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

24 Health Matrix __ (forthcoming May 2014).

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

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INTRODUCTION

A. The churn problem

The Affordable Care Act has been called a Rube Goldberg Device.[1] It follows a circuitous path to cover most Americans. Rather

[1] A Rube Goldberg Device accomplishes a task "by complex means [that] seemingly could be done simply." Merriam-Webster Dictionary. David Brooks popularized the use of the expression to describe the Affordable Care Act (Citation for Meet the Press, July 7, 2013).

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

For many insurance affordability programs,[2] eligibility turns on an individual or family's income, measured as a percentage of the federal poverty level (FPL).[3] In states expanding Medicaid[4], individuals and families are Medicaid-eligible if their income does not exceed 138% FPL.[5] Above that level, those earning up to 400% FPL are eligible — on a sliding scale — for subsidized Exchange coverage.[6]

But income as a percentage of FPL is a volatile factor; income shifts as measured by FPL are common. This leads to "churning," the frequent changing into and out-of coverage eligibility.[7] Under the Affordable Care Act, churning is expected between Medicaid eligibility and Exchange subsidy eligibility because of the many factors that affect one's income as a percentage of FPL.[8]

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[2] The insurance affordability programs are Medicaid, the Children's Health Insurance Program (CHIP), or premium and cost-sharing assistance for purchasing private health insurance through state insurance Exchanges. See Robert Wood Johnson Foundation *Determining Eligibility for Insurance Affordability Programs*, http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2013/rwjf404380 (last visited Aug. 21, 2013).

[3] *See id.*

[4] *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2608 (2012) (Congress may offer States grants to expand Medicaid eligibility, but States must have a genuine choice whether to accept the offer.). As of this writing, 24 states will expand Medicaid eligibility. http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

[5] *See* 42 U.S.C. § 1396a (2012).

[6] *See* 26 U.S.C. § 36B (2012); Parents may purchase S-CHIP coverage for their children up to age 19 if they are 139-200% federal poverty level.

[7] Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid And Insurance Exchanges*, 30 HEALTH AFFAIRS 228, 228 (2011).

[8] *See id.* at 228; Covered California, *Bridge Plan: A Strategy to Promote Continuity of Care & Affordability through Contracts with Medi-Cal Managed Care Plans*, at 2

For example, Ben earns $15,500 a year in 2012, when the FPL for an individual was $11,170. Ben is ineligible for Medicaid because his income exceeds 138% of FPL, or $15,414.60 (138% of $11,170).[9] But the next year, with the same income, Ben will be Medicaid eligible because the FPL for 2013 grows to $11,490, placing Ben's income just above the 138% threshold of $15,856.20.

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia[10]	
Persons in family/household	Poverty guideline
1	$11,170
2	$15,130
3	$19,090
4	$23,050
5	$27,010
6	$30,970
7	$34,930
8	$38,890
For families/households with more than 8 persons, add $3,960 for each additional person.	

(Feb. 23, 2013) http://www.healthexchange.ca.gov/BoardMeetings/Documents/February26_2013/VI._BRB_Bridge_Plan_(Update).pdf

[9] Of course, the Medicaid expansion will not take effect until 2014, but Federal Poverty Level figures for 2014 and beyond are not available as of this writing. Indeed, state Exchanges are directed to use 2013 Federal Poverty figures to calculate eligibility for 2014.

[10] U.S. Department of Health & Human Services, 2013 Poverty Guidelineshttp://aspe.hhs.gov/poverty/13poverty.cfm

2013 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA[11]	
Persons in family/household	Poverty guideline
1	$11,490
2	$15,510
3	$19,530
4	$23,550
5	$27,570
6	$31,590
7	$35,610
8	$39,630
For families/households with more than 8 persons, add $4,020 for each additional person.	

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

But if Linh gives birth to twins, Kyle and Kevin, all four family members will be eligible for Medicaid because Linh and Ben's combined income of $31,000 is less than the Medicaid threshold for a family of four: $32,499 (138% of $23,550).

Moreover, while Linh is pregnant, she may be Medicaid eligible as most states cover pregnant women with income up to or above 185% FPL.[12] Kyle and Kevin will also likely be Medicaid eligible after they are born.

Those dizzying back-and-forths occurred without Ben's income changing by a dime. But realistically, Ben and Linh's income will fluctuate. Their work hours may be cut;[13] they could lose or change jobs; they might take unpaid leave to care for Kyle and Kevin; or they could divorce (changing the size of the family, and thus the threshold FPL).

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[11] *Id.*

[12] 42 U.S.C. § 1396a (2012).

[13] *See* Lisa Myers and Carroll Ann Mears, *Businesses Claim Obamacare has Forced them to Cut Employee Hours*, NBC News (Aug. 13, 2013, 6:17 PM), http://investigations.nbcnews.com/_news/2013/08/13/20010062-businesses-claim-obamacare-has-forced-them-to-cut-employee-hours; http://online.wsj.com/article/SB10001424127887323740804578602062545635342.html

And if Linh and Ben's income passes 138% FPL, their children may be covered by CHIP while the Linh and Ben are covered by Exchange plans. The same family, could be covered by different insurance plans with different provider networks.[14]

The many variables affecting eligibility multiplied by the 21.3 million Americans expected to enroll in Medicaid by 2022,[15] along with the existing 66 million enrollees,[16] make a significant amount of churning inevitable.[17] Indeed, 35% of adults with income below 200% FPL will experience an income change affecting their Medicaid eligibility within six months; 50% will experience a change within a year.[18] And 24% will churn at least twice within a year; 39% will churn twice in two years; and in all, 38% will churn at least four times in as many years.[19]

Churning creates many problems. Switching between Medicaid and Exchange coverage undermines continuity of care when it causes enrollees to change provider networks and begin treatment with a new provider. Improving continuity of care is a major objective of the Affordable Care Act.[20] Indeed, one major problem with care in

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[14] *See* Tenn. Ins. Exch. Planning Initiative, *Bridge Option: One Family, One Card Across Time* (Nov. 2011), http://www.tn.gov/nationalhealthreform/forms/onefamily.pdf.

[15] Kaiser Family Foundation, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384_es.pdf (last visited Aug. 21, 2013).

[16] *See* MACPAC, MACStats: Medicaid and CHIP Program Statistics 94 (June 14, 2013, 9:23 AM), available at http://www.macpac.gov/macstats (enrollment data is for 2010 and includes 9.7 million dual-eligibles).

[17] *See* Sommers & Rosenbaum, *supra* note 2 at 230.

[18] DHMH et al., *Analysis of the Basic Health Program* (Jan. 17, 2012) at 9, http://dhmh.maryland.gov/docs/BHP%2001%2018%2012%20Report%20Analysis%20FINAL.pdf.

[19] *Id.*

[20] See ACA § 1331 ("A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section … to improve the continuity of care); ACA § 2602 ("The goals of the Federal Coordinated Health Care Office are as follows: … (6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals"); ACA § 10331 (Directs the secretary to develop a public reporting program for consumer that will among other measures report on

the United States is the practice of treating the uninsured in Emergency Departments. There, patients see different care providers on each visit, and follow-up is rare. The Affordable Care Act, by expanding coverage seeks to ensure that patients see a single provider responsible for their care — improving outcomes and decreasing costs.[21]

But churn works against that goal. When patients switch providers, records transfer and may be lost.[22] Providers must familiarize themselves with a new patient. Things may be overlooked; symptoms communicated to one provider may not be communicated to the next.[23] Thus, a patient forced to frequently switch primary care providers, may not be significantly better off than one who visits the Emergency Room.

