INST., *supra* note 17, at 4-5.

93. *Id.*

94. *Id.*

95. 42 U.S.C. § 18051(d)(2) (2012).

2. Undermining the State-Based Exchange System

Basic Health could also undermine state-based Exchanges. Exchanges are arguably the centerpiece of health care reform. Through Exchanges the Act adopts a private market-based system as the primary mechanism for coverage. By regulating that system, the Act avoids the harshest consequences of a purely private market-based system, while retaining many benefits. Exchanges pool insureds to maximize individual buying power. They standardize benefits and place plans under a single roof, so consumers can compare plans without fear of selecting a plan with insufficient coverage. They automate eligibility and enrollment. Exchanges also subsidize middle class or lower enrollees to make coverage affordable.

But Basic Health could threaten the long-term viability of Exchanges by undermining their ability to self-sustain. Through 2014, state-based Exchanges will be administered using federal grant money. But after 2014, that federal funding ends. Many state Exchanges will then need to self-sustain. Indeed, in California, the legislature has prohibited using state general fund money to support Exchange operations. Thus, after 2014, California's Exchange as well as many other states' and the federally-operated Exchange in states that declined to create their own will support themselves by charging Exchange issuers user fees.

To self-sustain, an Exchange must maintain sufficient enrollment to make it worth the issuers' while. The Exchange must also maintain a good risk-mix to keep issuers in the Exchange market: the insured pool must include a sufficient number of young, healthy individuals. A market comprised of mostly high-risk enrollees drives away issuers.

The Basic Health Program removes many Exchange-eligibles from the Exchange population — including many young and healthy people.⁹⁶ Younger individuals disproportionately earn under 200% FPL. Indeed, some studies find those earning under 200% are the youngest and the healthiest of the Exchange-eligible population.⁹⁷ Without Basic Health,

96. See Hwang et al., *supra* note 72, at 1319.

97. Sara Rosenbaum, *Medicaid's Next Fifty Years: Aligning an Old Program with the New Normal*, 6 ST. LOUIS U. J. HEALTH L. & POL'Y 329, 334 (2013) ("The estimated 56 million low income adults and 35 million children who will experience post-reform churn across the Medicaid and Exchange markets represent the healthiest risk groups across the two markets. Unlike the millions of older and sicker adults who gain enormous benefits from health reform, this group is in the workforce and in relatively good health. The cause of their cross-market churn is, of course, income fluctuation, which is more likely to occur in working families than in adults who are in poorer health and living on fixed incomes. For these families, income fluctuates as younger workers enter and leave the job market, add or drop hours of employment, or have children, thereby increasing family size in relation to total household income, which in turn triggers an effective decline in family income in relation to the federal poverty level.").

these individuals would be eligible for the highest Exchange subsidies, and thus are likely to enroll for Exchange coverage. But with Basic Health, these young and healthy individuals must enroll in Basic Health to receive federal subsidies, imperiling the Exchange's risk-mix.

Removing the under 200% population is a recipe for high premiums and adverse selection as the healthier are progressively pushed out by higher premiums. If this happens on a large scale, Exchange coverage could become unaffordable and ultimately replicate the dysfunctional individual insurance market that existed before the Affordable Care Act.

Basic Health may also add undue administrative complexity to operating an Exchange; it is yet another program for eligibility to be determined. Determining Basic Health eligibility may conflict with existing processes in place for eligibility determinations. Many such processes are backed by expensive and complex IT systems that are already implemented. Modifying them to add new eligibility determinations will add costs. And costs will multiply if this is done state-by-state — a likely scenario.

Basic Health may also confuse consumers; it is a new program with likely different eligibility, plans, benefits, and networks. Given the government's expensive investment in educating the public on how the Affordable Care Act works — and in particular how to enroll in an Exchange plan — adding yet another coverage program undermines this effort.

Thus, with respect to Basic Health, several of the Affordable Care Act's values are in tension. While Basic Health may address some churn consequences and offer affordable coverage for lower-income individuals, it may do so at the expense of the Act's other goals: administrative simplification, consumer friendliness, preserving state autonomy and finances, and (perhaps most importantly) ensuring a successful Exchange. Enacting a program that jeopardizes Exchanges is bad policy on the whole, even if it provides good benefits at low cost.

