Analysis of the

Basic Health Program

January 17, 2012

Analysis conducted by
DHMH, Medicaid Office of Planning

and

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BASIC HEALTH PROGRAM

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BASIC HEALTH PROGRAM

Executive Summary

One of the major policy decisions presented to states under the Affordable Care Act (**ACA**) is whether to implement the Basic Health Program (**BHP**). This paper presents the analysis, conducted by the Office of Planning with the Maryland Medical Assistance Program (**Medicaid**), to help guide Maryland's decision.

The BHP is a health coverage option found in Section 1331 of the ACA. Under the BHP, Maryland could elect to cover adults between 138 percent and 200 percent of the Federal Poverty Line (**FPL**) not through the Maryland Health Benefit Exchange (**Exchange**), but rather through the managed care organizations (**MCO**) under contract to Medicaid.[1]

Financial Issues

Unless supplemented with state funds, the BHP would operate with less overall financial support than a similar product in the Exchange. This outcome would occur because the federal government only would provide a subsidy to the BHP equivalent to 95 percent of the funding it otherwise would have spent on the premium tax credits for adults up to 200 percent of the FPL to purchase products in the Exchange, thereby immediately saving the federal government money. In addition, the premium contributions collected from the covered individuals in the BHP could not exceed the premiums these individuals would have paid to purchase a product in the Exchange. As a result, the BHP only is financially self-sustaining if the premiums paid to MCOs are below the level of premiums that similar coverage would cost in the Exchange.

If the BHP is *significantly* more cost-effective than the Exchange, such that the BHP not only makes up the difference of the reduced federal subsidies but also has additional funds with which to operate, than the BHP must reduce the cost-sharing obligations for covered individuals. The state may not keep the difference, but instead must use the "surplus" to make the BHP even more affordable. This possibility, which depends on relatively low premiums to the MCOs relative to products in the Exchange, is one reason that consumer advocates support the BHP.

In the analysis presented below, which is based upon the best assumptions we can make at this time, the BHP only would operate without state subsidies if the premiums in Maryland's individual market increase by at least 16 percent to 24 percent in 2014 as a result of new market rules under the ACA (guarantee issue, community rating, and the merger of the Maryland Health Insurance Plan (**MHIP**) into the individual market). Only with these steep premium increases would the commensurate federal BHP subsidies rise to the level necessary to avoid the need for state subsidies.

The inherent uncertainty about whether the BHP will be cost-effective, when compared to the Exchange, is further complicated by several unknowns in the federal government's treatment of the

[1] The ACA directs states to disregard 5 percent of income when determining Medicaid eligibility, thus functionally raising the income limit of Medicaid to 138 percent of the FPL.

administrative costs of the BHP. Crucial guidance is needed from the federal government to determine: (a) whether any portion of the federal BHP allocation may be utilized to support the state's administrative costs to operate the BHP, and (b) whether any portion of the Exchange start-up funding (under the establishment grants) may be used to create the necessary infrastructure for the BHP. If federal funding is not available for these costs, then even if the BHP is cost-effective for consumers, it would create a new expense for the state.

Churn

Apart from the potential reduction in cost sharing, some individuals urge states to adopt the BHP for other reasons, such as providing continuity with the same MCO (and related provider network) as individuals move above or below the income level at 138 percent of the FPL between Medicaid and the Exchange. Moreover, some support the BHP because it would allow families with minor or dependent children to be covered by the same MCO up to 200 percent of the FPL, given Medicaid's higher coverage standards for children.

As described in the full report, researchers have found that income fluctuations for individuals and households making between 138 percent and 200 percent of the FPL are frequent enough that up to 50 percent of individuals may find themselves eligible for Medicaid at one point in a year yet ineligible at another point in that same year. The BHP would provide a cushion for such individuals so that they would not have to enter the Exchange directly from Medicaid due to periodic income fluctuations.

Still, the BHP would introduce a second income level where churn would occur: at 200 percent of the FPL, where adults would move between the BHP and the Exchange. The data presented in the report indicates that the churn at this income level is comparable to the churn at 138 percent of the FPL.

Administrative Issues

If Maryland chooses to implement the BHP, new administrative functions and capabilities would need to be developed at Medicaid, potentially without access to Exchange establishment grant funding. The most significant new administrative function would be the capacity to invoice and collect premiums from the adults enrolled in the BHP; currently Medicaid invoices and collects premiums only for a small group of enrollees. These enrollees are Maryland Children's Health Program (**MCHP**) children whose family incomes are between 200 percent and 300 percent of the FPL as well as individuals who qualify under the Department's Employed Individuals with Disabilities (**EID**) program. The programs combined total less than 16,000 individuals.

Federal Uncertainty

Even if the other factors clearly supported adoption of the BHP (financial, churn, administrative, etc.), it is difficult to know the full ramifications of implementing the BHP until the federal government addresses several key variables. Two of the major variables were mentioned above: whether federal subsidies could support the administrative costs of the BHP, and whether establishment grant funds may be used for planning and implementation activities. A third major variable is the process by which the federal government will calculate the federal BHP payments to the states, and how it will reconcile over- and under-payments to the states based on the covered individuals' reported income in the year following BHP enrollment.

Effect of the BHP on the Exchange

If Maryland chooses to implement the BHP, adults below 200 percent of the FPL would not have the option of securing coverage through the Exchange. This would reduce the overall size of the enrolled population in the Exchange. This would create two major effects: (a) the financial self-sustainability of the Exchange would be affected, if the business model of the Exchange is based on user fees within the Exchange, as opposed to a more broad-based approach, and (b) the ability of the Exchange to "move the market" might be diminished with a smaller scale. In the modeling presented below, it appears the Exchange would have enough covered lives, even if the BHP is implemented, to be viable.

Administrative Timeline

Unlike other ACA provisions, such as the insurance market reforms, the BHP does not have an implementation deadline. As a result, the state could await further federal guidance (and the resolution of key federal unknowns) prior to making any final decision on the BHP. Moreover, Maryland could establish a BHP at the time of its choosing, including in 2015 or later, once the state has information on the rates in the individual market in the Exchange. Operating a BHP would not require state legislation, although it might require a state appropriation, if federal start-up or ongoing administrative funding is not available.

Key Factors for Policymakers

This paper provides an overview of the implementation issues surrounding the BHP for the State of Maryland. It is intended to provide policymakers with some background on the issues likely to arise if Maryland were to create a BHP. There are four major issues policymakers should consider:

- Churning, Aligning Families and the Consumer Experience;
- Administrative Issues and the Need for Federal Guidance;
- Affordability for the State; and
- Effect on the Maryland Health Benefit Exchange.

Churning, Aligning Families and the Consumer Experience

State policymakers will have to weigh the benefits of the BHP against the benefits of the Exchange for the consumer. The BHP may be an attractive option for those earning 138 percent to 200 percent of the FPL for several reasons. First, it could reduce the negative effects experienced by individuals that churn in and out of Medicaid eligibility throughout a year. Rather than forcing those who are temporarily ineligible for Medicaid into the Exchange, the BHP could allow individuals to remain with their Medicaid MCOs and maintain continuity of care. Second, it would permit parents with children in Medicaid or MCHP to be in the same health plan as their children, therefore aligning families

into one plan or provider network.[2] Finally, the state may be able to provide greater coverage or reduced cost sharing to BHP enrollees if it is able to finance these features.

Administrative Issues and the Need for Federal Guidance

If the state were to implement a BHP, there may be significant administrative duties associated with managing the program. These issues involve assessing the quality of care, managing a trust fund for federal payments, collecting and distributing enrollee premiums, liaising with the federal government, and other functions. Policymakers should be aware that the state would have to increase state personnel or contract out major functions to third party vendors.

A short term, yet significant, consideration for policymakers is the present absence of federal rules and regulation for the BHP. Currently, the only official provisions governing the program are found in Section 1331 of the ACA. The federal government has not begun the rulemaking process for the BHP. This is a concern because some of the ACA's provisions could be interpreted in such a way as to implicate state funds. In particular, it is unclear whether federal dollars will be available for state administrative costs – a potentially large cost.

The provisions in Section 1331 that seriously impact state responsibilities and costs include but are not limited to:

- the availability of federal dollars for state administrative costs;
- the manner in which federal payments will be calculated; and
- the process for correcting over- and under-payments to the state.

These issues have major cost implications for the states, but they require federal interpretation of Section 1331 to be resolved. Maryland would not be able to assess with certainty its financial responsibilities until this guidance is released. As of this date, the federal government has not indicated when it will begin the rulemaking process for the BHP or whether it plans to release preliminary guidance as it did for the Essential Health Benefits requirement.

Affordability for the State

The BHP is intended to save federal funds by offering the states roughly 95 percent of the amount of money the federal government would have spent on covering individuals in the Exchange. The state would use its existing Medicaid managed care system to create a new BHP program that may be able to cover individuals at lower costs than Exchange plans. If there were savings, the program could use them to enhance the plan even more in the form of lower cost sharing and greater coverage.

