# Options to Increase Health Coverage in West Virginia

## Basic Health Program and State Innovation Waiver

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**We examine two alternative policy proposals to increase health coverage in West Virginia, which in 2014 under the Affordable Care Act (ACA) expanded Medicaid to adults with incomes up to 138 percent of the Federal Poverty Line (FPL). The first proposal is a federal Basic Health Program (BHP) 1331 option that would provide a new affordable health plan option to West Virginians with incomes up to 200 percent of the FPL. The second proposal is an approach using a federal 1332 Innovation Waiver that would allow the state to offer a new affordable health plan option to higher income individuals. Both approaches would provide a new, more affordable health insurance plan option that is similar to existing Medicaid coverage for West Virginians with incomes under 138 percent of the FPL.**

BHP is a state option under the ACA that is currently in effect in New York and Minnesota. We find that a BHP would be feasible at provider payment rates of Medicaid plus 25 percent, a little lower than Medicare rates. A BHP would increase health coverage and significantly reduce the health care spending of enrollees. Removing BHP enrollees from West Virginia's nongroup market would greatly reduce the size of the market and moderately reduce nongroup premiums.

A federal Innovation Waiver approach would require West Virginia to move from a federally facilitated state private insurance marketplace or exchange to a new state-based, state-run version. The new plan would compete with other plans in the nongroup market, likely leading to lower premiums. However, nongroup premiums would have to decline by at least 8 percent for the proposal to not result in increased spending by either federal or state governments.

# Introduction

There has been recent legislative interest in state initiatives to provide a more affordable health coverage option to lower-income workers and to address the issue of a "Medicaid cliff" that could create a disincentive to workers to increase their household income above Medicaid income eligibility.[1] In this report, we estimate the impact of two types of new state programs that have been proposed to improve the affordability of existing private insurance options for lower income workers: a Basic Health Program (BHP) option and a federal Innovation Waiver approach.

## Basic Health Program Option

Under the BHP, those currently eligible for Marketplace premium tax credits (PTCs) with incomes up to 200 percent of the federal poverty level (FPL) would instead be eligible for the BHP. We assume BHP premiums would be $10 a month for those with incomes above 150 percent of the FPL and zero below that.

For those eligible, the BHP has several advantages compared to Marketplace coverage. BHP coverage would have a higher actuarial value (meaning it would require less out-of-pocket spending in deductibles and copays) than what is available in the Marketplace. For people with incomes between 150 percent and 200 percent of the FPL, the monthly premium of $10 is lower and much simpler than Marketplace PTCs, which are computed on a sliding scale by family income. Also, those receiving Marketplace PTCs must reconcile the amounts with the IRS at tax time; BHP enrollees would not have to do so.

Coverage through the BHP and the Marketplace would be free for people with incomes between 138 percent and 150 percent of the FPL. Congress approved enhanced Marketplace PTCs in the Inflation Reduction Act of 2022 that provide zero-premium coverage to those below 150 percent of the FPL. However, those enhanced PTCs are set to expire after three years. BHP coverage would have lower premiums for those with incomes between 150 and 200 percent of the FPL and would have lower deductibles and cost-sharing than Marketplace coverage at all incomes.

The BHP builds from a state's Medicaid provider networks and payment arrangements to create a plan similar to Medicaid coverage. The state would contract with insurers to provide coverage to BHP enrollees; it is likely the insurers would include current Medicaid insurers. Provider payment rates would be between Medicaid and commercial insurance. These plans can be coordinated with Medicaid managed care, so those currently in Medicaid would not have to switch insurers or health care providers if they become eligible for BHP when their incomes rise. The BHP would be separate from the Marketplace and from West Virginia's private nongroup market more generally. Thus, fewer people would remain in that market and premiums would change because of changes in health risk.

To pay state BHP costs, the federal government pays 95 percent of the PTCs that BHP enrollees would have received in the Marketplaces. This federal funding is put into a trust fund that can only be used for BHP health care costs. Thus, without additional state funding, the state would need to set BHP

provider payment rates, actuarial value, and premiums such that the cost of the program does not exceed federal payments. We tested a range of provider payment rates and found that Medicaid plus 25 percent would be financially viable for the state. For comparison, Medicare rates in West Virginia are estimated to be Medicaid plus 29 percent (Zuckerman, Skopec, and Aarons 2021). Prescription drugs would be reimbursed at commercial levels because Medicaid rebates would not be available, and it would be difficult for the state to negotiate substantially lower rates than commercial pharmacy benefit managers.

## Federal Innovation Waiver Approach

Under this approach, the state would offer health coverage based on Medicaid to West Virginians with incomes too high for Medicaid. The eligibility level for the program could be higher than with a BHP option; we looked at eligibility at 300 percent of the FPL. The plan would be based on Medicaid managed care, with similar networks, but cost sharing would be increased to set the actuarial value as low as 85 percent. Provider payment levels for all costs except prescription drugs would be between Medicaid and commercial. For our analysis, we assumed Medicaid plus 25 percent, the same as under a BHP. Although the plan is based on Medicaid, Medicaid prescription drug rebates would not be available for the new population.