II. THE BRIDGE PROGRAM

A. An Overview of the Bridge Program

The Bridge Program was first proposed in 2011 by the Tennessee Insurance Exchange Planning Initiative, a group formed to explore the State's options in implementing the Affordable Care Act.⁹⁸ Tennessee proposed a special category of plans for residents losing Medicaid eligibility.⁹⁹ These plans would offer former Medicaid enrollees consistent

98. See TENN. INS. EXCH. PLANNING INITIATIVE, *supra* note 13, at 1; BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 835 (6th ed. 2008) (stating that in 1994 Tennessee launched TennCare under a § 1115 waiver, which allows states to waive most Medicaid requirements and allows Tennessee to offer only Managed Care plan).

99. TENN. INS. EXCH. PLANNING INITIATIVE, *supra* note 13, at 1.

coverage as they transitioned from Medicaid to the Exchange.¹⁰⁰ Tennessee also proposed having Medicaid managed care plans participate in the Exchange as Qualified Health Plans.¹⁰¹ Individuals and families leaving Medicaid could keep the same plan and provider network.¹⁰² From the enrollee's perspective, the only practical difference would be premium contributions (depending on the cost of the plan).

The federal government showed receptiveness to Bridge Programs in December 2012.¹⁰³ The Department of Health and Human Services, Centers for Medicare and Medicaid Services issued guidance allowing Exchanges to permit state Medicaid Managed Care issuers to offer Qualified Health Plans on the Exchange.¹⁰⁴

Several features define a Bridge plan. First, a Bridge plan is an Exchange plan. With few exceptions, the rules and regulations that apply to Exchange plans apply to Bridge plans. Premium subsidies and cost-sharing reductions also apply. A Bridge plan is a Medicaid plan sold on the Exchange. Second, unlike other Medicaid plans, Bridge plans must be a private, commercial plan —not a public plan.

Third, unlike a typical Exchange plan, a Bridge plan is not guaranteed issue for the entire market. Enrollment is limited to qualified individuals and families. To qualify, the individual or family must be leaving Medicaid.¹⁰⁵ Children of parents transitioning from Medicaid are also Bridge eligible.¹⁰⁶ Additionally, states may impose a maximum income for eligibility, though there is no federal requirement to do so. Fourth, enrollee participation in a Bridge plan is optional. Eligible individuals are encouraged — but not required — to select a Bridge plan from the Exchange.¹⁰⁷ But the nature of Bridge plans will likely make them the most affordable (and best value) option for eligible individuals.

100. *Id.*

101. *Id.*

102. COVERED CAL., *supra* note 7, at 1.

103. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ON EXCHANGES, MARKET REFORMS, AND MEDICAID 1, 6 (2012), *available at* <http://www.cms.gov/CCIIO/Resources/Files/Downloads/Exchanges-faqs-12-10-2012.pdf>.

104. *Id.*

105. COVERED CAL., *supra* note 7, at 6 (explaining that initial enrollment would be limited to individuals transitioning from Medi-Cal CHIP (formerly HFP) coverage).

106. *See* TENN. INS. EXCH. PLANNING INITIATIVE, *supra* note 13, at 1.

107. COVERED CAL., *supra* note 7, at 7.

1. How the Bridge Program May Mitigate Churn Consequences

If Medicaid Bridge plan premiums are sufficiently low, the Bridge Program could keep the benefits of the Basic Health Program while shedding many drawbacks. Individuals leaving Medicaid following income increases could keep their plans, with no changes in provider networks and no disruptions in treatment, ensuring continuity of care.¹⁰⁸

And the Bridge Program may prevent families from splitting into different eligibility groups.¹⁰⁹ If one family member loses Medicaid eligibility while other family members remain eligible, all the family members are eligible for a Bridge plan. This ensures that families share the same coverage and provider network. Concomitantly, it alleviates consumer confusion.

States also stand to benefit. Because Bridge plans are Exchange plans, the costs of administering Bridge plans are covered by federal grants until 2015 (states will fund costs after that). But because the program would be running by 2015, no additional administrative expenses are needed to create and implement eligibility rules for a new program. And no new enrollment expenses associated with creating a new program within an existing state entity or creating a new state entity to run the program would accrue to the state.

2. Premium Share and Subsidies

Bridge enrollees are responsible for a portion of plan premiums. But if procurement strategies work effectively and premiums are sufficiently low, individual Bridge enrollees may have little or no premium contribution.

A Bridge enrollee's premium contribution and subsidy is determined in the same manner as any Exchange plan.¹¹⁰ Premium subsidies turn on one's income and the cost of a benchmark plan.¹¹¹ Enrollees are expected to pay up to a certain percentage of their income for coverage. If coverage costs less than that percentage, they get no subsidy. If coverage costs more, they get a subsidy to bring the cost down to that percentage.