Policymakers will have to analyze the available data to see whether this goal is attainable. In particular, they will have to discern whether the state would be able to deliver coverage at a price that is below the second lowest costing silver tier plan in the Exchange. If costs are below what the federal

[2] Between 138 percent and 305 percent of the FPL, parents and their children will not be covered in the same program: parents will be in the Exchange, and children in Medicaid or MCHP. The BHP plan could allow parents with incomes up to 200 percent of the FPL to remain in the same Medicaid MCO as their children.

government will cover for the states, then the state could be able to devise a program that would be less costly for the consumer than an Exchange plan. If the costs are above, then the state may have to make up the difference with state funds. If the costs are virtually the same as the federal payment and maximum enrollee premiums, then the state would have to decide whether other policy justifications – such as mitigating churn and keeping families together in the same plan – justify implementing a BHP.

At this point in time, it is difficult to adequately estimate what the costs of insurance in the Exchange will be because many policy decisions related to health care reform provisions have not been made. This paper provides preliminary estimates, but it cannot definitively predict what program costs or federal payments will be.

Effect on the Maryland Health Benefit Exchange

The BHP would have an impact on the Exchange because it would transfer a large cohort of enrollees from the Exchange into the BHP. Such a shift would affect the risk pool, insurer participation, and premiums in the Exchange. It is unclear whether this would have a beneficial, detrimental, or neutral effect on the Exchange in these areas. If the Exchange intended to rely on user fees as a means to pay for its operations, then that amount would be affected as well with diminished enrollment. Any decision on the BHP should involve Exchange stakeholders.

Basic Health Plan Requirements

Overview

The ACA provides states with the option of establishing a BHP for individuals with low incomes who are ineligible for Medicaid. The BHP option allows states to contract with health plans to offer an insurance product to individuals with incomes between 138 percent and 200 percent of the FPL.[3] If a state chooses to implement the BHP option, then eligible individuals may not obtain coverage through the Exchange.

Under the BHP, each fiscal year, the federal government pays the state 95 percent of the premium tax credits and cost-sharing reductions it would have provided to those individuals in the Exchange.[4] If the federal payments exceed program expenditures, the savings can only be used to either reduce premiums and cost sharing for enrollees or expand the benefit package.

Eligibility

Individuals must meet all of the following criteria to qualify for the BHP:

- Not eligible for Medicaid;
- Adult with household income between 138 percent and 200 percent of the FPL or lawful alien with income below 138 percent of the FPL who does not qualify for Medicaid because of length of residency;
- Not offered employer-sponsored insurance (ESI) that meets the ACA's minimum essential benefits and affordability criteria; and,
- Under the age of 65 years.

Plan Design

The ACA provides broad guidance on the plan design of the BHP, mandating that it cover "essential health benefits." On December 16, 2011, the U.S. Department of Health and Human Services (**HHS**) issued a bulletin on essential health benefits that explained that a state will be permitted to select from any of the following four types of benchmark plans to establish their own essential benefits:

1. the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
2. any of the largest three State employee health benefit plans (by enrollment);

[3] See Footnote 1.

[4] ACA §1331(d). For the purposes of this paper, Medicaid assumes that the federal payments will represent 95 percent of the premium tax credits and cost-sharing subsidies. Medicaid is aware that the ACA's language indicates that states may be eligible for only 95 percent of the premium tax credits, but 100 percent of the cost-sharing subsidies that would have been spent in the Exchange. This issue can only be resolved through federal interpretation. Medicaid chose to use 95 percent of cost-sharing subsidies in order to render a conservative cost estimate.

3. any of the largest three national Federal Employees Health Benefit Plan (FEHBP) options by enrollment; or
4. the largest insured commercial non-Medicaid Health Maintenance Organization operating in the State.

This guidance provides states with substantial flexibility in designing the essential health benefits. But under the ACA, the Medicaid expansion population receives a benchmark plan, which includes not only the essential health benefits but also some traditional Medicaid services like transportation.

The ACA further requires states to contract with MCOs or plans with as many of the features of managed care as possible. These plans must have a medical loss ratio of at least 85 percent, meaning that 85 percent of the money spent on a plan must go towards providing enrollees with health care services and improving the quality of care, while only 15 percent can go to administrative costs, overhead costs, or profit. This is higher than what is required in the Exchange; the small and individual group market plans in the Exchange require a medical loss ratio of 80 percent.

Out-of-Pocket Spending

For out-of-pocket spending, premiums may not exceed what the individual would have paid in the Exchange if he or she had enrolled in the second lowest cost silver plan. Further, cost sharing may not exceed what is required in the Exchange under the platinum plan (10 percent of annual income) for individuals with incomes up to 150 percent of the FPL or the gold plan (20 percent of annual income) for those between 150 and 200 percent of the FPL.[5]

Financing the Exchange and Consumer Affordability

As mentioned above, the BHP is funded through the premium tax credits and cost-sharing subsidies that the federal government would have otherwise spent on the enrollee's coverage in the Exchange if they had opted to choose the second-lowest costing silver tier plan.

Federal Calculation of Premium Subsidies

The federal premium subsidy is not meant to cover the full premium amount; there is an individual financial responsibility that is capped based on income levels. Table 1 presents the estimated maximum premium payments of individuals who would qualify for subsidies in the Exchange. These estimates assume a household size of one. The maximum annual and monthly premium payments were estimated using the premium percentages per income level, as defined in §1331(a) and §1401(a) of the ACA. The BHP may charge enrollee premiums up to this level.

[5] Note: federal guidance is still needed to clarify these maximum amounts. Some commentators think there was a drafting error since the cost-sharing amounts differ in the BHP from the amounts allowed in the Exchange.

Table 1. Maximum Premium Payments in the Exchange, by Income as % of the FPL

Percentage of the FPL	Annual Income*	Maximum Annual Premium Payment	Maximum Monthly Premium Payment
100%	$10,890	$218	$18
133%	$14,484	$290	$24
150%	$16,335	$653	$54
200%	$21,780	$1,372	$114
250%	$27,225	$2,192	$183
300%	$32,670	$3,104	$259
400%	$43,560	$4,138	$345

* Based on the 2011 HHS Federal Poverty Guidelines for a household of one.

These maximum enrollee premium payments – which are a percentage of income – will increase over time in two ways. First, through 2018, the percentage of income will be "adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year."[6] Since premiums typically grow at a faster rate than income, the percentage of income that enrollees will have to pay will increase. Second, beginning in 2019, the maximum percentage of income will continue to increase through the regular indexing formula in the ACA.[7] This trend will also gradually slow the rate of growth of the premium tax credits that form the basis of the federal payments for states to operate the BHP.[8]

Federal Calculation of Cost-Sharing Subsidies

The cost-sharing subsidies are payments the federal government would make to offset the additional co-pays of low-income enrollees in the Exchange. These subsidies are passed on to states to operate the BHPs, although states receive 95 percent[9] of the amount intended to offset the increased costs that would have been incurred by plans operating in the Exchange.

Like any federal program, Congress may choose to reduce the scope of cost-sharing subsidies that are provided under any BHP that is enacted by states. The cost-sharing subsidies have already been targeted by the federal government as a source of deficit reduction by the Budget Control Act (**BCA**) of 2011. Under that legislation, the cost-sharing subsidies will be reduced in January of 2013.[10] The

[6] The Congressional Budget Office. see http://www.cbo.gov/ftpdocs/121xx/doc12188/05-12-Subsidies_in_Exchanges.pdf.
[7] This depends on whether or not the Exchange subsidies at a national level reach a defined percentage of GDP.
[8] Id.
[9] See Footnote 4.
[10] Redhead, C. Stephen, Budget Control Act: Potential Impact of Automatic Spending Reduction Procedures on Health Reform Spending. Congressional Research Service, November 22, 2011.

amount and the manner of the reduction are still unknown. If Maryland were to implement a BHP, a conservative approach would be to expect that any future federal BHP payments might be reduced.

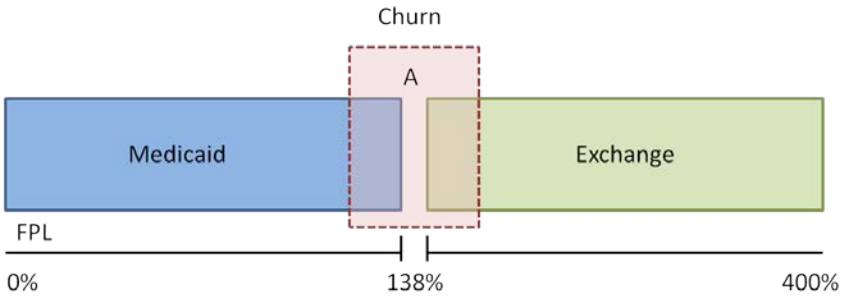
Churning

One of the primary policy justifications for the BHP is to reduce the percentage of individuals moving between Medicaid and the Exchange that have to enroll in different insurance plans. Individuals are expected to move between Medicaid and the Exchange as their households move above or below the line at 138 percent of the FPL that divides Medicaid and the Exchange (*See* Figure 1). This movement across programs is called "churning."

Researchers have estimated that approximately 35 percent of adults with incomes below 200 percent of the FPL will experience a change in income that will affect their Medicaid eligibility within six months and that approximately 50 percent will experience a change within a year. They further found that 24 percent will churn at least twice within a year and 39 percent will churn twice within two years. In all, 38 percent will have churned four times or more over four years.[11]

These fluctuations could arise for a number of reasons: *e.g.*, small changes in income; additions or subtractions in the household size; and children aging out of Medicaid or the MCHP into adulthood and the Exchange. These transitions between Medicaid and the Exchange, in part, prompted us to review whether or not a BHP would increase provider and benefit network continuity for individuals.