West Virginians with incomes up to 300 percent of the FPL could use their Marketplace PTCs to purchase the Medicaid buy-in, and there would be additional state premium subsidies for those with incomes up to 250 percent of the FPL, making premiums comparable with the BHP option. Those with incomes under 150 percent of the FPL would get coverage with the same actuarial value as Marketplace coverage with cost sharing reductions (CSR). Those with incomes from 150 percent to 200 percent of the FPL would get 94 percent AV coverage, compared with 87 percent AV for Marketplace coverage with CSRs. Those with incomes over 200 percent of the FPL would get 85 percent AV coverage. Most current Marketplace enrollees have 60 percent or 70 percent AV coverage.

Unlike the BHP, the Innovation Waiver approach would create new plan options that would be part of the nongroup market and would compete with existing plans. Some current nongroup enrollees would enroll in the plan even if they were not eligible for PTCs. Also, unlike the BHP, this option would require federal approval of a Section 1332 waiver and would require West Virginia to move from using a federally facilitated ACA state Marketplace or Exchange and become a state-based marketplace. By law, a Section 1332 waiver must not increase the federal deficit; total federal spending must not exceed what it would have been without the waiver. If federal spending is lower under the waiver, the state can request that the savings be passed back to the state. We considered several potential sources of savings and determined that the only substantial source would be from reductions in premiums due to increased competition with Medicaid-based plans in the nongroup market. In this proposal, the state would target those savings to make health coverage more affordable for those with incomes up to 250 percent of the FPL.

We also considered a hybrid option that would enact a BHP and make a Medicaid-based plan available to those with incomes above 200 percent of the FPL.

# Methods

We produce our estimates using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020 and 2022). The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—such as novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

Medicaid enrollment and costs were set based on data received from the state. We updated the model using state-level Marketplace enrollment from the 2022 OEP snapshot released by the Centers for Medicare and Medicaid Services. By comparing those enrollment estimates with estimated Marketplace enrollment before the enhanced PTCs, we measured how the demand for Marketplace coverage increased in West Virginia because of enhancing PTCs. These data also allowed us to estimate the distribution of Marketplace enrollees by age, sex, and choice of metal tier. We incorporated data on off-Marketplace nongroup enrollment from the state. The model used 2023 nongroup market premiums at Bronze, Silver, and Gold levels. We estimated the increase in Marketplace coverage because of losses of Medicaid enrollment after the PHE expires using our recently updated estimates of Medicaid enrollment in 2022 and 2023 (Buettgens and Green 2022). We describe the details of our methodology in a separate report (Buettgens and Banthin 2022).

Costs to the state for BHP were computed as follows. We began with current spending on Medicaid expansion adults, the Medicaid population most similar to the population expected to enroll in the BHP. We adjusted spending to account for the differences in health risk between the existing expansion population and the BHP population using a risk rating factor on the MEPS-HC specifically designed for Medicaid risk adjustment. We then added some additional BHP cost sharing to be like New York's and Minnesota's plans, with an actuarial value of about 98 percent. Prescription drugs are carved out of Medicaid managed care, and Medicaid drug rebates will not be available in the BHP, so the cost for prescription drugs will be the same as that in the Marketplaces. Other health spending was set to a certain percentage above Medicaid provider payment rates. We simulated a range of rates, but we focus on Medicaid plus 25 percent. The latter is a little lower than estimates of Medicare payment rates in West Virginia, which are Medicaid plus 29 percent (Zuckerman, Skopec, and Aarons 2021). We charge BHP premiums to beneficiaries: None below 150 percent of the FPL and $10/month above that income.

Federal BHP payments were computed using the latest federal guidance. The state can choose to base BHP payments on current premiums or on the past year's premiums aged to the current year. For this analysis, we use current payments. If the state chooses the former, payments for the first year of

BHP implementation may differ from the actual risk pool, particularly if the Medicaid buy-in is also implemented at this time.

Premiums for the Innovation Waiver approach were based on current Medicaid spending levels. As with BHP, we adjusted current Medicaid spending for differences in the risk pool and lowered the actuarial value to a base of 85 percent (higher at lower incomes). Prescription drug spending is unchanged from current commercial rates. Provider payment rates for the remaining health spending were set to Medicaid plus 25 percent.

We expect that commercial insurers will lower premiums in response to the Innovation Waiver new plan, which would otherwise provide more comprehensive coverage for similar or lower premiums. Our estimates are derived from recent research that found that the number of insurers in a rating region is highly important in explaining premium variation (Holahan, Wengle, and O'Brien 2022). The presence of a Medicaid insurer in the rating area lowered premiums by $35 over a market with the same number of insurers but no Medicaid insurer. In response to a competing Medicaid-like new plan and insurer, other insurers have negotiated more favorable provider payment rates or narrowed their own networks (Wengle et al. 2020). The buy-in would increase competition and add an option with lower provider payment rates, so the situation would be similar. However, the magnitude of the premium change is uncertain, and it may take several years to reach the final level. Our estimated premium impact was set to be less than what the national regression from (Holahan, Wengle, and O'Brien 2022) would predict because West Virginia is largely rural, so provider concentration and the ability to negotiate lower rates may differ from other states.

# Results

We begin by estimating the number and characteristics of uninsured West Virginians in 2023. We then present health coverage and cost results both for BHP and for the introduction of Innovation Waiver Medicaid-like plans in the nongroup market.