Exchanges offer an array of plans. By law, all plans provide specified minimum benefits.¹¹² In some states, all plans will, by law, provide

108. *See id.* at 5, 7 (explaining that this proposal would allow individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage to Covered California to stay with the same issuer and provider network).

109. *Id.* at 1, 5.

110. *See id.* at 5-7.

111. 26 U.S.C. § 36B (2012); COVERED CAL., *supra* note 7, at 6 (stating federal subsidies are based on the second lowest silver plan).

112. 42 U.S.C. § 18022(b) (2012).

identical benefits.¹¹³ In those states, plans differ by their premiums, provider network, and quality.

In all states, plans are categorized by their actuarial value (a measure of the expected percentage of covered services the plan pays at the point of service): bronze (60%), silver (70%), gold (80%), platinum (90%).¹¹⁴ Actuarial value is an average, not an absolute. Some procedures incur higher cost-shares, others lower. And the cost-share is further limited by annual out-of-pocket caps; after the cap is reached, enrollees need not spend anything further out-of-pocket.¹¹⁵

For an example of the plans that may be available to an individual, Anna has twelve plan options, three in each tier (there are no Bridge plan options in this example). Anna's premium contribution for each plan is calculated based on the benchmark plan, the second least expensive silver level plan. For Anna, the benchmark plan is \$160 a month.

Available Exchange Plans (in monthly premiums)			
	Least expensive	Second least expensive	Third least expensive
Bronze (60% actuarial value)	\$100	\$110	\$120
Silver (70% actuarial value)	\$150	\$160 [benchmark]	\$170
Gold (80% actuarial value)	\$200	\$220	\$240
Platinum (90% actuarial value)	\$250	\$280	\$300

113. COVERED CAL., COVERED CALIFORNIA QUALIFIED HEALTH PLAN CONTRACT FOR 2014, at 7 (2013), available at <http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%207,%202013/QHP%20Model%20Contract%20Clean.pdf>.

114. See 42 U.S.C. § 18022.

115. For 2014, the annual cap was going to be \$6,350 for individuals and \$12,700 for families. Avik Roy, *Yet Another White House Obamacare Delay: Out-Of-Pocket Caps Waived until 2015*, FORBES (Aug. 13, 2013, 12:59 AM), <http://www.forbes.com/sites/theapothecary/2013/08/13/yet-another-white-house-obamacare-delay-out-of-pocket-caps-waived-until-2015/> (noting that the caps will now take effect in 2015).

Anna's contribution is based on her income. If Anna's income is \$17,235 (exactly 150% FPL), she must contribute 4% of her income towards a plan.

Income Contribution for Exchange Plans ¹¹⁶		
Income as a percent of poverty line	Initial premium percentage	Final premium percentage
Up to 133%	2.0%	2.0%
133% – 150%	3.0%	4.0%
150% – 200%	4.0%	6.3%
200% – 250%	6.3%	8.05%
250% – 300%	8.05%	9.5%
300% – 400%	9.5%	9.5%

Anna's 4% contribution is measured against the \$160 benchmark plan. The result is her premium subsidy.

$$4\% \times \$17,235 \text{ [Anna's income]} = \$689.40 \text{ or } \$57.45 \text{ per month [Anna's contribution]}$$

$$\$160 \text{ [benchmark plan]} - \$57.45 \text{ [Anna's contribution]} = \$102.55 \text{ [the government's contribution]}$$

Anna's subsidy is \$102.55. If she buys the benchmark plan, she will pay \$57.45 a month. Anna is free to buy any plan, but the government's contribution remains \$102.55 a month; she will pay the difference if she buys a more expensive plan. But if she buys the \$100 bronze plan she will pay nothing because it costs less than the government's \$102.55 contribution. Similarly, if she buys a \$200 gold plan, she must contribute \$97.45.¹¹⁷ When she enrolls and pays her contribution the government will pay the insurer its portion.

116. 26 U.S.C. § 36B.

117. Given that her income qualifies her for cost sharing reductions, a silver level plan will actually have lower co-pays and a lower deductible than the gold level plan.