Figure 1. Churn at 138 Percent of FPL



Churning can negatively affect the consumer in several ways. If Maryland were to forgo implementing a BHP, then the eligible population would enter the Exchange to purchase insurance. They would receive premium tax credits to offset premium costs and cost-sharing subsidies paid to their insurance carrier to offset deductibles and co-pays. Unlike the BHP, which may be able to provide a greater benefit package and reduced cost sharing, Exchange enrollees would likely only receive the essential health benefits in a Qualified Health Plan and would have to pay the maximum out-of-pocket costs allowable under the law. They would also have to estimate their income prospectively each year to calculate their premium tax credit with the Internal Revenue Service (**IRS**) and then reconcile that

[11] Sommers, Benjamin D. and Sara Rosenbaum. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. Health Affairs. February 2011. vol. 30 no. 2 228-236.

estimate with actual income at the end of the year. If they incorrectly estimated income, they would have to either pay back the excess amount given to them via the tax credit or would receive a rebate.

Individuals moving between the Exchange and Medicaid may confront administrative hurdles when enrolling in plans in the Exchange from Medicaid. The shift in coverage could result in coverage gaps as well as forcing the individual to complete the complicated end of the year federal income tax reconciliation process. It should be noted that the high level of churn predicted by researchers indicates that many members of this population may have to make adjustments when filing their taxes. This could result in unexpected tax bills at the end of the year.

Another concern would be that individuals might not be able to see their current health care providers if those providers do not participate in Exchange plans. This issue could be compounded if the individuals moving between the Exchange and Medicaid had children that were covered in MCHP, as individuals would then have to navigate two provider networks for one family's care. Low-income individuals may also be more sensitive to the cost-sharing requirements of Exchange plans at 138 percent of the FPL as well.

There is a high likelihood that individuals will be able to maintain the same MCO if the state permits only Medicaid MCOs to participate in the BHP. Ideally, individuals will have the same choice of MCOs in the BHP and Medicaid. But likely, the state will not require that all existing Medicaid MCOs also participate in the BHP. Rather the state will seek to encourage the Medicaid MCOs to operate in both programs, although the benefits under each system may vary. For instance, under the Medicaid program these individuals would be entitled to the essential health benefits plus some additional services. Under the BHP program, the same individuals would be entitled to only the essential health benefits (and not the additional services mandated by Medicaid). However, if there are savings in the BHP program to fund such additional services then the state could offer BHP enrollees a greater benefit package.

The differences in services notwithstanding, physicians enrolled in the Medicaid program may not wish to take on new patients in a BHP program. For instance, should the BHP reimbursement rates be close to existing Medicaid reimbursement rates, physicians may opt to limit their practices to a discrete number of total Medicaid and BHP patients.[12] If such physicians are enrolled already in the Medicaid program and reluctant to see new BHP enrollees, there may be a lack of available physicians for any new BHP program. Medicaid will have to engage in extensive discussions with MCOs and physicians to see whether there will be a sufficient number of providers in the BHP and Medicaid if the BHP were to be implemented.

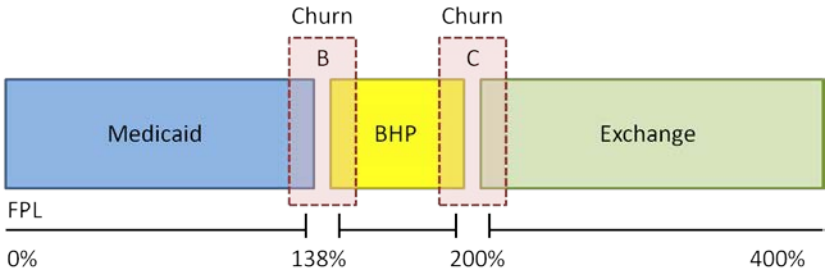
Churning at 200 Percent of the FPL

There is evidence that suggests the rate of churning will be similar at 200 percent of the FPL, which is the upper income limit under a BHP. Medicaid reviewed the churn level of its enrollees in MCHP Premium. This cohort of children has household income between 200 percent and 300 percent of the FPL. For enrollees that were enrolled in FY 2010, Medicaid found that 55 percent had a change in their eligibility that made them eligible for another Medicaid program from FY 2010 to FY 2011. This

[12] Maryland Medicaid fees are currently 74 percent of the 2011 Medicare fees.

represents a drop in income because there are no other Medicaid programs that service enrollees above the eligibility threshold of MCHP Premium. This shift shows what churn at the 200 percent of the FPL may look like because it shows fluctuations above the level (those enrolling in MCHP Premium) and below the level (those enrolling in other Medicaid programs).

Figure 2. Churn at 138 percent and 200 percent of the FPL



MCHP Premium's experience complements a study completed by John Graves, Rick Curtis, and Jonathan Gruber in the New England Journal of Medicine, which found that the level of churn at 200 percent of the FPL would be close to their estimate of churning at 138 percent of the FPL if the BHP was integrated into Medicaid. If there was a separate BHP agency and program, the authors estimated that churn would increase to 56 percent within one year.[13] Both Medicaid's review of MCHP Premium churning and the study in the New England Journal of Medicine indicate that the rate of churning at 200 percent of the FPL is likely to be similar to the rate at 138 percent of the FPL.

Administrative Issues

If Maryland implemented a BHP, it would make sense to simply build onto HealthChoice, the existing Medicaid managed care program. This would essentially guarantee continuity of insurers, *i.e.*, the Medicaid HealthChoice MCOs, between Medicaid and BHP, provided that the HealthChoice MCOs are willing to operate in the BHP. It could make the experience for the consumer seamless, fulfilling one of the goals of the BHP.

However, building onto HealthChoice will require additional administrative resources to operate a BHP at a state level. The BHP will require that the Department serve not only more individuals but also it will require also that the Department take on new functions. In particular, as advocated by many current HealthChoice MCOs, the Department would be in the business of collecting premiums from enrollees, combining that premium with the federal subsidies, and providing the total health plan cost to the MCOs, thereby removing the burden of collecting the enrollee portion of the total cost from the MCOs themselves. Such a function would impose significant administrative costs on the Department. Additionally, the ACA requires that there be a federal oversight process for state BHPs and that states, at

[13] Graves, John A., Ph.D., Rick Curtis, M.P.P., and Jonathan Gruber, Ph.D. Balancing Coverage Affordability and Continuity under a Basic Health Program Option. N Engl J Med 2011; 365:e44.

a minimum, operate a separate trust fund to receive federal payments. At this time, however, it is unclear what the specific responsibilities of the state will be.

Administrative Expenses and ACA Requirements

A major concern for Maryland would be the language in the ACA that states that federal BHP payments can only be used to lower premiums and cost sharing or to expand benefits.[14] Several commentators and states have pointed out that this language may preclude states from using BHP payments to fund the state administrative costs of the BHP.

If this were the case, it is unclear where the money would come from to operate these costs and it could fall on Maryland to make up the difference. At a minimum, there would be state costs to manage the program and ensure program quality. Furthermore, there would be cost allocation requirements with the Exchange to handle eligibility issues. The ACA mandates that a state operate a separate trust fund to manage BHP payments, which may have to be funded with state dollars.

The federal government may interpret the relevant passage to include administrative costs, but until that guidance is released, it is an open question.

The ACA also creates a federal oversight process for the program. The oversight process is not specified in the ACA. It should be mentioned that through regulation and oversight, the federal government could make policy decisions that Maryland would have to abide by if it operated a BHP. It is impossible to assume what these policy decisions may turn out to be, but they could result in additional federal mandates or loss of future flexibility in operating a BHP option.

Reconciliation

The federal government has a process to correct inaccurate payments made to the BHP. If HHS were to over- or under-estimate the premium tax credit and cost-sharing subsidy payments to a state, they must correct the over- or under-payment by adding or subtracting the money from the next fiscal year's payment.[15] In this scenario, a state would conceivably be financially responsible for costs that may arise if the payments are made in error. It may be that this could be handled by establishing a safe harbor threshold that would allow states that receive an overpayment to avoid reductions in the next fiscal year's disbursement. However, the federal government would have to establish this as a rule.

It is also unclear exactly how the federal government will calculate the federal payment. The ACA language reads that HHS consider the following when making the determination on a per enrollee basis:

> "the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance

[14] ACA §1331(d)(2).
[15] ACA § 1331(d)(3)(B).

> payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled."[16]

Beyond this provision, HHS has not specified how it will make the calculation. This may be of concern to policymakers, because it is the federal government that will determine the federal payments and it is unclear what role a state would play in the calculation and reconciliation of the amount.

Premium Collection; Other Internal Administrative Issues

Currently Medicaid invoices and collects premiums only for a small group of enrollees. These enrollees are MCHP children whose family incomes are between 200 percent and 300 percent of the FPL as well as individuals who qualify under the Department's EID program. The programs combined total less than 16,000 individuals, much less than the anticipated enrollment of the BHP, which is estimated at close to 81,500 in FY 2015. As discussed above, this increase in invoicing and collection volume likely would be more than what Medicaid's existing division would be able to manage and it may require that either a third party contractor or an increase in Medicaid personnel be brought on to manage the increased workflow. This would require additional administrative expense.