And that assumes the patient dutifully reenrolls every time his eligibility changes. A patient churning out of Medicaid may well let coverage lapse for a month or two before enrolling in an Exchange plan. And though they may risk an individual mandate penalty, the penalty is only triggered when the individual is owed a tax refund — not the case for all individuals close to 138% FPL. And if different members of the same household are enrolled in different networks

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"an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use."

[21] John A. Graves, Ph.D., Rick Curtis, M.P.P., and Jonathan Gruber, Ph.D., *Balancing Coverage Affordability and Continuity under a Basic Health Program Option* e44(1) ("Avoiding disruptions in coverage is an important goal because it can reduce unnecessary administrative costs and improve health plans' incentives to invest in achieving longer-term health outcomes. Continuity of coverage can also help maintain clinician–patient relationships, especially in places where there are substantial differences between the clinicians participating in Medicaid and those participating only in private plans.")

[22] See *The advantages of electronic health records: Electronic records can improve patient care. Here's how.* http://www.apa.org/monitor/2012/05/electronic-records.aspx ("With electronic health records, the transfer of complete records from provider to provider or facility to facility happens electronically. That also means records don't get lost or delayed when patients change providers or providers make referrals.")

[23] *See* Sommers & Rosenbaum, *supra* note __, at 229.

and plans due to different eligibly-status, it further increases the likelihood that one will not be reenrolled when eligibility changes.

Churn is frustrating and financially disruptive for enrollees. The Affordable Care Act's success depends on public support.

B. Two approaches to churn consequences

This article evaluates two approaches to mitigate the consequences of churn under the Affordable Care Act.[24] The first is the Basic Health Program. Authorized by the Act, it gives states an alternative means for covering citizens earning between 138% and 200% FPL.[25] Under Basic Health, states can offer coverage that functions similarly to Medicaid beyond 138% FPL. Medicaid enrollees who pass 138% would have substantially the same coverage up to 200% FPL — though enrollees would incur some premium contributions and cost sharing.[26] Basic Health would mitigate many harmful effects of churn at 138%, though churn would occur at 200% FPL. Still, that shift may be an improvement as it shifts churn to a population better able to weather coverage changes.

The other approach is the Bridge Program. Under the Bridge Program, Medicaid managed care issuers would offer their same coverage on the Exchange. These plans would be called "Bridge Plans," and would let Medicaid enrollees who pass the 138% line

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[24] At least one other solution has been proposed. Sara Rosenbaum & Benjamin D. Sommers suggested as a mitigation measure "a subsidy structure utilizing annual enrollment periods." Sara Rosenbaum & Benjamin D. Sommers, Rethinking Medicaid in the New Normal, 5 St. Louis U.J. Health L. & Pol'y 127, 146 (2011). Subsidy and Medicaid eligibility would be determined for a plan year. *Id.* When individuals sign up for coverage, their incomes would be compared to the subsidy scale as of that date, and the subsidy would have been locked in for the next twelve months. Id. Using an annual enrollment process and a twelve-month projected income approach, the law could have offered far more stability in enrollment.

[25] 42 U.S.C. § 18051 (2012); DEBORAH BACHRACH ET AL., *The Role of The Basic Health Program In The Coverage Continuum: Opportunities, Risks, And Considerations For States* 4 (2012).

[26] *Id.* at 5.

purchase identical coverage, benefits, and provider network access — at a highly subsidized rate. Access to bridge plans may not be perpetual. At the states' discretion, enrollees may eventually earn, or time-out of eligibility. But when they do, they would simply buy comparable coverage on the Exchange.

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

I. THE BASIC HEALTH PROGRAM

A. An overview of the Basic Health Program

1. Washington State's Basic Health

The Affordable Care Act's Basic Health Program is modeled after Washington State's Basic Health program.[27] In the mid-1980s, Washington State explored ways of expanding coverage to residents.[28] A major barrier to that expansion was the growing cost of care.[29] Managed care offered a solution.[30] But implementing that solution involved many false starts.

In 1983, the legislature created a committee to study the problem of uncompensated charity care, estimated to cost $60 million a year.[31] The committee saw expanding coverage as the solution and proposed

[27] *See* America's Healthy Future Act of 2009, S. 1796, 111th Cong. § 2239 (2009). *See also* Cantwell Amendment to America's Healthy Future Act of 2009, (Aug. 23, 2013) http://op.bna.com/hl.nsf/id/sfak-7weshg/$File/Cantwell%20Amendment.pdf.
[28] Carolyn W. Madden, Geoffrey Hoare, Marilyn Mayers, William J. Hagens, *Washington State's Basic Health Plan: Choices and Challenges,* 13 J. PUB. HEALTH POL'Y. 81, 82 1992.
[29] *Id.* at 82.
[30] *Id.*
[31] *Id.*

expanding Medicaid eligibility, made affordable, by adopting a managed care system.[32] The committee also recommended a statewide charity pool, funded by state hospital contributions.[33] The legislature ultimately rejected legislation implementing the committee's plan, following hospital opposition.[34]

Washington's governor then ordered a study of options for controlling state-purchased health care costs.[35] The study recommended a six-year plan to increase managed care.[36] A second study (ordered by the legislature) examined means of encouraging the use of managed care.[37] That study's final report focused on using managed care to increase access to low-income residents — rather than to simply reduce costs.[38] It concluded that expanding managed care could increase Medicaid eligibility.[39]

These twin studies led to two bills (one in '85, one in '86) to implement what was called a "Basic Health Plan."[40] The plans would increase access to care while controlling expenditures.[41] They would cover non-elderly uninsured with income below 200% FPL.[42] Coverage would be basic, but comprehensive — with an emphasis on prevention.[43] Coverage would be through a managed care system under contract with the state.[44]

Both bills failed.[45] Legislators disagreed about the magnitude of funds required and the appropriate funding source.[46] The '85 bill would tax hospital and physicians, angering providers.[47] The '86 bill

32 *Id.*
33 *Id.*
34 *Id.*
35 *Id.* at 83.
36 *Id.*
37 *Id.*
38 *Id.*
39 *Id.*
40 *Id.*
41 *Id.*
42 *Id.*
43 *Id.*
44 *Id.*
45 *Id.*
46 *Id.*
47 *Id.*

imposed a "sin tax," largely on cigarettes, angering groups wanting cigarette tax revenue to go elsewhere.[48] Legislators also worried that Basic Health would become a fiscal "black hole."[49] Indeed, no one knew how many eligible residents there were, how many would enroll, nor whether employers would drop coverage in favor of Basic Health.[50] For answers, the legislature created a new commission.[51]

The McPhaden Commission formed in 1986.[52] Composed of legislators from both parties, care providers, businesses, and constituent groups, it was tasked with fleshing out the details of a workable Basic Health Plan.[53] The Commission had a substantial budget, staff, and the authority to hire consultants and create technical advisory committees.[54]

The Commission surveyed statewide to determine the number of Basic Health eligible persons in Washington and their characteristics.[55] It generated actuarial estimates of various program designs.[56] It considered governance and administration of the programs.[57]

The result was Basic Health Plan legislation that passed in 1987.[58] That Basic Health Plan was temporary, limited to a five-year demonstration.[59] That limit created implementation problems as providers were leery of investing in a program that might be short-lived.[60]

The plan also limited enrollees.[61] Only 30,000 residents, from at least five congressional districts, could enroll in the demonstration.[62] This further dampened provider enthusiasm for the program.[63]

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48 *Id.*
49 *Id.*
50 *Id.*
51 *Id.*
52 *Id.* at 83-84.
53 *Id.* at 84.
54 *Id.*
55 *Id.*
56 *Id.*
57 *Id.*
58 *Id.*
59 *Id.* at 85.
60 *Id.* at 86.
61 *Id.* at 85.

