LAO
70 YEARS OF SERVICE

March 18, 2013

Hon. Bill Emmerson
Senator, 23rd District
Room 5082, State Capitol
Sacramento, California 95814

Dear Senator Emmerson:

Issues Related to the California Health Benefits Exchange. You requested that we analyze various fiscal and policy issues related to the California Health Benefits Exchange (Exchange). Specifically, you expressed concerns as to whether the Exchange will meet the federal requirement that it be financially self-sufficient beginning January 1, 2015. You requested that our office assist you in evaluating whether the Exchange's plans represent the most cost-efficient approach, and to what extent the Exchange presents risks either to the state budget or to the costs of health care in the Exchange or more broadly in California. More specifically, you asked that we respond to several questions on the following topics: (1) projected operating losses, (2) potential extra activities, (3) service center operations, and (4) complex application processes. Subsequently, your staff sent us an additional request related to the so-called Bridge Plan (a component of the Exchange's operations that has recently been adopted in concept by the Exchange Board) described below, and asked that we make it our highest priority. Accordingly, we are responding to your request on a flow basis, with our responses to your questions about the Bridge Plan first. We plan to address all of your remaining questions by April 5, 2013.

Issues Specifically Related to the Bridge Plan. In an e-mail sent on February 13, 2013, your staff requested that our office analyze the following issues:

- Assuming eligibility up to 200 percent of the federal poverty level (FPL), how might the existence of a Bridge Plan affect the benchmark plan used to determine the level of federal tax subsidies available to other Exchange enrollees? Although it is impossible to know beforehand what premium levels will be offered, please evaluate how a decrease of 5 percent or 10 percent in the premium of the benchmark plan would affect (if at all) the value of subsidies received by Californians in non-Bridge Exchange plans.
- How would a Bridge Plan affect the total risk pool present in the Exchange, if at all? Would a Bridge Plan be considered part of the overall risk pool, or would it be a stand-alone risk pool? How might the answer to this question affect the gross premiums (that is, prior to applying subsidies) available in the Exchange?

Your staff also indicated that it would welcome our office's thoughts regarding any additional advantages and disadvantages associated with creating a Bridge Plan.

Below, we provide our analysis of the two sets of issues identified in the e-mail from your staff. Our analysis is based on our best understanding of federal law and guidance at this time. We note that the decision to establish a Bridge Plan involves major policy choices and requires significant analysis to identify and assess all of the potential advantages and disadvantages. Our office has not completed such an analysis at this time, but we are able to provide our initial assessment of the issues you identify in your questions as well as a list of some additional questions—the answers to which may raise potential issues to consider when determining whether or not California should create a so-called Bridge Plan and the characteristics of such a plan if one were created.

LAO Bottom Line. Establishing a Bridge Plan in California has the potential to significantly affect—either positively or negatively—the affordability of coverage offered to the eligible Bridge population. However, based on our understanding of existing federal law and guidance, it would not have a direct effect on the benchmark plan and premium subsidies available to other Exchange enrollees. At this time, it is unclear how a Bridge Plan would affect the total Exchange risk pool, but the extent of such an effect would be limited by the fact that the change in the number of individuals who obtain Exchange coverage is likely small compared to the total number of Exchange enrollees. Each non-bridge plan offered on the Exchange would potentially be affected differently.

ACA Background

The Patient Protection and Affordable Care Act of 2012 (ACA) contains several provisions that are intended to expand the number of people with health coverage. We discuss some of these provisions below.

Authorizes Medicaid Expansion for Adults Up to 138 Percent FPL. In California, the Medicaid Program is administered by the state Department of Health Care Services, and is known as Medi-Cal. Currently, the income threshold used to determine eligibility for Medi-Cal varies. For some groups, such as parents, the income threshold is about 100 percent FPL. (In 2012, the FPL is $11,170 per year for an individual and $23,050 for a family of four.) For other groups, the income threshold is significantly higher—reaching up to 200 percent FPL for pregnant women and 250 percent FPL for children (when the transition of the state's Healthy Families Program into Medi-Cal is complete in 2013).