The BHP also would require programming changes to the Medicaid Management Information System (**MMIS**), including changes to the capitation rates, benefit package, and provider rates. These changes are necessary to handle the claims processing needs of the BHP. But the existing MMIS system is not flexible, nor receptive to such programmatic changes. This means that implementing a BHP would be challenging. One of Medicaid's key priorities independent of the BHP, however, is developing a new claims processing system, which would alleviate this concern if implemented in a timely manner.

Cost and Enrollment Model Development

Medicaid asked The Hilltop Institute to estimate the costs and enrollment of a potential Basic Health Program in Maryland. Hilltop revised and updated the health care reform financial modeling tool that it had developed for the Health Care Reform Coordinating Council to include more recent Current Population Survey (**CPS**) and American Community Survey (**ACS**) data for Maryland that have recently become available. The CPS and ACS are both conducted by the U.S. Census Bureau.

Hilltop also revised the model to estimate the state's gross costs of establishing a BHP; federal payments for a BHP based on 95 percent of premium tax credits and cost-sharing subsidies that the federal government would have otherwise paid to the individuals in the Exchange; and the enrollees' maximum payments for premiums, as specified by the ACA.

Furthermore, Hilltop supplemented the financial modeling tool with an econometric model that predicts take-up participation) rates of health care coverage in the BHP and the Exchange as functions of

[16] ACA § 1331(d)(3)(A)(ii).

the relative "after-tax price of purchasing health care through an insurance plan relative to the after-tax price of purchasing health care directly if uninsured."[17]

Projecting Potential Enrollment in a BHP

Based on an analysis of the ACS and CPS data, Hilltop estimated that approximately 120,000 uninsured individuals aged 21 to 64 years with incomes between 138 percent and 200 percent of the FPL would be eligible for enrollment in a BHP. Calibrating the model to a take-up rate of 75 percent for all years prior to health care reform, the model predicts that, if the state of Maryland establishes a BHP, approximately 82,000 people will enroll in the program by fiscal year (FY) 2016 (see Table 2). The take up rate is predicted to increase in later years, reaching 80 percent in FY 2020.

Table 2. Projection of Individual Enrollment and Percentage of Uninsured under Health Reform

Fiscal Years	2014	2015	2016	2017	2018	2019	2020
1. Medicaid Expansion	79,437	164,758	170,748	177,259	183,864	190,565	197,361
2. Medicaid "Woodwork" Effect	5,286	23,489	32,617	40,533	40,888	41,242	41,596
Total New Medicaid (1+2)	*84,723*	*188,247*	*203,365*	*217,792*	*224,752*	*231,807*	*238.957*
3. Basic Health Program (138-200% FPL)	**40,358**	**81,456**	**82,147**	**83,101**	**84,018**	**84,900**	**85,748**
3.1 BHP with Income between 138-149% FPL	7,669	15,478	15,609	15,791	15,965	16,133	16,294
3.2 BHP with Income between 150-200% FPL	32,689	65,978	66,538	67,310	68,053	68,767	69,454
Total New DHMH (1+2+3)	*125,081*	*269,703*	*285,512*	*300,893*	*308,770*	*316,707*	*324,705*
4. Exchange (200-400% FPL) with Subsidy	63,438	128,479	129,991	131,933	133,803	135,607	137,347
5. New Direct Purchase without Subsidy >400%FPL	28,459	57,435	57,892	58,875	59,820	60,730	61,604
Total New Coverage	**216,978**	**455,617**	**473,395**	**491,701**	**502,393**	**513,044**	**523,656**
6. Existing Direct Purchase Coverage: now likely to purchase coverage through the Insurance Exchange	88,617	179,044	180,529	182,014	183,500	184,985	186,470
Potential Exchange Enrollment (4+5+6)	***180,514***	***364,958***	***368,412***	***372,822***	***377,123***	***381,322***	***385,421***
7. Current Medicaid (Excluding PAC)	950,218	962,177	972,464	984,635	996,852	1,009,115	1,021,423

[17] (Heim, B.T., & Lurie, I.Z. (2009). Do increased premium subsidies affect how much health insurance is purchased? Evidence from the self-employed. Retrieved from http://home.comcast.net/~bradheim/files/HeimLurieSEHI.pdf.

Fiscal Years	2014	2015	2016	2017	2018	2019	2020
8. New Medicaid (1+2)	84,723	188,247	203,365	217,792	224,752	231,807	238,957
Total Medicaid with Health Care Reform (HCR) (7 +8)	**1,034,941**	**1,150,424**	**1,175,829**	**1,202,427**	**1,221,604**	**1,240,922**	**1,260,380**
Remaining Uninsured (without HCR)	795,132	791,232	787,332	790,182	793,031	795,880	798,729
Remaining Uninsured (with HCR)	445,897	335,614	313,936	298,480	290,637	282,835	275,072
Uninsured as % of Total Population (without HCR)	13.2%	13.0%	12.8%	12.8%	12.7%	12.7%	12.6%
Uninsured as % of Total Population (with HCR)	7.4%	5.5%	5.1%	4.8%	4.7%	4.5%	4.3%
Total Population	6,025,354	6,086,850	6,137,340	6,187,830	6,238,320	6,288,810	6,339,300

A population not reflected in this model is the lawful adult aliens with income below 138 percent of the FPL who do not qualify for Medicaid because they have not resided in the United States for five or more years. These individuals will be allowed to enroll in the BHP. This is an attractive feature of the program, because it could allow families to be aligned in the same plans. For instance, lawful adult aliens may have children who are U.S. citizens and are eligible for Medicaid. This population also would benefit if Maryland were able to enhance the benefit package or reduce cost-sharing and premium amounts for the BHP. At this time, Hilltop and Medicaid are unable to estimate this population due to a lack of a data. However, Medicaid is aware that the extension of BHP coverage to this population may be beneficial to consumers.

Constructing Cost Scenarios

As described above, after establishing a BHP, each fiscal year the federal government will pay the state 95 percent of the premium tax credits and cost-sharing reductions it would have provided to those individuals in the Exchange. Therefore, the state's net cost of operating a BHP depends mainly on two factors: 1) the state expenditures per enrollee, and 2) the market costs of obtaining coverage through the Exchange. Since there are different potential iterations of a Maryland BHP, Hilltop constructed three cost scenarios, shown in Table 3.

Table 3. Alternative Scenarios for Annual Cost per Person

Scenario	Description	FY 2014 State Cost	FY 2014 Market Cost
1	Base-Cost Scenario	$6,871	$6,293
2	High-Cost Scenario	$7,316	$6,293
3	Urban Institute Estimates	$6,775	$8,128

Hilltop designed an approach to its BHP analysis that other organizations have employed when analyzing the BHP option.[18] Hilltop modeled the enrollment population and state costs off of a similarly situated population receiving state benefits and estimated the market costs by reviewing the individual and small group markets operating in the state. Hilltop's estimates reflect a Base-Cost scenario and a High-Cost Scenario as well as estimating what the Urban Institute's costs would be in FY 2014.

Hilltop's cost estimates do not factor in what will happen under health care reform – they merely assume that individual market costs continue to rise at the rate at which they currently rise. Thus, the impact of health care reform features such as new community rating rules, risk-adjustment measures, and the guarantee issue surrounding current MHIP enrollees and other high-risk individuals are not included in the calculation of market costs. It is difficult to estimate these costs because there are a number of policy decisions regarding them that have to be addressed by the state before Hilltop would be able to assess their effect. Furthermore, the impact of new enrollees entering into the individual market could not be fully assessed until an Exchange Board study is completed.

Hilltop's analysis does indicate that the market costs per person in the Exchange would be less expensive than the state costs per person if the individual market's costs were not affected by the health care reform issues listed in the paragraph above. Since the federal payments are based off of the market costs, Hilltop's analysis shows that under their scenarios, program costs could not be covered exclusively by federal funds and enrollee premiums. However, if the market cost were 16 percent higher than this initial estimate under the Base-Cost Scenario and 24 percent higher under the High-Cost Scenario, then the BHP would be cost neutral to the state, provided that the state collected the maximum enrollee premium. These percentage increases would mean that the market costs would rise to $7,305 per person in the Base-Cost Scenario and $7,780 per person in the High-Cost Scenario in FY 2014.

As the base estimate for state costs, Hilltop used Maryland's actual sum of MCO capitation payments and fee-for-service (FFS) service costs provided to Medicaid Parent Expansion enrollees (adults with children that have incomes between 30 percent and 116 percent of the FPL).[19] The projected FY 2014 cost per enrollee is shown in Row 1 of Table 3. Hilltop excluded the costs of Long Term Care, Personal Care, and Emergency Transportation from the total Medicaid Expansion costs per enrollee, because these services will more than likely not be provided to BHP enrollees under the essential health benefits package. A breakdown of costs, as reported by Maryland Medicaid MCOs' Health Finance Management Reports (HFMRs), shows 8 percent administrative costs. Costs for providing health care services for the BHP enrollees, whose incomes will be between 138 percent and 200 percent of the FPL, are likely to be very close to the current costs for Medicaid Parent Expansion enrollees. Therefore, Hilltop determined that $6,871 is the most pertinent starting point for estimating PMPY costs of Maryland BHP enrollees.