Although the plan covered the poor, it did not use Medicaid funds.[64] This was in part because Basic Health covered some swaths of the population not eligible for federal Medicaid funds.[65] But there was also a desire to avoid the stigma of Medicaid welfare funding.[66]

Within geographic and enrollment limits, Basic Health would cover individuals under 65 with income below 200% FPL.[67] Enrollees would make premium and co-payments on a sliding scale.[68]

Care under Basic Health was provided by managed care systems under contract with the State.[69] The care was basic but comprehensive: it emphasized preventive benefits, but included hospital, physician, ER, and ambulance services.[70] But it did not cover prescription drugs, mental health, vision, or dental. And there was a 12-month wait for pre-existing conditions.[71]

Basic Health signed its first service contract in late 1988.[72] The next year, Basic Health expanded to two more counties and capacity was added to existing counties.[73] By 1991, fifteen managed care providers enrolled 20,700 residents, in 14 counties.[74] In 1993, the legislature made Basic Health permanent, and enrollees doubled in 1994.[75] That year prescription drug benefits were also added.[76] Soon after, Basic Health Plus was created to cover women and children who churned into and out of Medicaid eligibility.[77] The result was,

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62 *Id.*
63 *Id.* at 86.
64 *Id.*
65 *Id.*
66 *Id.*
67 *Id.* at 85.
68 *Id.* at 89.
69 *Id.* at 85.
70 *Id.* at 83.
71 Health Care Auth., State of Wash., *A Study of Washington State Basic Health Program* 4 (2002).
72 Madden, *supra* note __, at 91.
73 Health Care Auth., State of Wash., *supra* note __ at 3.
74 Madden, *supra* note __ at 91.
75 Health Care Auth., State of Wash., *A Study of Washington State Basic Health Program* 3 (2002).
76 *Id.* at 4.
77 *Id.* at 2.

from the perspective of enrollees, seamless coverage: "To the member, it's all Basic Health."[78]

A little over 20 years after Basic Health took effect, Washington Senator Maria Cantwell included an amendment to the Affordable Care Act bill to give states the options of following Washington State's lead.[79]

2. The Basic Health Program under the Affordable Care Act

Section 1331 of the Affordable Care Act establishes a "Basic Health Program" for states to provide "standard health plans."[80] The plans are in lieu of Exchange plans for individuals and families earning between 138-200% FPL.[81] Plans offered under the Basic Health Program must provide, at a minimum, essential health benefits.[82] Premiums may not exceed what an eligible individual would pay for the benchmark plan, the second lowest cost silver plan in their rating area.[83] And cost-sharing may not exceed that of a platinum plan (90%) — but only for individuals with a household income of 150% FPL or lower; for individuals above 150% FPL, cost sharing may not exceed that of a gold plan (80%).[84]

While the Basic Health Program has been called a "quasi-public option" or "single-payer lite," it does not involve a public health

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78 *Id.*

79 Janet Varon, *The Basic Health Option: Considerations for States Implementing Federal Health Reform*, NATIONAL HEALTH LAW PROGRAM, 2 (Dec. 6, 2010), *available at* http://www.familiesusa.org/conference/health-action-2011/speaker-materials/NHELP-Paper-Basic-Health-Option.pdf.

80 42 U.S.C § 18051 (West 2013).

81 *Id.*

82 *Id.*

83 *Id.* (As discussed in detail below; second lowest-cost silver plan available to an individual on the Exchange is the "benchmark" plan. It is used to determine an individual's premium subsidy.); Marketplace insurance plans are divided into four categories based on premium and out-of-pockets costs: "bronze," "silver," "platinum," and "gold." *See* U.S. Ctrs. for Medicare and Medicaid Servs., How Do I Choose Marketplace Insurance, https://www.healthcare.gov/how-do-i-choose-marketplace-insurance/ (last visited Aug. 8, 2013).

84 42 U.S.C § 18051 (2012).

insurer: Basic Health is implemented through contracts with private insurers.[85]

Under Basic Health, states may select plans from HMOs, licensed health insurers, and networks of care providers established to offer services under the program.[86] In negotiating contracts, states are to consider "innovation" including:

1) care coordination and care management (especially for enrollees with chronic health conditions);

2) incentives for use of preventative services; and

3) establishing providers and patients relationships that maximize patient involvement in care decision-making, including providing incentives for appropriate use of care.[87]

In turn, providers should use managed care, or as many attributes of managed care as possible.[88] In selecting plans, states must include performance measurers that focus on quality of care and improved health outcomes; plans must track their performance using these measures and report findings to the state.[89] Enrollees will have access to these reports.[90]

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[85] *See* Bachrach *supra* note __ at 8; Ryan Grim, *Senate Committee Passes Quasi-Public Option* http://www.huffingtonpost.com/2009/10/01/senate-committee-passes-q_n_306831.html. CF Igor Volsky Media mischaracterizes Cantwell's Basic Health Plan amendment as 'quasi public option.' http://thinkprogress.org/politics/2009/10/02/62618/cantwell-not-public-plan/ ("Under Cantwell's proposal, states would use their purchasing power to negotiate for more affordable coverage options, improve efficiencies, and even lower the health care costs within the Exchange (by shifting lower income and disproportionately sicker individuals into the Basic Health Plan), but they would have to contract with private insurers. Cantwell herself "declined to liken her proposal to a controversial public option, which has become a major sticking point in health care reform." "I think we've hit the sweet spot," she said. "Everybody says they want to have private providers and we're saying fine.""")

[86] *Id.*; BACHRACH, *supra* note ___ at 4.

[87] *Id.*

[88] *Id.*

[89] *Id.*

[90] *Id.*

States may also negotiate regional compacts with other states, and may agree to have the same issuers provide standard health plans to eligible residence in all states.[91]

To fund Basic Health, the federal government will pay states — on an individual enrollee basis — 95% of what the enrollee would have received under the Exchange in premium tax credits and cost-sharing reductions.[92] But the Act limits states' use of those funds to premium and cost-sharing reductions for enrollees or to providing additional benefits for enrollees.[93]

Individuals are eligible to enroll in Basic Health plans if (1) they are not enrolled in Medicaid; (2) they earn between 133% FPL and 200% FPL; (3) they are not eligible for minimum essential coverage from an employer-sponsored plan; and (4) they are under 65.[94] Eligible individuals may not purchase coverage from the Exchange.[95] Thus, no effort is needed to encourage eligible consumers to choose Basic Health plans over Exchange plans.[96] And, lawful adult aliens earning below 138% FPL and who have not lived in the US for five years are eligible for a Basic Health plan — though they are ineligible for Medicaid.[97]

However, the Affordable Care Act provides only a broad sketch of Basic Health Regulations implementing the specifics are needed, but these regulations currently exist only in draft form.[98]

B. How the Basic Health Plan may mitigate the effects of churn

Unlike the Bridge Program, Basic Health was not created to reduce the effects of churn. Yet, it may be used for that purpose.