## The Uninsured in West Virginia

### ELIGIBILITY FOR ASSISTANCE

We estimate that about 42,000 uninsured West Virginians are eligible for Medicaid or Children's Health Insurance Program (CHIP), but not enrolled (table 1). Only 6.3 percent of West Virginians eligible for Medicaid or CHIP are uninsured. Thus, take-up in those programs is high, but the eligible population is large. Additional outreach and assistance efforts could increase health coverage significantly.

TABLE 1

**Characteristics of Uninsured Nonelderly West Virginians in 2023**

*Thousands of people*

| Characteristics | Uninsured under Current Law | | |
|---|---|---|---|
| | Number of uninsured | % of total | Uninsured rate |
| **Eligibility** | | | |
| Medicaid/CHIP | 42 | 41.1% | 6.3% |
| Marketplace PTC < 200% FPL /BHP eligible | 13 | 12.5% | 29.9% |
| Marketplace PTC > 200% FPL | 21 | 21.1% | 21.4% |
| Other | 26 | 25.3% | 4.1% |
| **Age group** | | | |
| 0–18 | 7 | 7.2% | 1.9% |
| 19–34 | 38 | 37.2% | 11.4% |
| 35–54 | 44 | 43.0% | 9.6% |
| 55–64 | 13 | 12.6% | 5.2% |
| **Education - Individual (Age 19-64)** | | | |
| *Subtotal* | 94 | 0.0% | 9.1% |
| Less than High School | 11 | 11.2% | 16.1% |
| High School | 48 | 51.3% | 11.7% |
| Some College | 23 | 24.8% | 8.0% |
| College Graduate | 12 | 12.6% | 4.5% |
| **Working Status - Family** | | | |
| No Worker in Family | 34 | 33.3% | 11.0% |
| Only Part-Time Worker in Family | 6 | 6.0% | 7.8% |
| One Full-Time Worker in Family | 52 | 50.8% | 7.4% |
| >1 Full-Time Worker in Family | 10 | 9.8% | 2.9% |
| **Total** | **102** | **100.0%** | **7.1%** |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Notes:** CHIP = Children's Health Insurance Program ; PTC = premium tax credits; FPL = Federal Poverty Line; BHP = Basic Health Program

We estimate that 13,000 uninsured West Virginians are eligible for Marketplace PTCs and have incomes up to 200 percent of the FPL. These people would become eligible for BHP if it were adopted. Nearly 30 percent of those potentially eligible for BHP are uninsured, indicating very low take-up of ACA Marketplace coverage.

We estimate that 21,000 uninsured West Virginians are eligible for PTCs with incomes above 200 percent of the FPL and a further 26,000 are not eligible for Medicaid, CHIP, or PTCs. Most of these have incomes too high to qualify for Medicaid and are disqualified from PTC eligibility by an offer of employer coverage deemed affordable under the ACA.

### WORK STATUS

Two thirds of uninsured West Virginians are in working families, and more than half are in families with at least one full-time worker. For many, employment does not provide affordable health coverage.

### ADULT EDUCATIONAL ATTAINMENT

Nearly 63 percent of uninsured adult West Virginians have a high school education or less than high school education. Those without some college have notably higher uninsurance rates than those with some college or a college degree.

### AGE

Only about 7 percent of uninsured West Virginians are children. Children are eligible for Medicaid and CHIP at much higher incomes than adults and have a much lower uninsured rate. Young adults have a notably higher uninsurance rate than older adults.

## Basic Health Program

### HEALTH COVERAGE

If BHP were fully implemented in 2023, we estimate that there would be between 20,000 and 22,000 BHP enrollees (table 2). People with incomes up to 200 percent of the FPL who currently have Marketplace PTCs would become eligible for BHP instead. Also, West Virginia has very high off-Marketplace nongroup enrollment (Other nongroup in table 2) relative to other states. Based on analysis of the large representative population of West Virginians in our model, we estimate that some of these off-Marketplace enrollees were eligible for PTCs but chose not to enroll in the Marketplace. Some would enroll in BHP. There would be between 7,000 and 9,000 fewer people lacking health insurance, a 6.6 or 8.9 percent reduction, respectively.