[18] See Palmer, J. (2011, April). Healthcare reform and the basic health program option: Modeling financial feasibility. Milliman Healthcare Reform Briefing Paper. (http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf) and Benjamin Elisabeth R. and Arianne Slagle (2011, June). Bridging the Gap: Exploring the Basic Health Insurance Option for New York. Community Service Society. (http://www.healthcarereform.ny.gov/research_and_resources/docs/bridging_the_gap_exploring_basic_health_insurance_option.pdf).

[19] Some services are carved-out of the managed care benefit package and are provided on a fee-for-service basis.

Data from the Maryland Insurance Administration (**MIA**) for the individual market in Maryland, as reported by Mercer/Oliver Wyman in a report for the Maryland Health Care Commission, include average insurance premiums for the state.[20] Through discussions with Mercer, Hilltop identified that the premiums do not reflect any cost-sharing amounts. Also, the Kaiser Family Foundation (**KFF**) (2011) State Health Facts used 2010 data from National Association of Insurance Commissioners and reported average premiums by state. The Maryland state averages from these two data sources are very close. Hence, Hilltop used their average and added $2,500 for co-payments and deductibles. The $2,500 amount for co-payments and deductibles was determined by assessing current cost-sharing amounts in the individual market. Projecting the data to FY 2014, the average annual cost per enrollee is estimated to be $6,293, as reported in Row 1 of Table 3. Hilltop used this estimate as the cost per enrollee for coverage obtained through the Maryland Health Benefits Exchange. This amount is used for the market cost of coverage in the base- and high-cost scenarios.[21]

As stated above, this market cost estimate does not estimate what the effects will be of health care reforms like, among others, the community rating rules, the guarantee issue, the merger of the MHIP population into the Exchange, the impact of risk adjustment programs, or whether the state chooses an Essential Health Benefits benchmark plan that adds more services than what is currently covered in the individual market. These policy issues are currently still being analyzed and discussed by the Legislature, the Exchange Board and various stakeholders and cannot be presently included into the market cost estimate with certainty.

These issues could raise individual market premiums between 4 to 40 percent, according to another report written by Mercer that was presented to the Exchange Board in November 2011.[22] The large range is driven by what may occur with the entrance of the MHIP population into the Exchange. This population's care in MHIP is currently subsidized through an assessment on hospitals. Mercer found that if that funding is no longer continued and distributed through the Exchange then market premiums could increase by 29 percent, but if it were continued then premiums would rise by only 2 percent. Mercer's estimate also does not include covering potentially healthier individuals who are uninsured presently. Furthermore, other ACA reforms, like establishing the benchmark plan for the Essential Health Benefits, will have to be resolved before Medicaid could estimate Exchange plan costs.

For the "High- Cost Scenario" shown in Row 2 of Table 3, Hilltop assumed increases in Medicaid physician fees to 100 percent of Medicare fees and the utilization of services provided by Federally Qualified Health Centers (FQHCs) at 15 percent of the volume of physician services (See Appendix B).

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[20] Mercer and Oliver Wyman (2011, June 16). *Potential impact of the Affordable Care Act on the current individual and small group markets*. Report to the Maryland Health Care Commission. Retrieved from http://mhcc.maryland.gov/smallgroup/affordable_care_20110711.pdf.

[21] The individual market costs used in this study were very close to the small market costs. Hilltop estimated that the cost of small group insurance plans in Maryland would be $6,386 in FY 2014 based on data from AHIP. This is only 1.5 percent higher than the $6,293 cost estimate based on the MIA and KFF data used for Hilltop's base- and high-cost scenarios.

[22] Mercer. (2011). Report of Market Rules and Risk Selection for the State of Maryland. Maryland Health Benefit Exchange. Retrieved at http://dhmh.maryland.gov/healthreform/exchange/pdf/FinalMDStudyofMarketRules-and-RiskSelectionReport.pdf.

An Urban Institute study[23] estimated the PMPY cost of $6,775 for a BHP in Maryland and a PMPY market cost of $8,128 for the Exchange in Maryland. Hilltop used these estimates for the cost-savings scenario shown in Row 3 of Table 3. To arrive at the market cost estimates, Urban Institute "combined insurers' claims payments and consumers' out-of-pocket costs." Furthermore, they assumed "health care costs per capita are lower for BHP-eligible adults than for other adults in the individual market, primarily because low-income working adults tend to be younger than other workers."

Basic Health Program Cost Model Output

As inputs for the BHP model, Hilltop used the FY 2014 cost estimates for the three scenarios reported in Table 3. Tables 4.1 through 6 show the output of the BHP financial model for these cost scenarios.

Each table shows estimates of the state's gross costs of establishing a BHP and the state's administrative costs of operating a BHP program, calculated as 10 percent of gross BHP program costs. The third row of each table shows federal payments for BHP based on 95 percent of premium tax credits and cost-sharing subsidies that the federal government would have otherwise paid to the individuals in the Exchange. The fourth row depicts enrollees' maximum payments for premiums and cost sharing, as specified by the ACA, assuming that all enrollees would make their payments on time. Row 5 shows the state's net costs of BHP, with the same assumption. Row 6 assumes that 10 percent of BHP enrollees will delay their premium and cost-sharing payments by 90 days. Row 7 shows the state's net total costs of BHP with the 90-day delay in payments.

Medicaid factored a 90-day delay in premium collection in response to an ACA provision affecting Qualified Health Plans in the Exchange. The law states that insurers in the Exchange grant enrollees a three-month grace period in which the insurer would cover them even if they had not paid their premiums. Medicaid assumes that it is possible that this provision may be extended to the BHP through regulation and wanted to account for it in the cost estimate.

Rows 8 and 9 show federal subsidies for coverage through the Exchange for individuals with income between 200 percent and 400 percent of the FPL, and total federal subsidies in the Exchange for individuals with income between 138 percent and 400 percent of the FPL (if a BHP is not established).

Table 4.1 shows the model output for the "Base-Cost Scenario" (Row 1 of Table 3) without any change in physician fees or utilization of FQHC services. The state's net costs, including administrative costs and assuming that 10 percent of enrollees delay their payments by 90 days, are projected to be $636 million through FY 2020.

[23] Dorn, S., Buettgens, M., & Carroll, C. (2011, September). Using the basic health program to make coverage more affordable to low income households: A promising approach for many states. Prepared for the Association for Community Affiliated Plans by the Urban Institute. Retrieved from http://www.urban.org/url.cfm?ID=412412

Table 4.1. Basic Health Program (BHP) Costs (Savings) in Million Dollars
Base-Cost Scenario

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
State's Gross Total Costs of BHP	**$277**	**$580**	**$606**	**$635**	**$666**	**$698**	**$731**	**$4,192**	**$3,144**	**$5,240**
State Administrative Costs of BHP	$28	$58	$61	$63	$67	$70	$73	$419	$314	$524
Federal Payments for BHP (Million $)	-$216	-$451	-$471	-$495	-$520	-$547	-$574	-$3,274	-$2,455	-$4,092
BHP Enrollees' Maximum Premium Payments without Delay	-$49	-$102	-$106	-$110	-$114	-$118	-$121	-$719	-$539	-$898
State's Net Costs of BHP without Payment Delay	**$41**	**$85**	**$89**	**$94**	**$98**	**$103**	**$108**	**$618**	**$464**	**$773**
BHP Enrollees' Premiums with 10% Delaying 90 Days	-$47	-$99	-$103	-$107	-$111	-$115	-$118	-$701	-$526	-$876
State's Net Total Costs of BHP with 90-Day Delay	**$42**	**$88**	**$92**	**$96**	**$101**	**$106**	**$111**	**$636**	**$477**	**$795**
Federal Subsidies for Coverage thru Exchange (200-400% FPL)	$203	$425	$447	$475	$505	$537	$572	$3,164	$2,373	$3,955
Total Subsidies in Exchange without BHP (138-400% FPL)	$429	$900	$943	$996	$1,052	$1,113	$1,177	$6,610	$4,958	$8,263

Table 4.2 shows the model output for the Base-Cost Scenario at the break-even point. It assumes that costs in the individual market would have risen by 16 percent above the projected individual market cost in the Base-Cost Scenario. In dollar terms, it requires the FY 2014 cost of a silver tier plan to be $7,305.

Table 4.2. Basic Health Program (BHP) Costs (Savings) in Million Dollars
Base-Cost Scenario at Break Even Point

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
State's Gross Total Costs of BHP	**$277**	**$580**	**$606**	**$635**	**$666**	**$698**	**$731**	**$4,192**	**$3,144**	**$5,240**
State Administration Costs of BHP	$28	$58	$61	$63	$67	$70	$73	$419	$314	$524
Federal Payments for BHP (Million $)	-$258	-$539	-$563	-$591	-$621	-$653	-$685	-$3,910	-$2,933	-$4,888
BHP Enrollees' Max. Premium Payments without Delay	-$49	-$102	-$106	-$110	-$114	-$118	-$121	-$719	-$539	-$898
State's Net Costs of BHP (without Payment Delay)	**-$1**	**-$3**	**-$3**	**-$3**	**-$3**	**-$3**	**-$3**	**-$18**	**-$13**	**-$22**
BHP Enrollees' Premiums with 15% Delaying 90 Days	-$47	-$99	-$103	-$107	-$111	-$115	-$118	-$701	-$526	-$876
State's Net Total Costs of BHP with 90 Day Delay	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Federal Subsidies for Coverage thru Exchange (200-400% FPL)	$267	$560	$588	$623	$661	$701	$745	$4,145	$3,109	$5,181
Total Subsidies in Exchange without BHP (138-400% FPL)	$538	$1,127	$1,181	$1,245	$1,315	$1,388	$1,466	$8,261	$6,196	$10,326

Table 5.1 shows the model output for the "High-Cost Scenario" (Row 2 of Table 3). This scenario assumes that physician fees will increase to 100 percent of Medicare fees, and FQHCs will provide 15 percent of all physician services. Under this scenario, the state's net costs, including 10 percent administrative costs, are estimated to be $935 million through FY 2020. This scenario also assumes that 10 percent of enrollees will delay their payments by 90 days.