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[91] *Id.*
[92] *Id.*
[93] *Id.*
[94] *Id.*
[95] *Id.*
[96] Something not true of the Bridge plan, as discussed below.
[97] Alison Siskin, Congressional Research Service *Treatment of Noncitizens Under the Patient Protection and Affordable Care Act* (Mar. 2011) at 6 http://www.ciab.com/workarea/downloadasset.aspx?id=2189 (lawful adult aliens are eligible for the Exchange at the highest level of subsidies, whether or not there is a bridge or Basic health program).
[98] *See* CMS-2380-P (September 21, 2013).

States might mitigate churn effects by offering Basic Health plans with similar coverage to Medicaid, "Medicaid-look-alike" plans.[99] Eligible individuals passing 138% FPL could enroll in plans substantially similar to their Medicaid coverage.[100]

To mitigate churn effects, Basic Health plans must provide comparable coverage to Medicaid plans. Otherwise, the Basic Health plan would just be another discrete plan to churn between. Offering comparable coverage will reduce churn consequences by allowing individuals who transfer out of Medicaid to keep their provider network and benefits until they reach 200% FPL.[101] And enrollees need not contend with premium sharing and subsidies under the Exchange. There would be no requirement to estimate income for the following year, under the threat of an end-of-year reconciliation.

Depending on the plans' cost, enrollees may be responsible for a portion of the premiums and cost-sharing. But states may not require enrollees to pay more in premiums than they would for the second lowest cost silver plan they would otherwise have been eligible for. And cost sharing may not exceed that of a platinum plan (90% actuarial value) for individuals earning up to 150%, or a gold plan (80% actuarial value) for all others.[102]

Basic Health may be characterized as simply kicking the problem down the road by shifting the Exchange threshold to 200% FPL. But churn may be less prevalent at 200% FPL. One study found that churn is likely to decrease at 200%.[103] The study followed individuals

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[99] *Id.* at 16.

[100] Ann Hwang, Sara Rosenbaum and Benjamin D. Sommers, *Creation Of State Basic Health Programs Would Lead To 4 Percent Fewer People Churning Between Medicaid And Exchanges*, Health Affairs, 31, no.6 (2012), 1318 ("If states designed Basic Health Programs that were not compatible with Medicaid in terms of benefits and providers, they would simply be adding another layer of churning at both 138 percent and 200 percent of the federal poverty level.")

[101] BACHRACH, *supra* note ___ at 6.

[102] The proposed rules provide that cost sharing must be reduced even further: 94% actuarial value for those up to 150% FPL and 87% for those up to 200% FPL. 78 Fed. Reg. 59133, 59149 (Sept. 25, 2013).

[103] Ann Hwang, Sara Rosenbaum and Benjamin D. Sommers, *Creation Of State Basic Health Programs Would Lead To 4 Percent Fewer People Churning Between Medicaid And Exchanges*, Health Affairs, 31, no.6 (2012), 1317

aged 19-62, with income below 400% FPL, and without employer-sponsored insurance.[104] After 24 months, 39.5% of the population experienced two eligibility changes at the 138% level.[105] At the 200% level, 36.1% experienced two eligibility changes.[106] Population members experiencing one change were 17.3% and 15.8% respectively.[107]

And beyond raw numbers, the study authors noted that at 200% FPL, individuals are more able to weather brief coverage gaps, provider changes, and cost sharing changes.[108] Shifting Exchange eligibility up would also protect lower income individuals from potential tax credit recoupment.

C. Practical issues with the Basic Health Program

The complexity of some states' Medicaid systems complicates providing Medicaid-comparable coverage. For example, California's Medi-Cal system is county focused, and divided between two delivery systems: fee-for-service and managed care.[109] [110] The managed care system has three models, each offering a different type of managed care.[111] And 16 not-for-profit health plans and four commercial for-

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[104] *Id.*

[105] *Id.*

[106] *Id.*

[107] *Id.*

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[109] *See* California Dept. of Health Care Services, Medi-Cal FAQs - Specific Questions http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFAQs1.aspx (county offices also make eligibility determinations and handle enrollment of eligible Californians.)

[110] Health Research Action, The Medi-Cal Managed Care Project http://www.dhcs.ca.gov/provgovpart/Documents/MMCDExpansion/Outreach%20_Education_Project_Overview.pdf

[111] The three are County Organized Health Systems (COHS), the two-plan model, and geographic managed care. *Id.* In COHS counties, all beneficiaries share the same managed health care plan. *Id.* The two-plan model supports two different health plans in the county: a "Local Initiative," where the community gives input in the development of the plan; and a "Commercial Plan," a private health plan that provides benefits to Medi-Cal enrollees. *Id.* The state contracts with both plans in counties with this model. *Id.* The third managed health care model is geographic managed care. Under that model, the State contracts with multiple commercial plans to provide benefits. *Id.*

profit plans provide Medi-Cal managed care services to approximately 4.5 million members.[112] Among managed care plans, there remain carve-outs where the state assumes responsibility for certain care on a fee-for-service basis.[113]

Still, California is unifying and simplifying its Medicaid system to coincide with Medicaid expansion. By 2014, managed care will be available in every county, and most members will be mandatorily enrolled into a managed care plan.[114] But 1 million to 1.5 million Californians are expected to continue to receive Medi-Cal services through a fee-for-service system.[115]

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

D. Potential downsides of the Basic Health Program

1. The federal government does not fully fund the Basic Health Program.

112 *Id.*

113 California Health Care Almanac, Medi-Cal Facts & Figures: A Program Transforms, at 26 (May 2013) http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFactsAndFigures2013.pdf; *See* also Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 St. Louis U. L.J. 7, 45 (2001) ("as states have begun to purchase managed care products, it is clear that virtually no vendors sell products as broad as Medicaid coverages either requires or permit. States have pursued a logical tactic of effectively breaking up their state plans into two components: one consisting of the managed care contract and the other consisting of residual benefits that remain directly administered by the state. The result has been a hodgepodge of state managed care agreements that vary enormously in what lies "inside" the agreement and what lies "outside" the scope of the contract and, thus remains a direct responsibility of the state agency.")

114 Email from Anthony Cava Spokesman Department of Health Care Services on file with author.

115 *Id.*

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

The Affordable Care Act leaves states to cover the administrative costs of the program.[116] It prohibits states from using Basic Health funds for the program's administrative costs.[117] Government funding (the 95% of what an individual would have received in premium tax credits and cost sharing on the Exchange) covers only the cost of coverage.[118]

And administrative costs in implementing and operating Basic Health may be substantial. Indeed, federal Medicare administrative expenses total $2 billion a year.[119] Even if the Basic Health Program is housed in an existing state agency, creating a new program always incurs administrative expenses. These includes assessing the quality of care, managing a trust fund for federal payments, collecting and distributing enrollee premiums, and liaising with the federal government.[120]

Collecting and distributing premiums in particular can be an expensive undertaking for states. Because the plans are not likely to be fully funded by the federal government, states will collect premium contributions from enrollees, combine that with federal subsidies, and pay the issuers.[121] This fund collection and channeling is not required for either Medicaid programs, nor Exchange plans.