TABLE 2

**Health Insurance Coverage Distribution of the Non-Elderly in 2023 with Basic Health Program**

*Thousands of people*

| | Current law ACA | | BHP with Lower take-up | | Change | Percent difference | BHP with higher take-up | | Change | Percent difference |
|---|---|---|---|---|---|---|---|---|---|---|
| Insured (Minimum Essential Coverage) | 1,307 | 91.8% | 1,314 | 92.2% | 7 | 0.5% | 1,316 | 92.4% | 9 | 0.7% |
| Employer | 702 | 49.3% | 708 | 49.7% | 6 | 0.8% | 708 | 49.7% | 6 | 0.8% |
| Private Nongroup | 46 | 3.2% | 46 | 3.3% | 1 | 1.8% | 49 | 3.4% | 3 | 6.9% |
| Basic Health Program, <138% FPL | 0 | 0.0% | 6 | 0.4% | 6 | 100.0% | 6 | 0.4% | 6 | 100.0% |
| Basic Health Program, ≥138% FPL | 0 | 0.0% | 14 | 1.0% | 14 | 100.0% | 16 | 1.2% | 16 | 100.0% |
| Medicaid Buy-In | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Marketplace with PTC, <150% FPL | 5 | 0.3% | 0 | 0.0% | -5 | -100.0% | 0 | 0.0% | -5 | -100.0% |
| Marketplace with PTC, 150-200% FPL | 9 | 0.6% | 0 | 0.0% | -9 | -100.0% | 0 | 0.0% | -9 | -100.0% |
| Marketplace with PTC, 200–250% FPL | 3 | 0.2% | 3 | 0.2% | 0 | 0.0% | 3 | 0.2% | 0 | 0.0% |
| Marketplace with PTC, 250–300% FPL | 2 | 0.1% | 2 | 0.1% | 0 | 0.0% | 2 | 0.1% | 0 | -0.5% |
| Marketplace with PTC, 300–400% FPL | 3 | 0.2% | 3 | 0.2% | 0 | 1.7% | 3 | 0.2% | 0 | 1.7% |
| Marketplace with PTC, > 400% FPL | 3 | 0.2% | 3 | 0.2% | 0 | -6.9% | 3 | 0.2% | 0 | -9.4% |
| Full-Pay Marketplace | 2 | 0.1% | 1 | 0.1% | -1 | -38.4% | 1 | 0.1% | -1 | -37.8% |
| Other Nongroup | 19 | 1.3% | 14 | 1.0% | -5 | -24.2% | 15 | 1.0% | -4 | -22.3% |
| Medicaid/CHIP | 488 | 34.3% | 488 | 34.3% | 0 | 0.0% | 488 | 34.3% | 0 | 0.0% |
| Disabled | 93 | 6.5% | 93 | 6.5% | 0 | 0.0% | 93 | 6.5% | 0 | 0.0% |
| Medicaid Expansion | 151 | 10.6% | 151 | 10.6% | 0 | 0.0% | 151 | 10.6% | 0 | 0.0% |
| Traditional Nondisabled Adults | 40 | 2.8% | 40 | 2.8% | 0 | 0.0% | 40 | 2.8% | 0 | 0.0% |
| Nondisabled Medicaid Children | 143 | 10.0% | 143 | 10.0% | 0 | 0.0% | 143 | 10.0% | 0 | 0.0% |
| Separate CHIP | 61 | 4.3% | 61 | 4.3% | 0 | 0.0% | 61 | 4.3% | 0 | 0.3% |
| Other Public | 71 | 5.0% | 71 | 5.0% | 0 | 0.0% | 71 | 5.0% | 0 | 0.0% |
| Uninsured (No Minimum Essential Coverage) | 117 | 8.2% | 110 | 7.8% | -7 | -5.7% | 108 | 7.6% | -9 | -7.9% |
| Uninsured | 102 | 7.1% | 95 | 6.7% | -7 | -6.6% | 93 | 6.5% | -9 | -8.9% |
| Noncompliant Nongroup | 16 | 1.1% | 16 | 1.1% | 0 | -0.2% | 15 | 1.1% | 0 | -1.8% |

| | Current law ACA | | BHP with Lower take-up | | Change | Percent difference | BHP with higher take-up | | Change | Percent difference |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | **1,424** | **100.0%** | **1,424** | **100.0%** | **0** | **0.0%** | **1,424** | **100.0%** | **0** | **0.0%** |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

**Notes:** ACA = Affordable Care Act; CHIP = Children's Health Insurance Program ; PTC = premium tax credits; FPL = Federal Poverty Line; BHP = Basic Health Program

### THE NONGROUP MARKET.

BHP is separate from the nongroup market, so the number of nongroup covered lives would decline from 46,000 to between 26,000 and 27,000, a decline of about 43 percent. Most of those moving to BHP would otherwise receive Marketplace PTCs, so only 12,000 people would remain in the Marketplace. The remaining nongroup enrollees would be healthier on average, lowering nongroup premiums by about 6 percent (table 3). This is larger decline than BHP analysis that we have conducted in other states, mainly because Marketplace take-up is currently very low in West Virginia, leading to adverse selection. However, the substantial loss of enrollment could affect insurer participation in the nongroup market. There is no indication that it affected participation in either of the current states with BHP, New York and Minnesota, but the situation in West Virginia could be different, particularly given its much smaller market.

TABLE 3

**Change in Nongroup Premiums in 2023 with Basic Health Program**

| | Change in nongroup silver premium from current law | Change in risk pool due to BHP | Reduction in silver loading |
|---|---|---|---|
| BHP with lower take-up | -14% | -6% | -8% |
| BHP with higher take-up | -13% | -6% | -8% |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Note:** BHP = Basic Health Program

### HEALTH CARE COSTS FOR BHP BENEFICIARIES

BHP coverage would have lower premiums and cost sharing than Marketplace coverage. While there are no premiums in either the Marketplace or BHP for those with incomes up to 150 percent of the FPL (at least while the enhanced PTCs in the Inflation Reduction Act of 2022 are in effect), those with incomes between 150 percent and 200 percent of the FPL would save $70 per year in premiums (table 4). For those with incomes up to 150 percent of the FPL, average annual out of pocket (OOP) health spending would be $1,075 per person with Marketplace coverage, versus $180 with BHP. Similarly, for those with incomes between 150 percent and 200 percent of the FPL, the difference in average annual OOP health spending would be $1,670 with Marketplace coverage, versus $200 with BHP.