Table 5.1. Basic Health Program (BHP) Costs (Savings) in Million Dollars
High-Cost Scenario

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
State's Gross Total Costs of BHP	**$295**	**$617**	**$645**	**$676**	**$709**	**$743**	**$778**	**$4,463**	**$3,347**	**$5,579**
State Administrative Costs of BHP	$30	$62	$65	$68	$71	$74	$78	$446	$335	$558
Federal Payments for BHP (Million $)	-$216	-$451	-$471	-$495	-$520	-$547	-$574	-$3,274	-$2,455	-$4,092
BHP Enrollees' Maximum Premium Payments without Delay	-$49	-$102	-$106	-$110	-$114	-$118	-$121	-$719	-$539	-$898
State's Net Costs of BHP without Payment Delay	**$61**	**$127**	**$132**	**$139**	**$146**	**$153**	**$160**	**$917**	**$688**	**$1,146**
BHP Enrollees' Premiums with 10% Delaying 90 Days	-$47	-$99	-$103	-$107	-$111	-$115	-$118	-$701	-$526	-$876
State's Net Total Costs of BHP with 90-Day Delay	**$62**	**$129**	**$135**	**$142**	**$148**	**$156**	**$163**	**$935**	**$701**	**$1,168**
Federal Subsidies for Coverage thru Exchange (200-400% FPL)	$203	$425	$447	$475	$505	$537	$572	$3,164	$2,373	$3,955
Total Subsidies in Exchange without BHP (138-400% FPL)	$429	$900	$943	$996	$1,052	$1,113	$1,177	$6,610	$4,958	$8,263

Table 5.2 shows the model output for the High-Cost Scenario at the break-even point. It assumes that costs in the individual market would have risen by 24 percent above the projected individual market cost in the High-Cost Scenario. It dollar terms, it requires the FY 2014 cost of a silver tier plan to be $7,780.

Table 5.2. Basic Health Program (BHP) Costs (Savings) in Million Dollars
High-Cost Scenario at Break Even Point

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
State's Gross Total Costs of BHP	**$295**	**$617**	**$645**	**$676**	**$709**	**$743**	**$778**	**$4,463**	**$3,347**	**$5,579**
State Administration Costs of BHP	$30	$62	$65	$68	$71	$74	$78	$446	$335	$558
Federal Payments for BHP (Million $)	-$277	-$580	-$606	-$637	-$669	-$702	-$737	-$4,209	-$3,157	-$5,261
BHP Enrollees' Max. Premium Payments without Delay	-$49	-$102	-$106	-$110	-$114	-$118	-$121	-$719	-$539	-$898
State's Net Costs of BHP (without Payment Delay)	**-$1**	**-$3**	**-$3**	**-$3**	**-$3**	**-$3**	**-$3**	**-$18**	**-$13**	**-$22**
BHP Enrollees' Premiums with 15% Delaying 90 Days	-$47	-$99	-$103	-$107	-$111	-$115	-$118	-$701	-$526	-$876
State's Net Total Costs of BHP with 90 Day Delay	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Federal Subsidies for Coverage thru Exchange (200-400% FPL)	$297	$623	$655	$693	$734	$778	$825	$4,605	$3,454	$5,757
Total Subsidies in Exchange without BHP (138-400% FPL)	$589	$1,234	$1,293	$1,363	$1,438	$1,518	$1,602	$9,036	$6,777	$11,295

Table 6 shows the output of the BHP financial model for a cost scenario based on the Urban Institute's BHP and market cost estimates, presented in Row 3 of Table 3. Again, the Urban Institute authors assume that the BHP enrollees are younger and healthier working adults that have lower cost per enrollee than the health benefits exchange enrollees. With these cost assumptions, the state's net total savings of implementing a BHP would be $582 million through FY 2020. However, it is important to note that, according to the ACA, the state must use the surplus funds to either reduce enrollees' premiums and cost sharing or expand their benefits. Therefore, from a financial point of view, establishing a BHP in Maryland will become cost neutral for the state under this scenario. Furthermore,

if the federal government does not allow program savings to be used for administrative costs, Maryland would have to cover the ten percent of administrative costs that is estimated to operate the BHP. These costs would rise to $72 million a year in FY 2020 (See Row 2 in Table 6).

Table 6. Basic Health Program (BHP) Costs (Savings) in Million Dollars Based on Urban Institute PMPY Cost Estimates

Basic Health Program (BHP)									RANGE	
	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	TOTAL	LOW	HIGH
State's Gross Total Costs of BHP	**$273**	**$572**	**$597**	**$626**	**$656**	**$688**	**$720**	**$4,133**	**$3,100**	**$5,166**
State Administrative Costs of BHP	$27	$57	$60	$63	$66	$69	$72	$413	$310	$517
Federal Payments for BHP (Million $)	-$292	-$610	-$638	-$670	-$703	-$739	-$776	-$4,428	-$3,321	-$5,535
BHP Enrollees' Maximum Premium Payments without Delay	-$49	-$102	-$106	-$110	-$114	-$118	-$121	-$719	-$539	-$898
State's Net Costs of BHP without Payment Delay	**-$40**	**-$83**	**-$87**	**-$91**	**-$95**	**-$100**	**-$104**	**-$600**	**-$450**	**-$750**
BHP Enrollees' Premiums with 10% Delaying 90 Days	-$47	-$99	-$103	-$107	-$111	-$115	-$118	-$701	-$526	-$876
State's Net Total Costs of BHP with 90-Day Delay	**-$39**	**-$81**	**-$84**	**-$88**	**-$92**	**-$97**	**-$101**	**-$582**	**-$436**	**-$727**
Federal Subsidies for Coverage thru Exchange (200-400% FPL)	$319	$670	$703	$744	$788	$835	$885	$4,943	$3,707	$6,179
Total Subsidies in Exchange without BHP (138-400% FPL)	$626	$1,312	$1,375	$1,449	$1,528	$1,613	$1,701	$9,604	$7,203	$12,005

Summary of the Financial Impact on Maryland

The two cost scenarios based on current individual market trends analyzed by Hilltop indicate that the BHP could not be operated in Maryland with only federal funds and enrollee premiums. However, if market costs were to rise by 16 percent above projected market costs in the Base-Cost Scenario and 24 percent in the High-Cost Scenario, then the program could be funded exclusively with federal dollars and enrollee premiums. It may be that market costs would rise by those percentages

depending on the effects of health care reform measures like the guarantee issue and the entrance of MHIP enrollees into the Exchange.

Hilltop's analysis assumes that individuals are not receiving the enhanced benefits under the Medicaid program but only the essential benefits package. Hilltop's model also envisions the state collecting the maximum allowable premium from the enrollee. In contrast, the Urban Institute's model indicates that Maryland would be able to operate the BHP with only federal funds and realize cost savings that could be put back into the program in order to lessen enrollee premiums or expand the benefit package.

Hilltop's and the Urban Institute's estimates are based on assumptions on the cost of Exchange plans, the content of the state's essential health benefits package, the risk profile of the BHP and Exchange populations, and other factors that are currently unknown. The reason Hilltop's estimates diverge from the Urban Institute's estimates is due to different approaches to these assumptions. These issues, particularly the issues concerning the cost of insurance in the Exchange, cannot be sufficiently modeled at this time.

The state will not know for certain what these variables will be until implementation of the Exchange. It should be noted that the ACA does not mandate that the BHP be implemented while these factors are unknown. There is no deadline for BHP implementation – Maryland could wait until 2015 or 2016 or later to create a BHP when the variables are better understood.

The Effect of the Basic Health Plan on the Maryland Health Benefit Exchange

A Basic Health Plan would affect the Maryland Health Benefit Exchange. Implementing the BHP would remove a portion of participants of the Exchange. The shift of this population could impact how it was financed and how it would draw participating health plans into the Exchange market. Because of its large effect, any discussion about the implementation of the BHP should be coupled with a discussion about Exchange operations and financial sustainability.

Implementing a BHP could remove a source of money for Exchange administration. The Exchange is currently deliberating on how to fund its operations. User fees may be a part of that strategy. Removing a large number of potential BHP enrollees may impact the ability of the Exchange to be financially sustainable, although the ACA requires that all Exchanges be self-sustainable by January 1, 2015.

The main purpose of establishing the Exchange is to increase competition among insurance carriers to provide coverage at lower-costs. If the potential number of individuals in the Exchange is small, however, then implementing a BHP could negatively affect the size of the risk pool. If establishing the BHP reduces the potential pool of total Exchange enrollees, some carriers may not have sufficient financial incentives to offer insurance coverage through the Exchange. This may lead to only one or two insurance carriers offering coverage in the Exchange, which eliminates competition among carriers.