Here are Anna’s actual costs based on her subsidy:

Anna’s Contributions for Each Exchange Plan			
	Least expensive	Second least expensive	Third least expensive
Bronze (60% actuarial value)	Nothing of \$100	\$7.45 of \$110	\$17.45 of \$120
Silver (70% actuarial value)	\$47.45 of \$150	\$57.45 of \$160 [benchmark]	\$67.45 of \$170
Gold (80% actuarial value)	\$97.45 of \$200	\$117.45 of \$220	\$137.45 of \$240
Platinum (90% actuarial value)	\$147.45 of \$250	\$177.45 of \$280	\$197.45 of \$300

By comparison, Ike, who earns more than Anna, receives a smaller subsidy.¹¹⁸ Ike (who lives in the same coverage area as Anna) earns \$22,980, exactly 200% FPL. Thus, his premium contribution is 6.3%, or \$120.65 a month, and his subsidy is \$39.35 a month:

$$6.3\% \times \$22,980 = \$1,447.74 \text{ or } \$120.65 \text{ a month [Ike's contribution]}$$

$$\$160 \text{ [benchmark plan]} - \$120.65 = \$39.35 \text{ [the government's contribution]}$$

118. Premium percentages for mid-range income percentages are calculated on a sliding scale in a linear manner and are rounded to the nearest one-hundredth of one percent. Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931, 50,931 (Aug. 17, 2011) (to be codified at 25 C.F.R. pt. 1). For example, an income of 275% is halfway between 250% and 300%, thus rounded to the nearest one-hundredth of one percent, the percentage is 8.78 (halfway between 8.05 and 9.5). *Id.* Similarly, the rate for 210% is 6.65%. *Id.*

Here are Ike’s plan options:

Ike’s Contributions for Each Exchange Plan			
	Least expensive	Second least expensive	Third least expensive
Bronze (60% actuarial value)	\$60.64 of \$100	\$70.64 of \$110	\$80.64 of \$120
Silver (70% actuarial value)	\$110.64 of \$150	\$120.64 of \$160 [benchmark]	\$130.64 of \$170
Gold (80% actuarial value)	\$160.64 of \$200	\$180.64 of \$220	\$200.64 of \$240
Platinum (90% actuarial value)	\$210.64 of \$250	\$240.64 of \$280	\$260.64 of \$300

But subsidies are not an entitlement. They are only a means to ensure affordability. If a benchmark plan costs less than one’s expected contribution, there is no subsidy, even if one’s income is below 400% FPL.¹¹⁹ For example, Justin lives in the same coverage area as Anna and Ike and earns \$34,470 a year in 2013, exactly 300% FPL. His expected contribution is \$272.89 and he receives no subsidy:

$$9.5\% \times \$34,470 = \$3,274.65 \text{ or } \$272.89 \text{ a month. [Justin’s contribution]}$$

$$\$160 - \$272.89 = -\$112.89 \text{ [government has no contribution]}$$

Because Justin’s contribution exceeds the cost of the benchmark plan, Justin receives no subsidy; he pays the full premium for all plans — regardless of the cost.

119. See 26 U.S.C. § 36B (2012).

Justin's Contributions for Each Exchange Plan			
	Least expensive	Second least expensive	Third least expensive
Bronze (60% actuarial value)	\$100 of \$100	\$110 of \$110	\$120 of \$120
Silver (70% actuarial value)	\$150 of \$150	\$160 of \$160 [benchmark]	\$170 of \$170
Gold (80% actuarial value)	\$200 of \$200	\$220 of \$220	\$240 of \$240
Platinum (90% actuarial value)	\$250 of \$250	\$280 of \$280	\$300 of \$300

This is not a loophole to the government's obligation to subsidize those who earn up to 400% FPL. Justin still gets the deal he would have gotten (insurance at 9.5% of income), but he does so without the complicated tax consequences, such as reconciliation, which may occur for individuals receiving premium subsidies. Reconciliation is the IRS's end-of-year calculation to determine whether the advance subsidy payments to an individual accord with an individual's tax-year income.¹²⁰ If the advance payments were too high (because the individual earned more than expected) the IRS will assess the difference.¹²¹ But overpayment assessments are capped based on income.¹²² If payments were too low, the IRS refunds the difference.¹²³

Premium subsidies work the same for Bridge plans. But Bridge plans are expected to cost less than most, if not all, plans available on the Exchange and thus will require little, if any, enrollee contribution. Small premiums are important if the transition from Medicaid to Exchange coverage is to be relatively seamless.

120. 26 C.F.R. § 1.36B-4 (2013); Hwang et al., *supra* note 72, at 1315.