Beginning January 1, 2014, the ACA gives state Medicaid programs the option to cover most adults under age 65—including childless adults—with incomes at or below 133 percent FPL. (After taking into account a technical adjustment to eligibility required under the federal law, the income limit is 138 percent FPL.) The federal government would pay for the large majority of the costs associated with the expansion.

Establishes Exchanges Where Individuals Can Purchase Health Coverage. The ACA establishes entities called Health Benefit Exchanges. Chapter 655, Statutes of 2010 (AB 1602, John A. Pérez), and Chapter 659, Statutes of 2010 (SB 900, Alquist and Steinberg), established the California Health Benefit Exchange—also known as the Exchange or "Covered California." Through the Exchange, nonelderly citizens and legal residents who are (1) not offered affordable job-based coverage and (2) not eligible for public health coverage (such as Medi-Cal) will be

eligible to purchase individual health coverage. Health plans offered through the Exchange must include a minimum set of benefits, known as the "essential health benefits," including physician services, hospitalizations, emergency services, and prescription drugs.

Provides Federal Subsidies for Certain Individuals Purchasing Coverage on the Exchange. Individuals with household incomes between 100 percent and 400 percent FPL who purchase coverage on the Exchange will be eligible for federal subsidies to offset a portion of the cost of that coverage. (Newly qualified aliens with income below 100 percent FPL will also be eligible for subsidies.) The amount of federal subsidies vary based on income—with greater federal subsidies available to households with lower incomes. We discuss how the federal subsidies will be calculated in more detail below.

WHAT IS A BRIDGE PLAN?

Bridge Plans Would Serve as a "Bridge" Between Medi-Cal and the Exchange. Under recent federal guidance, states have the option to create so-called Bridge Plans upon federal approval, whereby Medi-Cal managed care plans would be certified to offer coverage on the Exchange as plans that serve as a bridge between Medi-Cal and the Exchange (such Medi-Cal managed care plans are hereafter referred to as bridge plans). Bridge plans would potentially be offered to a limited Exchange population, including one or more of the following groups: (1) Medi-Cal enrollees who have an increase in household income that causes them to become ineligible for the program, (2) parents who have household income that is too high to qualify for Medi-Cal, but who have children enrolled in Medi-Cal, and (3) certain other low- to moderate-income adults whose income exceeds the Medi-Cal income threshold (such as individuals with household incomes between 139 percent and 200 percent FPL). A bridge plan would be one federally subsidized coverage option available to the eligible population. The population eligible for the Bridge Plan (hereafter referred to as the Bridge population) would also have the option to receive federal subsidies to purchase other health plans offered on the Exchange.

Characteristics of Bridge Plans That Would Meet Requirements for Federal Approval Are Still Uncertain. There is limited federal guidance about what flexibility would be given to states that wish to establish them. In guidance issued on December 10, 2013, the federal government indicated its willingness to approve some version of a Bridge Plan, but noted certain provisions of federal law with which states would need to comply, such as ensuring bridge plans generally meet the federal requirements for health plans that are offered on the Exchange. Despite this initial federal guidance, many of the characteristics of a Bridge Plan are still uncertain at this time. The federal government indicated that additional Bridge Plan guidance will be issued soon.

"Narrow" Bridge Plan Is One Option. On February 26, 2013, the Covered California board authorized, contingent on federal approval, implementation of one version of a Bridge Plan that is sometimes referred to as the narrow Bridge Plan. Under this version, Medi-Cal managed care plans would be certified as bridge plans to offer federally subsidized coverage to the following Exchange populations: (1) Medi-Cal enrollees who have an increase in household income that causes them to become ineligible for the program and (2) parents who have household income that is too high to qualify for Medi-Cal, but who have children enrolled in Medi-Cal. Other populations who are eligible for federally subsidized Exchange coverage would not be eligible

for a bridge plan, but they would be eligible to purchase the other plans offered through the Exchange (non-bridge plans). The bidding process for plans seeking to offer coverage on the Exchange would be amended to allow them to submit bids after the rates for the non-bridge plans are known.