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116 42 U.S.C. § 18051 (2010); *see also* BACHRACH, *supra* note ___ at 17.
117 42 U.S.C. § 18051 (d)(2) (2012).
118 42 U.S.C. § 18051 (d)(3)(A)(i) (2012); The Hilltop Institute, Analysis of the Basic Health Program (Jan. 2012) at 12 https://www.statereforum.org/sites/default/files/bhp_01_18_12_report_analysis_final.pdf (page 1)
119 CBO's May 2013 Medicare Baseline http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205_Medicare_0.pdf (though this is a small fraction of the over $500 billion annual Medicare expenditures).
120 The Hilltop Institute, Analysis of the Basic Health Program (Jan. 2012) at 4.
121 *Id.* at 11.

Thus, this new duty would require increasing personnel or contracting out to third parties.[122]

And this is not the only potential cost arising out of Basic Health. The federal government's 95% contribution may guarantee a low or zero premium for Basic Health enrollees, but it may not cover all an enrollees claims during the plan year. If the premiums and federal contributions fail to cover claims, states are liable for the shortfall.[123]

Moreover, the lack of final federal regulations for Basic Heath creates financial uncertainty for states. How the federal government will reconcile under- and over-payments of state subsidies is unknown.[124] Also unknown is how precisely federal payments will be calculated.[125] The federal government could alleviate some of the financially difficult aspects of Basic Health through regulations, although the proposed rules do not elaborate on this topic.[126] Indeed, the Act's language that federal contributions can "only be used to reduce the premiums and cost-sharing of, or to provide additional benefits" suggests that regulations alone cannot lift the state's administrative burden.[127]

2. Basic Health undermines the state based Exchange system.

Basic Health could also undermine state-based Exchanges. Exchanges are arguably the centerpiece of health care reform. Through Exchanges, the Act adopts a private market-based system as the primary mechanism for coverage. By regulating that system, the Act avoids the harshest consequences of a purely private market based system, while retaining many benefits.

Exchanges pool insureds to maximize individual buying power. They standardize benefits and place plans under a single roof, so

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122 *Id.* at 4.
123 The Hilltop Institute Analysis of the Basic Health Program at 5; *See* Tennessee, *Bridge Option supra* note __ at 3.
124 *Id.* at 4.
125 *Id.*
126 *Id.*
127 *See* 42 U.S.C. § 18051 (2012).

consumers can compare plans without fear of selecting a plan with insufficient coverage. They automate eligibility and enrollment to ensure that citizens are not excluded from the market place. Exchanges also subsidize middle class or lower enrollees to make coverage affordable.

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

To self-sustain, the Exchange must maintain sufficient enrollment to make it worth the issuers' while. Indeed, in Washington State's foray into Basic Health, insurers and providers were initially reticent to get too involved given the limited number of enrollees.[128] The Exchange must also maintain a good risk-mix to keep issuers in the Exchange market: the insured pool must include a sufficient number of young, healthy individuals. A market comprised of mostly high-risk enrollees will drive away issuers.

The Basic Health Program removes many Exchange-eligibles from the Exchange population — including many young and healthy.[129] Younger individuals disproportionately earn under 200% FPL. Indeed, some studies find those earning under 200% are the youngest and the healthiest of the Exchange-eligible population.[130]

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[128] *See* MADDEN supra note ___ at 86.

[129] *See* Ann Hwang, Sara Rosenbaum and Benjamin D. Sommers, *Creation Of State Basic Health Programs Would Lead To 4 Percent Fewer People Churning Between Medicaid and Exchanges*, Health Affairs, 31, no.6 (2012), 1318.

[130] Sara Rosenbaum, *Medicaid's Next Fifty Years: Aligning an Old Program with the New Normal*, 6 St. Louis U.J. Health L. & Pol'y 329, 334 (2013)("The estimated 56 million low income adults and 35 million children who will experience post-reform churn across the Medicaid and Exchange markets represent the healthiest risk groups across the two markets. Unlike the

Without Basic Health, these individuals would be eligible for the highest Exchange subsidies, and thus are likely to enroll for Exchange coverage. But with Basic Health, these young and healthy individuals are required to enroll in the Basic Health to receive federal subsidies, imperiling the Exchange's risk-mix.

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

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

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

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millions of older and sicker adults who gain enormous benefits from health reform, this group is in the workforce and in relatively good health. The cause of their cross-market churn is, of course, income fluctuation, which is more likely to occur in working families than in adults who are in poorer health and living on fixed incomes. For these families, income fluctuates as younger workers enter and leave the job market, add or drop hours of employment, or have children, thereby increasing family size in relation to total household income, which in turn triggers an effective decline in family income in relation to the federal poverty level.")

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

II. THE BRIDGE PROGRAM

A. An overview of the Bridge Program

The Bridge program was first proposed in 2011 by the Tennessee Insurance Exchange Planning Initiative, a group formed to explore the State's options in implementing the Affordable Care Act.[131] Tennessee proposed a special category of plans for residents losing Medicaid eligibility.[132] These plans would offer former Medicaid enrollees consistent coverage as they transitioned from Medicaid to the Exchange.[133]

Tennessee proposed having Medicaid managed care plans participate in the Exchange as Qualified Health Plans.[134] Individuals and families leaving Medicaid could keep the same plan and provider network.[135] From the enrollee's perspective, the only practical

131 Tenn. Ins. Exch. Planning Initiative, *Bridge Option: One Family, One Card Across Time* (Nov. 2011) http://www.tn.gov/nationalhealthreform/Exchange.shtml ; Barry R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS (6th ed. 2008) at 835 (Tennessee launched TennCare under a § 1115 waiver {allowing states to waive most all Medicaid requirements, and allowing Tennessee to offer only Managed Care plans} in 1994).
132 Tenn. Ins. Exch. Planning Initiative *supra* note ___ at 1.
133 *Id.*
134 *Id.*
135 Covered California *supra* note __ at 1.
February 23, 2013

difference would be premium contributions (depending on the cost of the plan).

The federal government showed receptiveness to Bridge Programs in December 2012.[136] The Department of Health & Human Services, Centers for Medicare & Medicaid Services issued guidance allowing Exchanges to permit state Medicaid Managed Care issuers to offer Qualified Health Plans on the Exchange.[137]

Several features define a "bridge" plan. First, a bridge plan is an Exchange plan. With few exceptions, the rules and regulations that apply to Exchange plans apply to bridge plans. Premium subsidies and cost-sharing reductions also apply. A bridge plan is a Medicaid plan sold on the Exchange.

Second, unlike other Medicaid plans, bridge plans must be a private, commercial plan, not a public plan.

Third, unlike a typical Exchange plan, a bridge plan is not guaranteed issue for the entire market. Enrollment is limited to qualified individuals and families. To qualify, the individual or family must be leaving Medicaid.[138] Children of parents transitioning from Medicaid are also Bridge eligible.[139] Additionally, states may impose a maximum income for eligibility, though there is no federal requirement to do so.

Forth, enrollee participation in a bridge plan is optional. Eligible individuals are encouraged — but not required — to select a bridge

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Bridge Plan: A Strategy to Promote Continuity of Care & Affordability through Contracts with Medi-Cal Managed Care Plans (Feb. 2013) at 4 http://www.healthexchange.ca.gov/BoardMeetings/Documents/February 26_2013/VI._BRB_Bridge_Plan_%28Update%29.pdf

136 CMS Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid at 6 http://www.cms.gov/CCIIO/Resources/Files/Downloads/Exchanges-faqs-12-10-2012.pdf

137 *Id.*

138 Covered California *supra* note ___ at 6 (initial enrollment would be limited to individuals transitioning from Medi-Cal CHIP (formerly HFP) coverage).