121. 26 C.F.R. § 1.36B-4.

122. 26 U.S.C. § 36B.

123. *Id.*

3. Cost Sharing

In addition to premium contributions (if any), Bridge enrollees incur a limited amount of cost-sharing.¹²⁴ Examples include a \$10 doctor visit co-pay, \$200 for a hospital admittance, or a 20% coinsurance for a specific procedure.

But cost-sharing for Bridge enrollees is limited. Cost-sharing subsidies offset most cost-sharing.¹²⁵ For example, an individual earning 138% FPL enrolling in a silver-level plan¹²⁶ (70% actuarial level) would receive a government subsidy boosting the actuarial value to 94%.¹²⁷ The insurer recoups the difference in cost sharing from the federal government.¹²⁸ For providers, this affords a far more reliable source of payment.¹²⁹

Income	Silver actuarial value plus subsidy
100–150% FPL	94%
151–200% FPL	87%
201–250% FPL	73%

B. Practical Issues with the Bridge Plan

1. Setting the Proper Price for a Bridge Plan

The Bridge Program has several practical hurdles, most relating to ensuring a proper price for Bridge plans. Too low or too high a price can create consequences for enrollees.

Offering a Bridge plan can affect an enrollee’s premium tax credit. In some cases, an individual may be worse off if a Bridge plan is available to him.¹³⁰ This is because a premium subsidy turns on the silver plan’s availability to the individual at the time of enrollment. As a silver-level Exchange plan, the Bridge plan can affect which plan is the second-lowest-cost silver plan.

124. See COVERED CAL., *supra* note 7, at 6.

125. See 42 U.S.C. § 18071 (2012).

126. Cost subsidies are available only for silver-level plans.

127. See TENN. INS. EXCH. PLANNING INITIATIVE, *supra* note 13, at 3; COVERED CAL., *supra* note 7, at 6-7 (stating the actuarial value of a silver plan is 70% with cost sharing subsidies bringing it up to 94%).

128. See TENN. INS. EXCH. PLANNING INITIATIVE *supra* note 13, at 3.

129. *Id.*

130. See *id.* at 2.

Unless the Bridge plan’s premium is at least as much below the otherwise-lowest-cost silver plan as the premium for the otherwise-lowest-cost silver plan is below the otherwise-second-lowest cost silver plan, the individual could end up worse off with a Bridge plan offered than without.

For example, Kelsey has an income of \$24,000 and her premium contribution share is 4% of her income. Under Scenario #1 with no Bridge plan available to Kelsey, Kelsey’s subsidy is \$170 per month. If Kelsey bought the lowest cost silver plan, she would pay \$50 a month.

Scenario #1 Monthly Costs (with No Bridge Plan)	
Lowest cost silver plan	Second lowest cost silver plan
\$220	\$250 (benchmark)

$$\$24,000 \times 4\% = \$960 \text{ or } \$80 \text{ per month. [Kelsey’s contribution]}$$

$$\$250 - \$80 = \$170 \text{ subsidy [the government’s contribution]}$$

Under Scenario #2, a Bridge plan is available to Kelsey, and it is less expensive than any other silver plan. It therefore bumps the previously lowest-cost plan into the benchmark position. With a less-expensive benchmark plan, Kelsey’s subsidy for all plans (including the Bridge plan) shrinks.

Scenario #2 Monthly Costs (with Bridge Plan Option)		
Bridge plan	Second lowest cost silver plan (formerly lowest cost silver)	Third lowest cost plan (formerly second lowest cost silver)
\$200	\$220 (benchmark)	\$250

With a benchmark plan available, Kelsey’s subsidy drops to \$140 from \$170:

$$\$24,000 \times 4\% = \$960 \text{ or } \$80 \text{ per month [Kelsey’s contribution]}$$

$$\$220 - \$80 = \$140 \text{ subsidy [the government’s contribution]}$$

With a subsidy of \$140, \$30 less than before, if Kelsey buys the Bridge plan (even though it is \$20 cheaper than the lowest-cost plan in Scenario #1), Kelsey’s monthly out-of-pocket is now \$60 instead of \$50. The lower cost Bridge plan costs Kelsey money!

To avoid this, a Bridge plan should be significantly cheaper than the previously lowest cost plan. This compensates for the lower premium subsidy brought about by the cheaper benchmark plan. For example, in Scenario #3 the Bridge plan is now \$40 cheaper, and this will save Kelsey money.