LAO ASSESSMENT

Based on conversations with your staff, we agreed to focus our analysis on this particular narrow version of a Bridge Plan approved by the Covered California Board. A different version of the Bridge Plan would potentially result in different answers to your questions and raise different issues for consideration. We note that, although the Board approved implementing this version of the Bridge Plan, there are still important details about the Bridge Plan that are still unclear at this time—such as the amount of time an individual will be allowed to maintain coverage in a bridge plan. In addition, creating such a Bridge Plan in California will also require changes to state law.

Below, we provide our responses to your questions about how a Bridge Plan would effect: (1) the benchmark plan and the amount of federal tax subsidies available to other Exchange enrollees and (2) how it would affect the risk pool present in the Exchange. We also provide a preliminary list of potential issues to consider when evaluating whether or not California should create a Bridge Plan.

Effect on Benchmark Plan and Federal Tax Subsidies for Other Exchange Enrollees

Net Consumer Premiums Depend on the Premium Difference Between the Benchmark Plan and the Plan Selected. The federal premium tax credit subsidy (premium subsidy) available to an individual purchasing coverage on the Exchange is based on the premium of the second-lowest-cost "silver" plan offered on the Exchange (on average, a silver plan pays 70 percent of the cost of covered benefits). (There are cost-sharing subsidies that are available if an individual below 250 percent FPL purchases a silver plan that are not available for bronze, gold, or platinum plans.) Hereafter, we refer to the second-lowest-cost silver plan as the "benchmark plan." The premium subsidies are structured in a way that ensure the premium an individual would pay for the benchmark plan will not exceed a specified percentage of household income, as shown in Figure 1 (next page).

Figure 1

Maximum Premium for Benchmark Plan Varies With Income

Household Income (As a Percent of FPL)	Maximum Premium for Benchmark Plan[a] (As a Percent of Income)
Below 133%	2.00-3.00%
133-150	3.00-4.00
150-200	4.00-6.30
200-250	6.30-8.05
250-300	8.05-9.50
300-400	9.50

[a] Benchmark plan is the second-lowest-cost silver plan.
FPL = federal poverty level.

Figure 2 illustrates a hypothetical example of Exchange health plan options and the federal premium subsidy available to a single adult with income 150 percent FPL. An individual may choose to purchase a non-benchmark plan offered on the Exchange that is more or less expensive than the benchmark plan, but the premium subsidy available to that individual will remain the same. It is important to note that a consumer's net premium largely depends on the difference between the premium of the plan that he or she selects and the benchmark plan premium.

Figure 2

Example of Coverage Options for an Individual With Income 150 Percent FPL

	Silver Plan A	Silver Plan B (Benchmark Plan)	Silver Plan C
Monthly premium[a]	$360	$400	$440
Less: federal premium subsidy[b]	343	343	343
Monthly Net Premium for Consumer	**$17**	**$57**	**$97**

[a] Example premiums are for illustrative purposes only and do not represent actual premiums or LAO projections.
[b] Premium subsidy = premium for benchmark plan - (4 percent of household income) = $400 - ($1,436 X 4 percent) = $343.
FPL = federal poverty level. In 2013, an individual with an income of 150 percent FPL makes $17,235 annually or $1,436 monthly.

Establishing a Bridge Plan Would Likely Change the Applicable Benchmark Plan, Thereby Affecting the Premium Subsidies for the Bridge Population. For illustrative purposes, we assume a bridge plan would be the lowest-cost or second-lowest-cost silver plan. Under this assumption, which we consider reasonable, offering a bridge plan would change the applicable benchmark plan for the Bridge population and likely reduce the amount of the premium subsidy

available to that population. In the example provided in Figure 3 offering a low-cost bridge plan to an individual eligible for the Bridge Plan has the effect of: (1) changing the benchmark plan from Silver Plan B to Silver Plan A, (2) reducing the monthly premium of the applicable benchmark plan from $400 to $360 (or by 10 percent), and (3) reducing the amount of the monthly premium subsidy from $343 to $303, and thereby making non-bridge plans $40 more expensive for that individual. However, the affordability of the bridge plan depends on the premium difference between the benchmark plan and the bridge plan. For example, if the monthly bridge plan premium were $303, then the net monthly premium (after subsidy) for the consumer would be zero. Alternatively, if the monthly bridge plan premium were $340, then the net monthly premium for the consumer would be $37—higher than the $17 monthly net premium for Silver Plan A that would have been available in the absence of a Bridge Plan.