139 Tenn. Ins. Exch. Planning Initiative, *Bridge Option: One Family, One Card Across Time* (Nov. 2011) at 2, http://www.tn.gov/nationalhealthreform/forms/onefamily.pdf.

plan from the Exchange.[140] But the nature of bridge plans will likely make them the most affordable (and best value) option for eligible individuals.

1. How the Bridge Program may mitigate churn consequences

If Medicaid Bridge plan premiums are sufficiently low, the bridge program could keep the benefits of the Basic Health Program while shedding many drawbacks. Individuals leaving Medicaid following income increases could keep their plans, with no changes in provider networks, and no disruptions in treatment — ensuring continuity of care.[141]

And the Bridge program may prevent families from splitting into different eligibility groups.[142] If one family member loses Medicaid eligibility, while other family members remain eligible, all the family members are eligible for a bridge plan. This ensures that families share the same coverage and provider network. Concomitantly, it alleviates consumer confusion.

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

2. Premium share and subsidies

Bridge enrollees are responsible for a portion of plan premiums. But if procurement strategies work effectively and premiums are

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[140] Covered California *supra* note ___ at 7.
[141] *Id.* at 6 (This proposal would allow individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage to Covered California to stay with the same issuer and provider network.)
[142] *Id.* at 4.

sufficiently low, individual bridge enrollees may have little or no premium contribution.

A Bridge enrollee's premium contribution and subsidy is determined in the same manner as any Exchange plan.[143] Premium subsidies turn on one's income and the cost of a "benchmark" plan, the second lowest cost silver plan available to the enrollee. [144] [145]

Under the Act, one's tax credit subsidy is the lesser of

1) the actual premiums one pays for coverage; and
2) the difference between a specified percentage of the individual's monthly income and the monthly premium for the second-lowest-cost silver plan (the benchmark plan).[146]

Put simply, individuals are expected to pay up to a certain percentage of their income for coverage. If coverage cost less than that percentage, they get no subsidy. If coverage cost more, they get a subsidy to bring the cost down to that percentage.

Exchanges offer an array of plans. By law, all plans provide specified minimum benefits.[147] In some states, all plans will, by law, provide identical benefits.[148] In those states, plans differentiate themselves by their premiums provider network, and quality.

In all states, plans are categorized by their actuarial value (a measure of the expected percentage of covered services the plan pays versus the consumer at the point of service): bronze (60%), silver (70%), gold (80%), platinum (90%).[149] Actuarial value is only an average, not an absolute. Gold plan enrollees will not pay 20% of every procedure.[150] Some procedures incur higher cost share, others

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143 *See id.* at 6.
144 26 U.S.C. § 36B (2012).
145 Covered California *supra* note ___ at 6 (Federal subsidies are based on the second lowest silver plan).
146 26 U.S.C. § 36B (2012).
147 42 U.S.C. § 18022 (2012).
148 Covered California Qualified Health Plan Contract For 2014 at 7. http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%207,%202013/QHP%20Model%20Contract%20Clean.pdf
149 *See* 42 U.S.C. § 18022 (2012).
150 *See* Department Of Health And Human Services Patient Protection and Affordable Care Act; Actuarial Value Calculator Methodology at 1.

lower. And the cost-share is further limited by annual out-of-pocket caps; after the cap is reached, enrollees need not spend anything further out of pocket.[151]

To take one example of the plans that may be available to an individual, Anna has 12 plan options, three in each metal tier (there are no bridge plan options in this example). Anna's premium contribution for each plan is calculated based on the benchmark plan, the second least expensive silver level plan. ForAnna, the benchmark plan is $160 a month.

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

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

Income contribution for Exchange plans.[152]

http://www.cms.gov/CCIIO/Resources/Files/Downloads/av-calculator-methodology.pdf

[151] For 2014, the annual cap was going to be $6,350 for individuals and $12,700 for families http://www.forbes.com/sites/theapothecary/2013/08/13/yet-another-white-house-obamacare-delay-out-of-pocket-caps-waived-until-2015/ (Caps will now take effect in 2015).

income as a percent of poverty line	initial premium percentage	final premium percentage
Up to 133%	2.0%	2.0%
133% – 150%	3.0%	4.0%
150% – 200%	4.0%	6.3%
200% – 250%	6.3%	8.05%
250% – 300%	8.05%	9.5%
300% – 400%	9.5%	9.5%

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

4% x $17,235 [Anna's income] = $689.40 or $57.45 per month [Anna's contribution]
$160 [benchmark plan] - $57.45 [Anna's contribution] = $102.55 [the government's contribution]

Anna's subsidy is $102.55. If she buys the benchmark plan, she will pay $57.45 a month. Anna is free to buy any plan, but the government's contribution remains $102.55 a month; she will pay the difference if she buys a more expensive plan. But if she buys the $100 bronze plan she will pay nothing because it cost less than the government's $102.55 contribution. Similarly, if she buys a $200 gold plan, she must contribute $97.45. When she enrolls and pays her contribution the government will pay the insurer its portion.

Here are Anna's actual costs based on her subsidy.

Anna's contributions for each Exchange plan			
	Least expensive	Second least expensive	Third least expensive
Bronze (60% actuarial value)	Nothing of $100	$7.45 of $110	$17.45 of $120

[152] 26 U.S.C. § 36B (2012)

Silver (70% actuarial value)	$47.45 of $150	$57.45 of $160 [benchmark]	$67.45 of $170
Gold (80% actuarial value)	$97.45 of $200	$117.45 of $220	$137.45 of $240
Platinum (90% actuarial value)	$147.45 of $250	$177.45 of $280	$197.45 of $300

Ike, whose income is higher than Anna's, receives a smaller subsidy.[153] Ike (who lives in the same coverage area as Anna) earns $22,980, exactly 200% FPL. Thus, his premium contribution is 6.3%, or $120.65 a month, and his subsidy is $39.35 a month:

6.3% x $22,980 = $1,447.74 or $120.65 a month [Ike's contribution]
$160 [benchmark plan] - $120.65 = $39.35 [the government's contribution]

Here are Ike's plan options:

Ike's contributions for each Exchange plan			
	Least expensive	Second least expensive	Third least expensive
Bronze (60% actuarial value)	$60.64 of $100	$70.64 of $110	$80.64 of $120
Silver (70% actuarial value)	$110.64 of $150	$120.64 of $160 [benchmark]	$130.64 of $170
Gold (80% actuarial value)	$160.64 of $200	$180.64 of $220	$200.64 of $240
Platinum	$210.64	$240.64 of	$260.64 of

[153] Premium percentages for mid-range income percentages are calculated on a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. For example, an income of 275% is halfway between 250% and 300%, thus rounded to the nearest one-hundredth of one percent, the percentage is 8.78 (halfway between 8.05 and 9.5). Similarly, the rate for 210% is 6.65%.

(90% actuarial value)	of $250	$280	$300

But subsidies are not an entitlement. They are only a means to ensure affordability. If a benchmark plan cost less than one's expected contribution, there is no subsidy, even if one's income is below 400% FPL.[154]

For example, Justin lives in the same coverage area as Anna and Ike, and earns $34,470 a year in 2013, exactly 300% FPL. His expected contribution is $272.89 and he receives no subsidy:

9.5% x $34,470 = $3,274.65 or $272.89 a month. [Justin's contribution]
$160 – $272.89 = -$112.89 [government has no contribution]

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

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

[154] *See* 26 U.S.C. § 36B (2012).