Scenario #3 Monthly Costs (with Lower Priced Bridge Plan Option)		
Bridge plan	Second lowest cost silver plan (formerly lowest cost silver)	Third lowest cost plan (formerly second lowest cost silver)
\$160	\$220 (benchmark)	\$250

$$\$24,000 \times 4\% = \$960 \text{ or } \$80 \text{ per month. [Kelsey’s share]}$$

$$\$220 - \$80 = \$140 \text{ subsidy [the government’s contribution]}$$

Now Kelsey’s subsidy is still only \$140 (versus \$170 without the Bridge plan), but because the Bridge plan costs only \$160, Kelsey pays only \$20 a month for the Bridge plan. Thus to keep Bridge enrollees from paying more for premiums, the Bridge programs must be a good deal less expensive than the alternatives.

A related problem occurs if the Bridge program costs significantly more than other Exchange plans. A Bridge plan that is too expensive, though it will not affect the benchmark or subsidy, gives eligible individuals no incentive to enroll. For example, a Bridge plan costing \$280 gives Kelsey no incentive to enroll:

Scenario with an Expensive Bridge Plan		
Lowest-cost plan	Second lowest cost silver plan	Bridge plan
\$220	\$250 (benchmark)	\$280

$\$24,000 \times 4\% = \960 or \$80 per month. [Kelsey's contribution]

$\$250 - \$80 = \$170$ subsidy [the government's contribution]

Kelsey receives the full \$170 subsidy, but if she applies it to the \$280 Bridge plan, she will pay \$110 per month. Given that she could buy the cheapest plan for only \$50 per month, the financial incentives work against her selecting the Bridge plan. Indeed, she may end up changing provider networks to avoid paying for the expensive Bridge plan, undermining the whole point of the Bridge program. Thus, Bridge plans must be competitively priced.

This discussion of overly expensive Bridge plans is not purely hypothetical. In California, for example, not all Medicaid managed care plans participating in the Exchange came in at the lower end of the premium spectrum for plan year 2014.¹³¹ Thus, consumer protections should ensure that the availability of a Bridge plan does not adversely affect consumers and their premium subsidies. This could be achieved by requiring Exchanges to exclude plans not in the consumer interest or to empower them to use selective contracting authority for the same purpose.¹³²

2. The Difficulty in Matching Medicaid Coverage

A Bridge plan must be available both as a Medicaid and an Exchange option. If a Medicaid plan is not available on the Exchange, there is no “bridge” for the consumer—the consumer must change plans and possibly providers.

This could happen if Medicaid insurers opt not to offer plans on the Exchange. Indeed, the primary hurdle for a successful Bridge Program is convincing Medicaid insurers to offer plans on the Exchange. This requires them to become certified as Qualified Health Plans and, in many cases, to obtain a license to sell health insurance in the commercial market.¹³³

Still, if a Medicaid enrollee is covered by a plan not available on the Exchange, it may be good policy to make available alternative Bridge plans. By offering a plan that is similar but not identical to the Medicaid plan, the enrollee can maintain a substantially similar provider network. Thus, losing eligibility would not mean changing care providers. Moreover, in states that implement strict benefit requirements for Medicaid and Exchange plans, the switch would not entail changing benefits.

131. See COVERED CAL., HEALTH INSURANCE COMPANIES AND PLAN RATES FOR 2014: MAKING THE INDIVIDUAL MARKET IN CALIFORNIA AFFORDABLE 6-7 (Aug. 6, 2013), https://www.coveredca.com/PDFs/English/plans/CC_Health_Plans_Booklet-8-6-13.pdf (providing Covered California's statewide average premium rates).

132. *Id.*

133. See S.B. 3, 1st Extraordinary Sess. (Cal. 2013).

And once enrollees switch into an Exchange Bridge plan, they could keep that same plan, even if they churn back into Medicaid because every Bridge plan on the Exchange will be available in Medicaid (even if the inverse is not true).¹³⁴

C. Legal Issues with the Bridge Plan

The Bridge Program raises several legal issues. Like the Basic Health Program, different values underlying the Affordable Care Act are in tension with Bridge Program implementation. And several important consumer protection reforms in the Act (crucial in the context of private commercial coverage) pose legal obstacles to a successful Bridge program.