TABLE 4

**Basic Health Program Would Lower Average Healthcare Costs Per Person**

| Income Range | Cost | Current Marketplace | BHP |
|---|---|---|---|
| < 150% FPL | Premiums | $0 | $0 |
| | OOP health spending | $1,075 | $180 |
| 150%-200% FPL | Premiums | $190 | $120 |
| | OOP health spending | $1,670 | $200 |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Notes:** FPL = Federal Poverty Line, OOP = out of pocket

## STATE GOVERNMENT FINANCIAL IMPACT

If provider payment rates are set at Medicaid plus 25 percent, we estimate that the BHP trust fund would run a surplus of between $15 and $18 million a year (table 5). Thus, federal BHP payments would modestly exceed state costs. Once the program is in place and BHP take-up is better known, the state may be able to increase payment rates.

TABLE 5A

**Total Spending on Acute Care for the Nonelderly by Income Group in 2023 With Basic Health Program**

*Millions of dollars*

| | | Current law all incomes | BHP with lower take-up | BHP with higher take-up |
|---|---|---|---|---|
| Household | Premiums | 1,619 | 1,550 | 1,552 |
| | Other Health Care Spending | 1,494 | 1,458 | 1,458 |
| | Subtotal, Household | 3,113 | 3,008 | 3,010 |
| Federal Government | Medicaid | 3,471 | 3,471 | 3,471 |
| | Marketplace PTC | 332 | 376 | 398 |
| | Marketplace CSR | 0 | 0 | 0 |
| | Additional | 0 | 0 | 0 |
| | Uncompensated Care | 166 | 164 | 163 |
| | Subtotal, Federal Government | 3,969 | 4,012 | 4,032 |
| State Government | Medicaid | 901 | 901 | 901 |
| | Marketplace PTC | 0 | -18 | -15 |
| | Marketplace CSR | 0 | 0 | 0 |
| | Additional | 0 | 0 | 0 |
| | Uncompensated Care | 104 | 103 | 102 |
| | Subtotal, State Government | 1,004 | 985 | 987 |
| Employers | Premium Contributions | 4,109 | 4,159 | 4,159 |
| Providers | Uncompensated Care | 142 | 139 | 136 |
| **Total, All Payers** | | **12,337** | **12,303** | **12,325** |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Notes:** PTC = premium tax credits; BHP = Basic Health Program; CSR = cost sharing reductions

TABLE 5B

**Differences in Total Spending on Acute Care for the Nonelderly by Income Group in 2023 With Basic Health Program**

*Change from current law (millions of dollars)*

| | | Current law all incomes | BHP with lower take-up | BHP with higher take-up |
|---|---|---|---|---|
| Household | Premiums | - | -69 | -67 |
| | Other Health Care Spending | - | -36 | -36 |
| | Subtotal, Household | - | -105 | -103 |
| Federal Government | Medicaid | - | 0 | 0 |
| | Marketplace PTC | - | 44 | 66 |
| | Marketplace CSR | - | 0 | 0 |
| | Additional | - | 0 | 0 |
| | Uncompensated Care | - | -2 | -3 |
| | Subtotal, Federal Government | - | 42 | 63 |
| State Government | Medicaid | - | 0 | 0 |
| | Marketplace PTC | - | -18 | -15 |
| | Marketplace CSR | - | 0 | 0 |
| | Additional | - | 0 | 0 |
| | Uncompensated Care | - | -1 | -2 |
| | Subtotal, State Government | - | -19 | -17 |
| Employers | Premium Contributions | - | 51 | 51 |
| Providers | Uncompensated Care | - | -3 | -5 |
| **Total, All Payers** | | **-** | **-34** | **-12** |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Notes:** PTC = premium tax credits; BHP = Basic Health Program; CSR = cost sharing reductions

Total federal spending on PTCs/BHP would increase by $44–$66 million a year, depending on take-up of the BHP. Reductions in premiums would lower per-person subsidies, but the federal government would have to pay for more enrollees. A BHP does not require a federal waiver, so there is no deficit neutrality requirement. This increase does not affect federal approval of a state BHP plan.

### SILVER LOADING

Those getting PTCs in the Marketplace with incomes up to 250 percent of the FPL are also eligible for CSRs, which make coverage more comprehensive. However, some choose to purchase Bronze coverage with their PTCs, getting less comprehensive coverage for a lower premium. A smaller number purchase Gold coverage with PTCs. After Congress stopped federal funding of CSRs in 2017, CSR costs are paid for by higher Silver premiums in the Marketplaces, called "silver loading."