Figure 3

Example Calculation of Premium Subsidies for the Bridge Population, With and Without Bridge Plan

	Without Bridge Plan		
	Silver Plan A	Silver Plan B (Benchmark Plan)	Silver Plan C
Monthly premium[a]	$360	$400	$440
Less: federal premium subsidy	343	343	343
Monthly Net Premium for Consumer	**$17**	**$57**	**$97**

	With Bridge Plan			
	Bridge Plan	Silver Plan A (Benchmark Plan)	Silver Plan B	Silver Plan C
Monthly premium[a]	—[b]	$360	$400	$440
Less: federal premium subsidy	$303	303	303	303
Monthly Net Premium for Consumer	—[b]	**$57**	**$97**	**$137**

[a] Examples represent a single individual eligible for a Bridge Plan with an income of 150 percent FPL. Premiums are for illustrative purposes only and do not reflect actual premiums or LAO projections.

[b] Example assumes Bridge Plan is the lowest-cost silver plan.

FPL = federal poverty level. In 2013, an individual with an income of 150 percent FPL makes $17,235 annually or $1,436 monthly.

Establishing a Bridge Plan Would Likely Have No Direct Effect on Individuals Ineligible for the Bridge Plan. A final regulation issued by the Internal Revenue Service on May 23, 2012 indicates that "a qualified health plan that is not open to enrollment by a taxpayer or family member at the time the taxpayer or family member enrolls in a qualified health plan is disregarded in determining the applicable benchmark plan." While not specifically addressing a Bridge Plan, in our view, this guidance suggests that the amount of the premium subsidy that an individual receives will be based on the premium of the second-lowest-cost silver plan available *to that particular individual*. Thus, offering a Bridge Plan to a subset of the Exchange population would not directly affect the applicable benchmark plan or the amount of the premium subsidies available to other Exchange enrollees who are ineligible for a Bridge Plan.

Effect on Exchange Risk Pool and Premiums

You asked our office to assess how a Bridge Plan would affect the overall Exchange risk pool and the gross premiums (prior to applying the federal premium subsidy) of plans available on the Exchange. Below, we provide some general comments on these issues. These are based on our current understanding of the individual market pricing rules and regulations that will be in place under the ACA beginning in 2014. However, the rules and regulations related to health plans sold on the individual market and the methods by which health plans establish premiums for these products are extremely complex. A comprehensive assessment of this issue would likely require the expertise of a person or entity that has extensive training in this particular subject area, such as a health actuary.

Bridge Plan Enrollees Would Likely Be Part of a Health Plan's Single Risk Pool. Health plan premiums largely depend on the health characteristics (and associated medical costs and financial risks) of people who obtain coverage from that plan—sometimes referred to as the plan's "risk pool." The ACA requires each health plan to include all enrollees in individual market products offered by the plan (except grandfathered plans) within a state—both inside and outside of an Exchange—in a single risk pool. In other words, the medical costs of all of the plan's individual market enrollees will be used to determine the premiums of all individual market products offered by that plan. This provision of the ACA was generally intended to prevent plans from creating separate risk pools in order to charge high-risk individuals more than low-risk individuals. It is possible that future federal guidance would exempt Bridge Plan enrollees from the single risk pool requirement, similar to the exemption for grandfathered plans. However, unlike the exemption for grandfathered health plans, there is no clear statutory authority to exempt Bridge Plans from this requirement. Therefore, based on the federal law and guidance that has been issued to date, we believe it is likely that Bridge Plan enrollees would be part of the single risk pool requirement that applies to health plans offering individual market products—both inside and outside of the Exchange.

Uncertain Effect on the Total Exchange Risk Pool. It is currently unclear how offering bridge plans would affect the total Exchange risk pool (the risk pool of all enrollees in individual market products offered through the Exchange). Bridge plans will be just one coverage option available to certain individuals purchasing Exchange coverage. In the absence of a Bridge Plan, many of the potential Bridge Plan enrollees would still purchase non-bridge plan coverage on the Exchange. If a Bridge Plan offers significantly lower premiums than what would otherwise be offered in the absence of a Bridge Plan, it may encourage a somewhat larger proportion of the healthy (low-risk) individuals to obtain coverage—thereby potentially reducing the overall risk of the population purchasing individual market coverage through the Exchange. While such an effect is uncertain, the extent of the effect would be limited by the fact that the additional Bridge population that would obtain coverage would likely be small compared to the total Exchange population.