Beginning in 2014, non-grandfathered individual or small group health plans may not reject applicants for any reason except application fraud. This is known as the guaranteed issue requirement.¹³⁵ And such plans must permit existing enrollees to renew their coverage at the end of each plan year, known as the guaranteed renewability requirement.¹³⁶

These reforms are backed by good and powerful reasons. In the individual market, issuers used to deny enrollment to those with preexisting conditions or a history of medical claims. Issuers would also terminate coverage for individuals with higher-than-expected claims during a plan year.¹³⁷ These practices were common in states without a guaranteed issue or renewability requirement — leaving those most needing care either unable to get it or unable to get it at affordable prices. But the guaranteed issue and guaranteed renewability requirements pose obstacles to the Bridge Program.

1. Guaranteed Issue Requirement

If the purpose of the Bridge program is to bridge Medicaid and Exchange coverage, it does not follow that *all* Exchange-eligible individuals should have access to Bridge plans.¹³⁸ Indeed, Bridge plan networks will

134. An enrollee who fell below 138% could always switch to Medicaid if he or she is dissatisfied with the Bridge plan for any reason.

135. 42 U.S.C. § 300gg-1 (2012).

136. 42 U.S.C. § 300gg-2(a) (2012).

137. See Memorandum from the Comm. on Energy and Commerce Staff to the Members and Staff of the Subcomm. on Oversight and Investigations 7 (June 16, 2009), *available at* http://democrats.energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf; *Terminations of Individual Health Policies by Insurance Companies, Hearing Before the Subcomm. on Oversight and Investigations*, 111th Cong. 2 (2009) (statement of Rep. Bart Stupak, Chairman).

138. See Letter from State of Tenn., to Ctrs. for Medicare & Medicaid Servs., Dep't of Health and Human Servs. app. C (Oct. 31, 2010), *available at*

likely have limited capacity. Allowing anyone to enroll could overwhelm these plans, forcing plans to close enrollment and excluding the very group the Bridge Program is designed to benefit.

Thus, the federal government has allowed states to limit eligibility by contract with the state Medicaid agency — rather than by statute or regulation — without running afoul of the guaranteed issue requirement. A state Medicaid agency can include in its contracts with Bridge plan issuers a provision that individuals transferring out of Medicaid are eligible for the Bridge Program, but the issuer need not allow other Exchange enrollees to enroll.

Under the government’s rationale, this contractual method does not violate the guaranteed issue requirement because it is imposed contractually through the Medicaid program. Therefore, it is merely an extension of Medicaid. This legal maneuver lets the Bridge Program sidestep the guaranteed issue requirement.¹³⁹

In the same vein, the Bridge Program’s goals are served by limiting eligibility to a specified maximum income. While it would be generous to allow Medicaid enrolled lottery winners to keep the same plans and provider network, the Bridge Program’s aims are not advanced by enrolling that population. Rather, given the limited capacity of Bridge plans and the affordability goal, only individuals transitioning out of Medicaid into the lower end of the Exchange subsidy should be assured access to the program.

2. Guaranteed Renewability Requirement

Guaranteed renewability also poses a potential problem. The Bridge Program is conceptually a transitional program. An individual’s remaining on a Bridge plan indefinitely regardless of how long he has been Exchange-eligible or how much he earns undercuts the program’s purpose, which is to ensure an easy transition into commercial Exchange-based coverage. But limiting the duration of eligibility runs afoul of the guaranteed renewability requirement.

As with the guaranteed issue requirement, states can address the renewability requirement by contracting with managed care providers through Medicaid to limit the duration of Bridge plan enrollment and set income caps. California followed this approach in enacting California’s Bridge Program legislation.¹⁴⁰

3. Qualified Health Plan Requirements under the Exchanges

The Bridge Program also conflicts with plan offering requirements. The Affordable Care Act and implementing regulations require each

<http://www.regulations.gov/contentStreamer?objectId=0900006480f62063&disposition=attachment&contentType=pdf>.

139. *Id.*

140. See S.B. 3, 1st Extraordinary Sess. (Cal. 2013).

Qualified Health Plan issuer to offer at least one plan at the silver level (70% actuarial value) and one at the gold level (80% actuarial value). California law requires Qualified Health Plan issuers to offer at least one plan at all five levels.¹⁴¹ And, with certain exceptions, each Exchange issuer that also participates in the private commercial market outside of the Exchange must offer each Qualified Health Plan both inside and outside of the Exchange.¹⁴²

Those requirements make sense for non-bridge Exchange plans. But Bridge plans are designed for low-income individuals with limited ability to cost share. For this population, only silver-level plans make sense because only silver plans are eligible for cost-sharing subsidies. Gold and platinum plans are a bad deal for low-income individuals because the cost-sharing subsidies for silver plans raise the actuarial value of silver above that of higher-priced gold and platinum plans.¹⁴³

For the same reason, a bronze level plan may not be suitable as a Bridge plan for many enrollees because bronze plans are not eligible for cost-sharing subsidies. Low-income individuals may have a hard time shouldering the high co-pays and deductibles (40% actuarial value) of bronze plans.¹⁴⁴ And the cost-sharing subsidies are needed to make the Bridge plans functionally similar to Medicaid. Thus, silver level plans make the most sense for Bridge plans.