However, it may be that carriers prefer to have the 138 percent to 200 percent of the FPL cohort served in a BHP rather than the Exchange because it would remove a less healthy population from Exchange plans. This would change the risk pool. For instance, if the BHP enrollees are sicker than the

average and leave the Exchange, costs could decline in the remaining individual market as a whole. As a result, implementing a BHP could lower the average cost of adults receiving individual coverage in the Exchange, which would be a clear benefit to other Exchange enrollees. Carriers might prefer this outcome and it may even encourage more participation in the Exchange.

Furthermore, as Table 2 illustrates, the BHP model projects that, after establishing a BHP in Maryland, approximately 188,000 people (sum of Rows 4 and 5) would enroll in the Exchange by FY 2016. Maryland has the option of combining the individual and small group insurance markets. Also, some of the approximately 165,000 people who currently have insurance coverage through the individual market may find it advantageous, over time, to purchase lower-cost coverage through the Exchange. These factors increase the pool of potential Exchange enrollees, making it possible to establish a BHP in Maryland without adversely affecting the size of the risk pool in the Exchange.

Other States' Experiences

Maryland is not the only state that is considering the Basic Health Program. According to the Association of Community Affiliated Plans (**ACAP**), California, Colorado, Connecticut, Hawaii, Illinois, New Jersey, Rhode Island, and Washington have all begun analyzing the BHP as an option for their states, although it appears that at this stage no state has announced that it has formally begun implementing the program.[24]

The BHP option in the ACA was created to encourage states to develop programs like the State of Washington's current BHP. However, Washington is contemplating whether or not to discontinue its current Basic Health Plan to manage its existing budget crisis.[25]

In September and October 2011, HHS initiated a Request for Information on the BHP so that states and interested stakeholders could relay to the federal government their concerns. After a review of the publicly available comments, the common theme in the letters reflects the need for more federal guidance. In particular, uncertainty in the manner of how federal payments will be assessed, how the reconciliation process will work, and whether federal payments would be able to cover administrative costs were cited as issues that the federal government needed to resolve.

Administrative Timelines

In order to implement the BHP, Maryland would have to develop a clear timetable for implementation. The federal government has not specified when it expects to begin the rulemaking process for the BHP, and it has not specified whether it will offer preliminary guidance in anticipation of rulemaking like it did with the Essential Health Benefits bulletin released in December 2011. To put it simply, the state does not know when this critical guidance will be released and it is unclear whether it would be available at any point during the 2012 Maryland General Assembly session.

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[24] Association of Community Affiliated Plans. Re: Request for Information Regarding State Flexibility to Establish a Basic Health Program Under the Affordable Care Act. (Letter to HHS). October 31, 2011 (accessed at http://communityplans.net.dnnmax.com/PolicySupport/CommentsandRegulations/CommentsonRegulationsOctober312011/tabid/443/Default.aspx).

[25] Vestal, Christine. (2012, January 11). "Medicaid: a year of excruciating decisions." Stateline.org. Retrieved at http://www.stateline.org/live/details/story?contentId=624072.

In addition to the federal guidance, decisions about Exchange operations would have to be completed before the state could begin planning for a BHP.

In order to build the BHP infrastructure described in the proceeding sections and start planning a budget, Medicaid would need at least nine months to prepare: procure a vendor for premium invoicing and collection; establish new regulations and rates; and secure contracts with MCOs.

Unlike other ACA provisions, such as the insurance market reforms, the BHP does not have an implementation deadline. As a result, the state could await further federal guidance (and the resolution of key federal unknowns) prior to making any final decision on the BHP. Moreover, Maryland could establish a BHP at the time of its choosing, including in 2015 or later, once the state has information on the rates in the individual market in the Exchange. Operating a BHP would not require state legislation, although it might require a state appropriation, if federal start-up or ongoing administrative funding is not available.

Deferring implementation may be a viable option, considering that the state will have more experience and knowledge about whether commercial products in the Exchange are affordable for individuals between 138 percent and 200 percent of the FPL once the Exchange is operating.

Conclusion

The BHP represents an innovative approach to providing coverage to a low-income population. It may be able to mitigate churning for individuals moving between Medicaid and the Exchange, as well as aligning parents and children in the same health plans if children are eligible for MCHP. This will limit the administrative complications that individuals will be exposed to if their Medicaid eligibility varies during a year. Furthermore, it may be able to cover legal immigrants that are not eligible for Medicaid.

However, there are several unknown factors that may determine whether the program will cost Maryland money. First, it is unclear at this time what the market costs of insurance will be. Since federal payments are tied to the market costs, it is not possible at this point in time to adequately assess whether the federal payment and enrollee premiums will cover BHP plan costs. There are also issues that the federal government must resolve through regulation in order for Medicaid to estimate what the financial liability of the state may be.

In light of these issues, Maryland may wish to explore postponing any decision on the BHP until additional information is known. The ACA does not mandate a date of implementation like it does for the Exchange, so a state is free to implement a BHP at a timetable of its own choosing. Maryland could wait until FY 2015 or after to implement a BHP once it has a full understanding of federal requirements and a definitive knowledge of the characteristics of the 138 percent to 200 percent of the FPL population.

Appendix A

Alternative FY 2014 Costs for a Basic Health Program in Maryland

Hilltop obtained per member per year (PMPY) health care cost estimates from several sources, as shown in Table 1A. Then Hilltop projected estimates from different base years to FY 2014 using Centers for Medicare & Medicaid Services (CMS) cost projections.[26]

Table 1A. Basic Health Program and Insurance Market Cost Estimates

Sources	FY 2014 Costs
1. Maryland Total FFS + MCO Payments (8% Admin Costs)	$6,871
2. Maryland Total FFS + MCO Payments (15% Admin Costs)	$7,287
3. Maryland Total FFS + MCO Payments with increase in Physician Fees and increase in utilization of FQHCs	$7,316
4. Maryland Total MCO Payments (8% Admin Costs)	$5,940
5. Maryland Total MCO Payments (15% Admin Costs)	$6,356
6. Milliman National Study (Exclude Admin Costs) [1]	$6,500
7. Milliman National Study (Include 15% Admin Costs)	$7,475
8. Mercer Study for California[2]	$6,235
9. New Mexico SCI enrollees[3]	$8,879
10. Maryland State Employees Health Insurance for Individual (POS)	$5,211
11. Maryland State Employees Health Insurance for Individual (PPO)	$5,523
12. Urban Institute Estimate for Maryland:	
a. Average BHP Cost	$6,775
b. Exchange/Market Cost	$8,128
13. Average of Maryland Insurance Administration and Kaiser/National Association of Insurance Commissioners for Maryland [4]	$6,293

[26] Centers for Medicare and Medicaid Services (2011). National health expenditure projections 2010-2020. Retrieved from https://www.cms.gov/NationalHealthExpendData/

Sources	FY 2014 Costs
14. Maryland Small Group Market Cost of Insurance[5]	$6,386
15. National Average of Small Group Market Cost of Insurance[6]	$6,153
16. National Individual Market Average Cost for Single Coverage[7]	$7,136
17. Virginia Individual Market Average Cost for Single Coverage[7]	$7,454

[1] J. Palmer: Premium for second lowest cost silver plan, excluding administrative costs.
[2] Based on 70 percent actuarial value, including 15% administrative costs.
[3] New Mexico physician fees as a percentage of Medicare fees approximate Maryland's Medicaid Fees. However, New Mexico's hospital costs are likely higher than Maryland's.
[4] Assumes $2,500 in out-of-pocket costs for deductibles and copayments.
[5] Based on America's Health Insurance Plans (AHIP) 2009 Small Group Survey.
[6] Based on America's Health Insurance Plans (AHIP) 2011 Small Group Survey.
[7] Based on America's Health Insurance Plans (AHIP) 2010 Individual Market Survey plus $2,500, added for out-of-pocket costs for deductibles and copayments.

As the base estimate for state costs, Hilltop used Maryland's actual sum of MCO capitation payments and fee-for-service (FFS) wraparound services costs provided to Medicaid Expansion enrollees (parents with incomes below 116 percent of the FPL). The projected FY 2014 cost per enrollee is shown in Row 1 of Table 1A. Hilltop excluded the costs of Long Term Care, Personal Care, and Emergency Transportation from the total Medicaid Expansion costs per enrollee, because these services will not be provided to BHP enrollees. A breakdown of costs, as reported by Maryland Medicaid MCOs' Health Finance Management Reports (HFMRs), shows 8 percent administrative costs. Costs for providing health care services for the BHP enrollees, whose incomes will be between 138 percent and 200 percent of the FPL, are likely to be very close to the current costs for Medicaid Expansion enrollees. Therefore, Hilltop determined that $6,871 is the most pertinent starting point for estimating PMPY costs of Maryland BHP enrollees.

As one of the estimates of costs of providing health insurance coverage through the Exchange, Hilltop increased administrative costs to 15 percent and estimated an annual premium cost of $7,287 (Row 2 of Table 1A). Row 3 shows Maryland's total FFS and MCO costs per enrollee of $7,316. For this estimate, Hilltop assumed that physician fees will increase to 100 percent of Medicare fees and that Federally Qualified Health Centers (FQHCs) will provide 15 percent of physician services with the implementation of health care reform. Analysis of changes in payments for and utilization of physician services is included in Appendix B of this report. Rows 4 and 5 depict Maryland's total MCO payments, with 8 percent and 15 percent administrative costs, respectively. These amounts exclude FFS wraparound costs.