All Marketplace enrollees currently getting CSRs would move to BHP, except for those with incomes between 200 and 250 percent of the FPL.[2] CSRs are small at that income, so BHP would eliminate nearly all CSR costs in Marketplace plans. We estimate that the resulting reduction in Silver loading to pay for CSRs would reduce Silver premiums by 8 percent (see table 5). Premiums for other metal tiers would not be affected. However, PTC amounts are based on the cost of the second lowest Silver plan, so the reduction in silver loading would also reduce PTCs available to purchase coverage at other metal tiers, so they would become more expensive. Some Marketplace enrollees would pay more for their current choice of metal tier, while others would switch to Silver plans.

### CHANGES IN ELIGIBILITY DURING A YEAR

Low-income families often have volatile income, causing them to gain or lose eligibility for health coverage programs during a year, often called "churn." The churn population that the state can best reach are those who transition between different public programs during a year. We estimate that without BHP, 68,000 West Virginians, 5 percent of the nonelderly, would be eligible for both Medicaid/CHIP and PTCs during a year (table 6). Those affected mostly have incomes below 200 percent of the FPL, with a median of 177 percent of the FPL.

TABLE 6A

**Eligibility Transitions over the Course of a Year**

| Eligibility Transitions without BHP | | | | Eligibility Transitions with BHP | | | |
|---|---|---|---|---|---|---|---|
| Medicaid/ CHIP eligibility | Marketplace PTC eligibility | Number | Share | Medicaid / CHIP/BHP eligibility | Marketplace PTC eligibility | Number | Share |
| Always | Never | 519,606 | 36% | Always | Never | 568,416 | 40% |
| Sometimes | Sometimes | 67,585 | 5% | Sometimes | Sometimes | 28,071 | 2% |
| Sometimes | Never | 208,548 | 15% | Sometimes | Never | 233,020 | 16% |
| Never | Always | 130,578 | 9% | Never | Always | 105,363 | 7% |
| Never | Sometimes | 47,930 | 3% | Never | Sometimes | 45,093 | 3% |
| Never | Never | 450,004 | 32% | Never | Never | 444,287 | 31% |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Notes:** CHIP = Children's Health Insurance Program ; PTC = premium tax credits; FPL = Federal Poverty Line; BHP = Basic Health Program

TABLE 6B

**Income Distributions of Those Eligible for Assistance During the Year**

*Eligibility for both Medicaid/CHIP and PTCs at any point during the year*

| | Without BHP | With BHP |
|---|---|---|
| 25th Percentile | 95% FPL | 256% FPL |
| Median | 177% FPL | 353% FPL |
| 75th Percentile | 330% FPL | 464% FPL |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Notes:** CHIP = Children's Health Insurance Program ; PTC = premium tax credits; FPL = Federal Poverty Line; BHP = Basic Health Program

With BHP, plans nearly identical to existing Medicaid plans would be offered by the West Virginia's existing Medicaid Managed Care Organizations These organizations could be required to use the same provider networks that serve existing Medicaid enrollees, so the transition could be smoother and not require changing health care providers.

Without BHP, 68,000 West Virginians churn between Medicaid and Marketplace eligibility. With BHP, only 28,000 West Virginians, 2 percent of the nonelderly, would churn between eligibility for Medicaid/CHIP/BHP and PTCs during a year. Not only would the number of people affected be smaller, but those affected would also have much higher incomes, with a median of 353 percent of the FPL.

BHP would increase the number of low-income people who maintain eligibility for Medicaid-like coverage throughout the year. We estimate that without BHP, 520,000 West Virginians would be

eligible for Medicaid or CHIP throughout the year. With BHP, 568,000 West Virginians would be eligible for Medicaid, CHIP, or BHP throughout the year.

Other categories of churn, such as those sometimes eligible for PTCs but never eligible for Medicaid/CHIP, would be little affected by BHP.

## Federal Innovation Waiver Approach

### HEALTH COVERAGE

We estimate that 27,000 West Virginians would enroll in a plan developed using the Federal Innovation Waiver approach. (table 7). This includes most of those currently getting Marketplace PTCs with incomes below 300 percent of the FPL. Those getting PTCs at higher incomes would stay in the Marketplace because PTCs would not be available for an Innovation Waiver plan. Some of those getting nongroup coverage without PTCs—both inside and outside the Marketplace—would choose the Innovation waiver plan instead. 9,000 more people would be enrolled in the nongroup market, including the new plan, an increase of 20.6 percent. These 9,000 people would otherwise be uninsured, reducing the number of uninsured West Virginians by 8.6 percent.