Moreover, most potential Bridge plan issuers have no interest in expanding their commercial coverage plans beyond those necessary to effectuate best value Bridge coverage. And although most Medicaid managed care issuers do not participate in the private commercial market, some do, such as issuers covering county workers in their relevant service area and Medicaid-managed care beneficiaries. In California, some Medicaid-managed care issuers are newly entering the individual and small group market in order to participate in the Exchange. Thus, it would be onerous for them to have to offer their Bridge products to the outside market as well.¹⁴⁵

Ultimately satisfying Exchange Qualified Health Plan requirements is only partially possible under existing law. State requirements may be

141. *Id.* (noting the other three are bronze, platinum, and catastrophic plans).

142. COVERED CAL., *supra* note 7, at 8.

143. Eligible individuals must have an income below 250% of the federal poverty level.

144. Young, healthy people are likely to opt for the bronze or catastrophic plans when they can. Their monthly premiums are lower, and unless they get unexpectedly sick or injured they are likely to have lower usage than average.

145. This would be necessary only to comply with the California rule that an issuer that participates in the outside commercial market (not Medicaid or CHIP) must offer all Qualified Health Plans both inside and outside the Exchange.

sidestepped.¹⁴⁶ Because a state statutory change was necessary to implement the Bridge Program in California, it was simple enough to exempt Bridge plan issuers from the required offerings mandate. But the federal requirement to offer at least a silver and gold plan is not waivable at the state level. Thus, Bridge plan issuers must offer eligible enrollees both a silver and a gold plan. This will create unnecessary work for the issuer who must create and obtain certification for the superfluous gold plan. And issuers and Exchange administrators must work to discourage people from enrolling in gold Bridge plans as they are not a good deal for Bridge-eligible individuals below 250% FPL.

CONCLUSION

Fundamentally, Basic Health creates an alternative to the Exchange while the Bridge Program works through the Exchange. This difference ultimately makes the Bridge Program's approach superior. Basic Health's primary deficiency is that its very existence threatens the Exchange. State-based Exchanges will stand or fall based on participation; a critical number of enrollees and a proper risk-mix ratio are essential. Basic Health threatens both of these by segmenting the market. It channels a group of largely young and healthy individuals away from the Exchange, leaving Exchange plan issuers fewer and less healthy customers. By contrast, the Bridge Program works within the Exchange framework and keeps all eligible populations in the Exchange. This encourages a healthy risk-mix ensuring a sustainable Exchange.

Basic Health also leaves too many questions about the cost to the state. Though the federal government will provide funding, it is unclear how administrative expenses will be covered and whether the government's contribution will completely cover the cost. If funds are insufficient, the Affordable Care Act leaves states few options in terms of reducing benefits or shifting costs to enrollees. Still, while Basic Health may be costly to the states, the Bridge Program has the potential to be more costly to enrollees because the Bridge Program has fewer restrictions that ensure that enrollee premium contributions are at a minimum.

Ultimately, the Bridge Program can better mitigate the effects of churn for several reasons. The Bridge Program can extend beyond 200% FPL. For instance in California, an enrollee remains eligible for Bridge plans until he exceeds 250% FPL. And because the federal government has not regulated at this point, theoretically states could have no maximum income for Bridge eligibility. At 250% FPL (\$58,875 for a family of four) individuals can better weather shifts and are less likely to see dramatic income shifts. And if they do cross 250% FPL, the shift will

146. See S.B. 3, 1st Extraordinary Sess. (Cal. 2013) (exempting Bridge plans from the requirement to sell plans at all five coverage levels).

be less dramatic than switching from one program – Medicaid – to another – Exchange coverage. The switch is between one Exchange plan to a different, but likely comparable, Exchange plan.

For these reasons, the Bridge Program is the superior approach. And given the risk the Basic Health Program poses to the Exchanges, arguably, Basic Health could undermine health care reform more than churn might.