In its study of BHPs, Milliman used $6,500 as the estimated PMPY cost of BHP enrollees, as shown in Row 6 of Table 1A.[27] Milliman reported using data from Massachusetts' Commonwealth Care programs, which provide coverage to people who do not qualify for Medicaid and whose income is less than 300 percent of the FPL. Hilltop also used PMPM costs estimated by Mercer for a feasibility study it conducted in 2011 for a BHP in California.[28] Hilltop used Mercer's PMPM estimate of $486 to derive a PMPY cost estimate of $6,235, reported in Row 8.

The State Coverage Insurance (SCI) program in New Mexico covers uninsured adults (parents and childless adults) aged 19 through 64 years with household incomes below 200 percent of the FPL. Therefore, New Mexico's SCI program enrollees are very similar to the potential BHP program enrollees. However, as explained in a footnote to Table 1A, although New Mexico physician fees as a percentage of Medicare fees are close to Maryland reimbursement rates, its hospital costs are likely higher than Maryland's. Therefore, Hilltop determined the $8,879 average PMPY costs are higher than what the payment rates would be in Maryland.

Furthermore, Hilltop calculated payments for Maryland state employees' health insurance program. The PMPY total cost per individual state employee is $5,211 for a point of service plan (Row 10 of Table 1A) and $5,523 for a preferred provider plan (Row 11), with an average of $5,367. These costs include medical and pharmaceutical coverage but exclude dental coverage. Because Maryland state employees have higher incomes and are healthier than Medicaid Expansion enrollees, their average cost is lower than that of Medicaid Expansion enrollees by 10 to 16 percent (compared to Rows 4 and 5 of Table 1A, MCO-only payments).

An Urban Institute study[29] estimated the PMPY cost of $6,775 for a BHP in Maryland (Row 12.a of Table 1A), and a PMPY market cost of $8,128 for the Exchange in Maryland (Row 12.b). Hilltop used these estimates for the cost-savings scenario shown in Table 6 in the text of the paper. To arrive at the market cost estimates, Urban Institute "combined insurers' claims payments and consumers' out-of-pocket costs." Furthermore, they assumed "health care costs per capita are lower for BHP-eligible adults than for other adults in the individual market, primarily because low-income working adults tend to be younger than other workers."

Data from the Maryland Insurance Administration (MIA) for the individual market in Maryland, as reported by Mercer/Oliver Wyman in a report for the Maryland Health Care Commission, include average insurance premiums for the state.[30] Also, the Kaiser Family Foundation (KFF) (2011) State

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[27] Palmer, J. (2011, April). Healthcare reform and the basic health program option: Modeling financial feasibility. Milliman Healthcare Reform Briefing Paper. Retrieved from http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf.

[28] Mercer. (2011, June 28). *State of California: Financial feasibility of a basic health program. Prepared for the California HealthCare Foundation*. Retrieved from http://www.mercer-government.mercer.com/basic-health-program/feasibility.

[29] Dorn, S., Buettgens, M., & Carroll, C. (2011, September). *Using the basic health program to make coverage more affordable to low income households: A promising approach for many states*. Prepared for the Association for Community Affiliated Plans by the Urban Institute. Retrieved from http://www.urban.org/url.cfm?ID=412412.

[30] Mercer and Oliver Wyman (2011, June 16). *Potential impact of the Affordable Care Act on the current individual and small group markets*. Report to the Maryland Health Care Commission. Retrieved from http://mhcc.maryland.gov/smallgroup/affordable_care_20110711.pdf.

Health Facts[31] used 2010 data from National Association of Insurance Commissioners and reported average premiums by state. The Maryland state averages from these two data sources are very close. Hence, Hilltop used their average and added $2,500 for co-payments and deductibles. Projecting the data to FY 2014, the average annual cost per enrollee is estimated to be $6,293, as reported in Row 13 of Table 1A. Hilltop used this estimate as the cost per enrollee for coverage obtained through the Maryland Health Benefits Exchange. This amount is used for the market cost of coverage in the base- and high-cost scenarios shown in Tables 4.1 through 5.2 in the text of the paper.

America's Health Insurance Plans (AHIP) conducted surveys of small group insurance plans in 2009[32] and 2011[33], and a survey of individual health insurance plans in 2009.[34] These surveys provided estimates of premiums for insurance coverage through small group and individual markets. AHIP member companies responding to the survey were asked to include only individual comprehensive or major medical coverage that was guaranteed renewable and met the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definitions of "creditable coverage." For individual market cost estimates, Hilltop added $2,500 for co-payments and deductibles, and then projected total payments to the FY 2014 base year. These data are reported in Rows 14 through 17 of Table 1A. Note that the $6,386 cost estimate based on AHIP's small group insurance plans in Maryland is only 1.5 percent higher than the $6,293 cost estimate based on the MIA and KFF data used for our base- and high-cost scenarios.

[31] Kaiser Family Foundation (2011). Average per person monthly premiums in the individual market, 2010. Retrieved from http://www.statehealthfacts.org/comparemaptable.jsp?ind=976&cat=5

[32] America's Health Insurance Plans (2009, March). *Small group health insurance in 2008: A comprehensive survey of premiums, product choices, and benefits*. Retrieved from www.ahipresearch.org/pdfs/smallgroupsurvey.pdf.

[33] America's Health Insurance Plans (2011, March). *Small group health insurance in 2010: A comprehensive survey of premiums, product choices, and benefits*. Retrieved from www.ahipresearch.org/pdfs/SmallGroupReport2011.pdf.

[34] America's Health Insurance Plans (2009, October). *Individual health insurance in 2009: A comprehensive survey of premiums, availability, and benefits*. Retrieved from www.ahipresearch.org.

Appendix B

Analysis of Changes in Payments for and Utilization of Physician Services

Hilltop used the FY 2014 cost estimate of $6,871 to estimate ranges for the PMPY costs of providing coverage through a BHP in Maryland. Three alternative costs were estimated based on assumptions about either keeping Medicaid fees at their current levels or 1) increasing Medicaid physician fees to 80 percent of Medicare fees, 2) increasing Medicaid fees to 90 percent, or 3) increasing Medicaid fees to 100 percent of Medicare fees. Each of the three alternative estimates was used to construct three additional cost estimates based on utilization of clinical services from FQHCs to: a) remain at their current levels (average of 4.1 percent of total volume of physician services), b) increase FQHCs' volume to 10 percent of the total volume of physician services, and c) increase FQHCs' volume to 15 percent of the total volume of physician services. It should be noted that it might become necessary for FQHCs to expand their current capacities to provide 15 percent of the volume of physician services. The estimated ranges of PMPY costs are shown in Tables 1B, 2B, and 3B.

Table 1B. Case 1: Increase Medicaid Physician Fees to 80% of Medicare Fees

FY 2014 FFS + Capitations PMPM	Percentage of Total	Base Case: FY 2014 Base Costs	Case 1.a: FY 2014 Costs with Increase in Fees Only	Case 1.b: FY 2014 Costs with Increase in Fees & FQHC Utilization	Case 1.c: FY 2014 Costs with Increase in Fees & FQHC Utilization
FQHCs as % of Total Utilization		**4.1%**	**4.1%**	**10.0%**	**15.0%**
% Increase in Physician Payments			9.0%	11.7%	14.0%
Physician PMPY	19.9%	$1,367	$1,491	$1,528	$1,558
Total PMPY Payment	**100.0%**	**$6,871**	**$6,995**	**$7,031**	**$7,062**

Table 2B. Case 2: Increase Medicaid Physician Fees to 90% of Medicare Fees

FY 2014 FFS + Capitations PMPM	Percentage of Total	Base Case: FY 2014 Base Costs	Case 2.a: FY 2014 Costs with Increase in Fees Only	Case 2.b: FY 2014 Costs with Increase in Fees & FQHC Utilization	Case 2.c: FY 2014 Costs with Increase in Fees & FQHC Utilization
FQHCs as % of Total Utilization		**4.1%**	**4.1%**	**10.0%**	**15.0%**
% Increase in Physician Payments			19.1%	20.7%	22.5%
Physician PMPY	19.9%	$1,367	$1,628	$1,651	$1,675
Total PMPY Payment	**100.0%**	**$6,871**	**$7,132**	**$7,155**	**$7,179**

Table 3B. Case 3: Increase Medicaid Physician Fees to 100% of Medicare Fees

FY 2014 FFS + Capitations PMPM	Percentage of Total	Base Case: FY 2014 Base Costs	Case 3.a: FY 2014 Costs with Increase in Fees Only	Case 3.b: FY 2014 Costs with Increase in Fees & FQHC Utilization	Case 3.c: FY 2014 Costs with Increase in Fees & FQHC Utilization
FQHCs as % of Total Utilization		**4.1%**	**4.1%**	**10.0%**	**15.0%**
% Increase in Physician Payments			30.8%	31.4%	32.5%
Physician PMPY	19.9%	$1,367	$1,789	$1,796	$1,812
Total PMPY Payment	**100.0%**	**$6,871**	**$7,293**	**$7,300**	**$7,316**