Offering Bridge Plans May Affect Risk Pools and Premiums for Non-Bridge Plans. While creating a Bridge Plan would likely have no major effect on the total Exchange risk pool, it may affect the risk pool of non-bridge plans. If one assumes the Bridge Plan will be the lowest-cost silver plan, it is likely that much of the Bridge population would obtain coverage from bridge

plans instead of non-bridge plans. The subsequent effect on each non-bridge plan's risk pool would depend on several factors, including: (1) how many Bridge Plan enrollees would have otherwise purchased coverage from the non-bridge plan and (2) how the overall health characteristics (and associated medical costs) of the Bridge Plan enrollees compare to the plan's other individual market enrollees. If the Bridge population would have been a small portion of the plan's overall individual market enrollment, then establishing a Bridge Plan would likely have a relatively minor impact on the plan's risk pool. On the other hand, if the Bridge population would have been a large portion of a plan's individual market enrollment, then establishing a Bridge Plan would potentially have a significant impact on the plan's risk pool. The direction of the impact would depend on the relative health characteristics of the Bridge population compared to those of other individual market enrollees.

We have not analyzed how the health characteristics of the Bridge population compare to those of other individual market enrollees. If one assumes Bridge Plan enrollees are somewhat healthier—and less costly—than other individual market enrollees, creating a Bridge Plan may adversely affect that risk pool of non-bridge plans and result in higher premiums. Alternatively, if one assumes Bridge Plan enrollees are less healthy than other individual market enrollees, then creating a Bridge Plan may improve the risk pool of non-bridge plans and result in lower premiums.

Other Potential Considerations

The Bridge Plan raises many potential issues for consideration, in addition to the issues discussed above. Many of the potentially significant benefits of a Bridge Plan have been outlined in recent Covered California Board meetings and briefs. These benefits include: promoting continuity of coverage and offering a more affordable product to certain populations. To the extent these benefits are achievable, they are important considerations.

Below, we provide a list of questions about the Bridge Plan concept intended to identify potential issues to consider when determining whether or not to establish a Bridge Plan and what the characteristics of such a program should be if established.

- What type of infrastructure changes would Medi-Cal plans need to make in order to comply with the requirements for individual market plans offered through the Exchange, such as having the ability to collect premiums?
- Should bridge plans seeking Exchange certification be allowed exemptions from certain requirements that apply to non-bridge plans offering coverage on the Exchange?
- If bridge plans were exempt from meeting certain quality or access standards, would these exemptions affect market competition within the Exchange by creating an "uneven playing field" for plans?
- Should there be a maximum income or duration limit for individuals obtaining bridge plan coverage?

- Is there a significant risk that bridge plans would offer higher net monthly premiums for the Bridge population than the lowest-cost option that would be available in the absence of a Bridge Plan?
- How would bridge plans provide mental health benefits that are currently carved-out of Medi-Cal plans, but that are required benefits for products offered on the Exchange?
- How would the provider payment structure for bridge plans differ from the existing Medi-Cal funding structure that includes such mechanisms as intergovernmental transfers and provider fees?
- Would establishing Bridge Plans affect long-term Medi-Cal enrollment and costs by maintaining continuous coverage in Medi-Cal/Bridge Plans?
- Should bridge plans be available to newly qualified immigrants who would otherwise qualify for state-only Medi-Cal?
- What impact would a Bridge Plan have on access to care for Medi-Cal enrollees, if any?
- How would a Bridge Plan affect safety net providers, such as public hospitals and community clinics? Would a Bridge Plan benefit some of these providers by potentially increasing patient volume and revenue?
- Given outstanding federal guidance on this issue and the significant amount of work that would be required to implement it, is it technically feasible for the state to establish a Bridge Plan within the next year?

If you have any further questions, please contact Ross Brown at (916) 319-8345 or Ross.Brown@lao.ca.gov.

Sincerely,

Mac Taylor
Legislative Analyst