TABLE 7

**Health Insurance Coverage Distribution of the Non-Elderly in 2023 with an Innovation Waiver Option**

*Thousands of people*

| | Current Law ACA | | Innovation waiver option | | Change | Percent difference |
|---|---|---|---|---|---|---|
| Insured (Minimum Essential Coverage) | 1,307 | 91.8% | 1,317 | 92.4% | 9 | 0.7% |
| Employer | 702 | 49.3% | 702 | 49.3% | 0 | 0.0% |
| Private Nongroup | 46 | 3.2% | 55 | 3.9% | 9 | 20.6% |
| Medicaid Buy-In | 0 | 0.0% | 27 | 1.9% | 27 | 100.0% |
| Marketplace with PTC, <150% FPL | 5 | 0.3% | 3 | 0.2% | -1 | -29.3% |
| Marketplace with PTC, 150-200% FPL | 9 | 0.6% | 0 | 0.0% | -9 | -96.1% |
| Marketplace with PTC, 200-250% FPL | 3 | 0.2% | 0 | 0.0% | -3 | -99.6% |
| Marketplace with PTC, 250-300% FPL | 2 | 0.1% | 2 | 0.2% | 0 | 6.6% |
| Marketplace with PTC, 300-400% FPL | 3 | 0.2% | 3 | 0.2% | 0 | 0.2% |
| Marketplace with PTC, > 400% FPL | 3 | 0.2% | 3 | 0.2% | 0 | -9.0% |
| Full-Pay Marketplace | 2 | 0.1% | 1 | 0.1% | 0 | -23.0% |
| Other Nongroup | 19 | 1.3% | 15 | 1.0% | -4 | -21.5% |
| Medicaid/CHIP | 488 | 34.3% | 488 | 34.3% | 0 | 0.0% |
| Disabled | 93 | 6.5% | 93 | 6.5% | 0 | 0.0% |
| Medicaid Expansion | 151 | 10.6% | 151 | 10.6% | 0 | 0.0% |
| Traditional Nondisabled Adults | 40 | 2.8% | 40 | 2.8% | 0 | 0.0% |
| Nondisabled Medicaid Children | 143 | 10.0% | 143 | 10.0% | 0 | 0.0% |

| | Current Law ACA | | Innovation waiver option | | Change | Percent difference |
|---|---|---|---|---|---|---|
| Separate CHIP | 61 | 4.3% | 61 | 4.3% | 0 | 0.0% |
| Other Public | 71 | 5.0% | 71 | 5.0% | 0 | 0.0% |
| Uninsured (No Minimal Essential Coverage) | 117 | 8.2% | 108 | 7.6% | -9 | -8.1% |
| Uninsured | 102 | 7.1% | 93 | 6.5% | -9 | -8.6% |
| Noncompliant Nongroup | 16 | 1.1% | 15 | 1.0% | -1 | -4.7% |
| **Total** | **1,424** | **100.0%** | **1,424** | **100.0%** | **0** | **0.0%** |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Notes:** ACA = Affordable Care Act CHIP = Children's Health Insurance Program ; PTC = premium tax credits; FPL = Federal Poverty Line.

## NONGROUP PREMIUMS

Unlike a BHP, the Innovation Waiver plan would be part of the single nongroup market risk pool and would compete with existing nongroup plans. The buy-in would be attractive to some buying nongroup coverage outside the Marketplace as well as those with incomes up to 300 percent of the FPL getting PTCs. We expect that insurers would respond to this new competition by reducing premiums (See the discussion in Methods for details). For these results, we estimated that nongroup premiums would decline by 8 percent (table 8). However, the magnitude of the decline is uncertain, and it may take several years to reach its final level.

TABLE 8

**Change in Nongroup Premiums in 2023 with an Innovation Waiver Option**

| | Change in Nongroup premium from current law | Change in nongroup risk pool | Reduction in silver loading | Reduction in premiums from competition |
|---|---|---|---|---|
| Innovation Waiver | -8% | 0% | 0% | -8% |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Unlike BHP, an Innovation Waiver plan approach would not substantially reduce Silver loading because there would still be people with incomes below 250 percent of the FPL receiving Marketplace CSRs (table 8). While there would be more people in the nongroup market, we estimate that the average health risk of nongroup enrollees would not change notably. Thus, the competition effect would be the only major change in nongroup premiums.

## FEDERAL AND STATE FINANCIAL IMPACT

We estimate that the federal government would save $17 million in federal PTC payment due to lower nongroup premiums, as well as $2 million in savings on uncompensated care, mainly through Medicare DSH (table 9). In the waiver establishing the buy-in, the state would request that PTC savings be passed

through to the state, so the federal government would end up paying slightly less. Thus, the buy-in would meet the deficit neutrality requirement.

TABLE 9

**Total Government Spending on Acute Care for the Nonelderly by Income**

*Group in 2023 with an Innovation Waiver option, millions of dollars*

| | Current law all incomes | Innovation Waiver option | Difference | Percent difference |
|---|---|---|---|---|
| **Federal Government** | | | | |
| Medicaid | 3,471 | 3,471 | 0 | 0.0% |
| Marketplace PTC | 332 | 314 | -17 | -5.3% |
| Marketplace CSR | 0 | 0 | 0 | - |
| Additional | 0 | 0 | 0 | - |
| Uncompensated Care | 166 | 165 | -2 | -1.1% |
| *Federal Savings Passed to the state* | *0* | *17* | *17* | - |
| **Subtotal, Federal Government** | **3,969** | **3,950** | **-2** | **0.0%** |
| **State Government** | | | | |
| Medicaid | 901 | 901 | 0 | 0.0% |
| Marketplace PTC | 0 | 4 | 4 | - |
| Marketplace CSR | 0 | 8 | 8 | - |
| Additional | 0 | 0 | 0 | - |
| Uncompensated Care | 104 | 103 | -1 | -1.1% |
| *Federal Savings Passed to the state* | *0* | *-17* | *-17* | - |
| **Subtotal, State Government** | **1,004** | **1,016** | **-6** | **-0.6%** |

**Source:** The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
**Notes:** PTC = premium tax credits; CSR = cost sharing reductions

The state government would spend $13 million in additional PTCs and CSRs for Innovation Waiver plan enrollees with incomes up to 250 percent of the FPL. The state would also save a small amount in uncompensated care provided to the uninsured. Federal pass-through funding would cover all state costs, with a modest surplus. However, the amount of the pass-through is determined by the reduction in nongroup premiums in response to competition with the buy-in. The size of the premium effect is uncertain, and premium changes in the first year or two may be smaller than the eventual impact.