Still, this is not a loophole to the government's obligation to subsidize those who earn up to 400% FPL. Justin still gets the deal he would have gotten (insurance at 9.5% of income), but he does so without the complicated tax consequences, such as reconciliation, which may occur for individuals receiving premium subsidies.

Reconciliation is the IRS' end-of-year calculation to determine whether the advance subsidy payments to an individual accord with an individual's tax-year income.[155] If the advance payments were too high (because the individual earned more than expected) the IRS will assess the difference.[156] If payments were too low, the IRS refunds the difference.[157] But overpayment assessment are capped based on income.[158]

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

3. Cost sharing

In addition to premium contributions (if any), bridge enrollees incur a limited amount of cost-sharing.[159] Examples include a $10 doctor visit co-pay, $200 for a hospital admittance, or a coinsurance for a specific procedure.[160]

But cost-sharing for Bridge enrollees is limited. Cost-sharing subsidies offset limit most cost-sharing.[161] For example, an individual

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155 26 C.F.R. § 1.36B–4; Ann Hwang, Sara Rosenbaum and Benjamin D. Sommers, *Creation Of State Basic Health Programs Would Lead To 4 Percent Fewer People Churning Between Medicaid And Exchanges*, Health Affairs, 31, no.6 (2012), 1315

156 26 C.F.R. § 1.36B–4.

157 26 C.F.R. § 1.36B–4.

158 26 U.S.C. § 36B (2012).

159 *See* Covered California *supra* note ___ at 6.

160 Coinsurance and copays never reside jointly in the same plan.

161 *See* 42 U.S.C. § 18071 (2012)

earning 138% FPL enrolling in a silver-level plan (70% actuarial level) would receive a government subsidy boosting the actuarial value to 94%.[162] The insurer recoups the difference in cost sharing from the federal government.[163] For providers, this affords a far more reliable source of payment.[164] The actual cost-sharing subsidies turn on income. Cost subsidies are available only for silver-level plans.

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

B. Practical issues with the bridge plan

1. Setting the proper price for a Bridge plan

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

Offering a Bridge plan can affect an enrollee's premium tax credit. In some cases, an individual may be worse off if a Bridge plan is available to him.[165] This is because a premium subsidy turns on the second-lowest-cost silver plan available to the individual at the time of enrollment (the benchmark plan). The Bridge plan, being a silver-level Exchange plan, can affect which plan is the second-lowest-cost silver plan.

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[162] Tenn. Ins. Exch. Planning Initiative *supra* note __ at 3; Covered California *supra* note __ at 6-7 (The actuarial value of a silver plan is 70% with cost sharing subsidies bringing it up to 94%).
[163] *See* Tenn. Ins. Exch. Planning Initiative *supra* note __ at 3.
[164] *Id.*
[165] *See id.* at 2.

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

For example, Kelsey has an income of $24,000 and her premium contribution share is 4% of her income. Under scenario #1 with no bridge plan available to Kelsey, Kelsey's subsidy is $170 per month.

Scenario #1 no bridge plan		
Lowest cost silver	2nd lowest cost silver	
$220	$250 (benchmark)	

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

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

If Kelsey bought the lowest cost silver plan, she would pay $50 a month.

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

Scenario #2 with bridge plan option		
Bridge plan	2nd lowest cost silver (formerly lowest cost silver)	Third lowest cost (formerly 2nd lowest cost silver)
$200	$220 (benchmark)	$250

With a Benchmark plan available, Kelsey's subsidy drops to $140 from $170:

$24,000 x 4% = $960 or $80 per month [Kelsey's contribution]
$220 – $80 = $140 subsidy [the government's contribution]

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

To avoid this ironic outcome, a Bridge plan should be significantly cheaper than the previously lowest cost plan. This compensates for the lower premium subsidy brought about by the cheaper benchmark plan.

For example, in scenario #3 the Bridge plan is now $40 cheaper, and this will save Kelsey money.

Scenario #3 with lower priced bridge plan option		
Bridge plan	2nd lowest cost silver (formerly lowest cost silver)	Third lowest cost (formerly 2nd lowest cost silver)
$160	$220 (benchmark)	$250

$24,000 x 4% = $960 or $80 per month. [Kelsey's share]
$220 – $80 = $140 subsidy [the government's contribution]

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

A related problem occurs if the bridge program costs significantly more than other Exchange plans. A Bridge plan that is too expensive — though it will not affect the benchmark or subsidy — gives eligible individuals no incentive to enroll.

For example, a Bridge plan costing $280 gives Kelsey no incentive to enroll:

Scenario with an expensive bridge plan.		
Lowest-cost plan	2nd lowest cost silver	Bridge plan
$220	$250 (benchmark)	$280

$24,000 x 4% = $960 or $80 per month. [Kelsey's contribution]
$250 – $80 = $170 subsidy [the government's contribution]

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

This of overly expensive Bridge plans is not purely hypothetical. In California, not all Medicaid managed care plans participating in the Exchange came in at the lower end of the premium spectrum for plan year 2014. Thus, consumer protections should ensure that the availability of a bridge plan does not adversely affect consumers and their premium subsidies. This could be achived by requiring Exchanges to exclude plans not in the consumer interest, or to

empower it to use selective contracting authority for the same purpose.[166]

2. The difficulty in matching Medicaid coverage.

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

This could happen if Medicaid insurers opt not to offer plans on the Exchange. Indeed, the primary hurdle for a successful Bridge program is convincing Medicaid insurers to offer plans on the Exchange. This requires them to become certified as Qualified Health Plans, and, in many cases, to obtain a license to sell health insurance in the commercial market.[167]

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

And once enrollees switch into an Exchange bridge plan, they would have the option of keeping that same plan, even if they churn back into Medicaid, because every bridge plan on the Exchange will be available in Medicaid (even if the inverse isn't true).[168]

C. Legal issues with the bridge plan

The Bridge Program raises several legal issues. Like the Basic Health Program, different values underlying the Affordable Care Act are in tension with Bridge Program implementation. And several

166 Tenn. Ins. Exch. Planning Initiative *supra* note __ at 2.
167 S.B. 3 2013 Leg., 1st Extraordinary Sess. (Cal. 2013).
168 An enrollee who fell below 138% could always switch to Medicaid if they are dissatisfied with the bridge plan for any reason.

important consumer protection reforms in the Act (crucial in the context of private commercial coverage) pose legal obstacles to a successful Bridge program.

Beginning in 2014, non-grandfathered individual or small group health plans may not reject applicants except for fraud in their applications: the guaranteed issue requirement.[169] And such plans must permit existing enrollees to renew their coverage at the end of each plan year: the guaranteed renewability requirement.[170]

These reforms are backed by good and powerful reasons. In the individual market, issuers used to deny enrollment for those with preexisting conditions or a history of medical claims. Issuers would also terminate coverage for individuals with higher-than-expected claims during a plan year.[171] These practices were common in states without a guaranteed issue or renewability requirement — leaving those most needing care unable to get it, and certainly not at affordable prices.[172]

But the guaranteed issue and guaranteed renewability requirements pose obstacles to the Bridge Program.