Securing federal approval of a Section 1332 waiver would require considerably more effort than setting up a BHP. West Virginia would also have to become a state-based Marketplace.

### OTHER BUY-IN OPTIONS CONSIDERED.

We simulated several other approaches to offering more affordable health plan options to lower income West Virginians, but we present the only ones that met the federal deficit neutrality requirement and generated enough pass-through savings to cover state costs. Options that failed one or both include:

Making federal PTCs available to the Innovation Waiver plan enrollees for those with incomes higher than 300 percent of the FPL, extending state subsidies above 250 percent of the FPL, and raising provider reimbursement to Medicare rates.

We find that combining the BHP and the Innovation waiver approach would be problematic for two reasons. First, total federal spending would likely rise due to increased enrollment, particularly in BHP. It would not be deficit-neutral, as required for a Section 1332 Innovation Waiver. Second, the nongroup premium decreases due to competition with the Innovation Waiver plan would reduce federal BHP payments substantially. Provider reimbursement for BHP would have to be reduced to levels near Medicaid to prevent the state from losing money. Extending Medicaid payment rates to a larger population would likely not be feasible. We simulated several different combinations of these two programs without finding one that was both federal deficit-neutral and did not require additional state funding for BHP.

# Discussion

Both BHP and the Innovation Waiver approach would expand coverage while paying health care providers more than Medicaid, close to Medicare rates, but less than commercial rates. However, BHP would not apply to those with incomes above 200 percent of the FPL and would be separate from the nongroup market. With the Innovation Waiver approach, a plan with lower provider rates would be available to all in the market as a competitor to existing commercial plans. We expect that commercial insurers would renegotiate provider payment rates and lower premiums in response. Markets with more competing insurers generally have lower premiums (Holahan, Wengle, and O'Brien 2022). In response to a competing insurer offering a Medicaid-like plan, other insurers have negotiated more favorable provider payment rates or narrowed their own networks (Wengle et al. 2020). However, the magnitude of these changes and the number of years it would take to reach their full effects are uncertain.

# Conclusions

### UNINSURED WEST VIRGINIANS

Just over 40 percent of uninsured West Virginians are eligible for Medicaid or CHIP; greater outreach and assistance efforts in these programs could significantly increase coverage. Take-up rates among those currently eligible for ACA Marketplace coverage with PTCs are notably low in West Virginia, particularly for those with incomes up to 200 percent of the FPL. This is one reason for interest in alternatives to the ACA Marketplace, such as BHP or other Medicaid-like more affordable health plan options.

### BASIC HEALTH PROGRAM

BHP would significantly increase health coverage and reduce health spending for eligible West Virginians with incomes between 138 percent and 200 percent of the FPL. It could also improve

continuity of health coverage for those with incomes near the Medicaid eligibility threshold. We estimate federal BHP payments would exceed state costs if BHP provider reimbursement is set at Medicaid plus 25 percent, which is a little lower than Medicare payment rates. BHP would reduce the size of the nongroup market by more than 40 percent, leading to potential concerns about insurer participation. However, the remaining enrollees would be healthier on average, reducing premiums. Some people currently choosing to apply their Marketplace PTCs to Bronze or Gold coverage would pay more for that coverage with BHP, though Silver coverage would be less expensive for people not receiving PTCs. Unlike the Medicaid buy-in, BHP would not require a Section 1332 waiver.

### INNOVATION WAIVER APPROACH

The Innovation Waiver approach could also increase health coverage, but the benefits would not be as concentrated on those with incomes below 200 percent of the FPL. Unlike BHP, the Innovation Waiver plan would be part of the nongroup market and would lead to increased enrollment and greater competition in that market. Commercial insurers would likely reduce premiums in response.

The Innovation Waiver approach would require a Section 1332 waiver of the Affordable Care Act, so it must not increase the federal deficit. Since the Innovation Waiver plan option would lead to more people getting PTCs, the cost of new enrollees must be offset by savings in PTCs from lower nongroup premiums. In fact, the approach would require the savings to be much larger than the cost of new enrollees so that the state could fund additional PTCs and CSRs for Innovation Waiver plan enrollees using federal pass-through funds. The exact magnitude of nongroup premium decreases is crucial because it determines both the magnitude of state assistance that can be provided and whether the Innovation Waiver would meet federal deficit neutrality requirements. However, the premium impact is uncertain and could take several years to fully materialize.

# Notes

[1] See, for example, HB 3001, which was introduced in the 2022 legislative session: http://www.wvlegislature.gov/Bill_Status/bills_history.cfm?INPUT=3001&year=2022&sessiontype=RS&btype=bill

[2] A very small number of enrollees over age 65 with incomes below 200 percent FPL could get Marketplace PTCs without being eligible for BHP.

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