1. Guaranteed issue

If the Bridge Program is to bridge Medicaid and Exchange coverage, it does not follow that *all* Exchange-eligible individuals should have access to bridge plans.[173] Indeed, Bridge plan networks will likely have limited capacity; allowing anyone to enroll would

169 42 U.S.C. § 300gg-1 (2012)
170 42 U.S.C. § 300gg-2 (2012).
171 *See* Memorandum from the Comm. on Energy & Com. Staff, to Members & Staff of the Subcomm. on Oversight & Investigations 7 (June 16, 2009), available at http://democrats.energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf; *see also* "Terminations of Individual Health Policies by Insurance Companies:" Hearing Before the Subcomm. On Oversight and Investigations, 111th Cong. 2 (2009) (statement of Bart Stupak, Chairman).
172 *See id.*
173 See Caroline M Brown, *Legal Memorandum on the Bridge Plan and its adherence to all provisions of the PPACA*, Covington & Burling LLP, http://www.tn.gov/nationalhealthreform/forms/lettertocms.pdf.

overwhelm these plans, forcing plans to close enrollment, excluding the very group the Bridge Program is designed to benefit.

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

Under the government's rationale, this contractual method does not violate the guaranteed issue requirement because it is imposed contractually through the Medicaid program. Therefore, it is merely an extension of Medicaid. This legal maneuver lets the Bridge Program sidestep the guaranteed issue requirement.[174]

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

2. Guaranteed renewability

Guaranteed renewability also poses a potential problem. The Bridge Program is conceptually a transitional program. If an individual can remain in a Bridge plan indefinitely — regardless of how long he has been Exchange-eligible or how much he earns — it undercuts the purpose of the program: ensuring an easy transition into commercial Exchange-based coverage. But limiting the duration of eligibility runs afoul of the guaranteed renewability requirement.

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174 *See* Caroline M Brown, *Legal Memorandum on the Bridge Plan and its adherence to all provisions of the PPACA*, Covington & Burling LLP, http://www.tn.gov/nationalhealthreform/forms/lettertocms.pdf.

As with the guaranteed issue requirement, states can address the renewability requirement by contracting with managed care providers through Medicaid to limit the duration of Bridge plan enrollment and set income caps. California followed this approach in enacting California's Bridge Program legislation.[175]

3. Qualified Health Plan requirements under the Exchanges

The bridge program also conflicts with plan offering requirements. The Affordable Care Act and implementing regulations require each Qualified Health Plan issuer to offer at least one plan at the silver level (70% actuarial value) and one at gold (80%). California law requires Qualified Health Plan issuer to offer at least one plan at all four levels.[176] And, with certain exceptions, each Exchange issuer that also participates in the private commercial market outside of the Exchange must offer each Qualified Health Plan both inside and outside of the Exchange.[177]

Those requirements make sense for non-bridge Exchange plans. But Bridge plans are designed for low-income individuals with limited ability to cost share. For that population, only silver-level plans makesense because only silver plans are eligible for cost-sharing subsidies. Gold and platinum plans are a bad deal, for that population, because the cost-sharing subsidies for silver plans raises the actuarial value of silver above that of higher-price gold and platinum plans.[178]

For the same reason, a bronze level plan may not be suitable as a Bridge plan for many enrollees because bronze plans are not eligible for cost-sharing subsidies. The population may have a hard time

[175] *See* S.B. 3 2013 Leg., 1st Extraordinary Sess. (Cal. 2013).
[176] See S.B. 3, 2013 Leg., 1st Extraordinary Sess. page 1 (Cal. 2013). The other two are bronze and platinum.
[177] Covered California Qualified Health Plan Contract For 2014 at 8. http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%207,%202013/QHP%20Model%20Contract%20Clean.pdf.
[178] Eligible individuals must have an income below 250% of the federal poverty level

shouldering the high co-pays (40% actuarial value) of bronze plans.[179] And the cost-sharing subsidies are needed to make the Bridge plans functionally similar to Medicaid. Thus, silver level plans make the most since for Bridge plans.

Moreover, most potential Bridge plan issuers have no interest in expanding their commercial coverage plans beyond those necessary to effectuate best value Bridge coverage. And although most Medicaid managed care issuers do not participate in the private commercial market, some do; for example, issuers covering county workers in their relevant service area in addition to Medicaid managed care beneficiaries. In California, some Medicaid managed care issuers are newly entering the individual and small group market in order to participate in the Exchange. Thus, it would be onerous for them to have to offer their bridge products to the outside market as well.[180]

Ultimately satisfying Exchange Qualified Health Plan requirements is only partially possible under existing law. State requirements may be sidestepped.[181] Because a state statutory change was necessary to implement the bridge program in California, it was simple enough to exempt Bridge plan issuers from the required offerings mandate.

But the federal requirement to offer at least a silver and gold plan is not waivable at the state level. Thus, Bridge plan issuers must offer eligible enrollees both a silver and a gold plan. This will create unnecessary work for the issuer who must create and obtain certification for the superfluous gold plan. And, ironically, issuers and Exchange administrators must work to discourage people from

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

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

[181] See S.B. 3, 2013 Leg., 1st Extraordinary Sess. page 1 (Cal. 2013) (exempting bridge plans from the requirement to sell plans at all five coverage levels).

enrolling in gold bridge plans as they are not a good deal for bridge-eligible individuals below 250% of the federal poverty level.

III. CONCLUSION: THE BRIDGE PROGRAM VERSUS BASIC HEALTH

Fundamentally, the two programs differ in that Basic Health creates an alternative to the Exchange, while the Bridge Program works through the Exchange. This difference plays out in a number of respects, but ultimately makes the Bridge Program's approach superior.

Basic Health's primary deficiency is that its very existence threatens the Exchange. State-based Exchanges will stand or fall based on participation; a critical number of enrollees and a proper risk-mix ratio are essential. Basic Health threatens both of theses by segmenting the market. It channels a group of largely young and healthy individuals away from the Exchange, leaving Exchange plan issuers fewer and less healthy customers.

By contrast, the Bridge program works within the Exchange framework and keeps all eligible populations in the Exchange. This encourages a healthy risk-mix ensuring a sustainable Exchange.

Basic Health also leaves too many questions about the cost to the state. Though the federal government will provide funding, it's unclear how administrative expenses will be covered, and whether the government contribution will completely cover the cost. If funds are insufficient, the Affordable Care Act, leaves states few options in terms of reducing benefits or shifting costs to enrollees.

Still, while Basic Health risks being costly to the states, the Bridge program has the potential to be more costly to enrollees because the Bridge program has fewer restrictions that ensure that enrollee premium contributions are at a minimum.

Ultimately, the Bridge Program can better mitigate the effects of churn for several reasons. The Bridge Program can extend beyond 200% FPL. For instance in California, eligibility for bridge plans remain until an enrollee crosses 250%. And because the federal government has not regulated at this point, theoretically states could

have no maximum income for bridge eligibility. At 250% FPL ($58,875 for a family of four) individuals can better weather shifts, and are less likely to see dramatic income shifts. And if they do cross 250%, the shift will be less dramatic than switching from one program, Medicaid, to another, Exchange coverage: the switch is between one Exchange plan to a different, but likely comparable Exchange plan.

For these reasons, the Bridge Program is the superior approach. And given the risk the Basic Health Program poses to the Exchanges, arguably, the potential problems Basic Health could cause for the overall success of health care reform may be greater than the consequences of churn.