Basic Health Program. The Affordable Care Act offers states another option besides Medicaid and the exchanges for health coverage for low-income residents.

WHAT’S THE ISSUE?
Having stable health insurance helps people obtain the medical care they need when they need it. Being able to remain with the same health plan and providers also promotes continuity in relationships with providers, which has been linked to higher-quality care. The Affordable Care Act (ACA) employs two main strategies for expanding health insurance coverage—first, by providing incentives for states to extend Medicaid coverage to millions more low-income people, and second, by allowing better-off people to purchase private health insurance through new health insurance exchanges or Marketplaces.

In addition to these primary avenues, the law also provides an additional means of expanding coverage, by allowing states to run a Basic Health Program.

Under such a program, states can offer public health insurance, beginning in 2015, to people whose incomes are too high to qualify for Medicaid but are below 200 percent of the federal poverty level.

To help pay for benefits under this program, states are eligible to receive the federal dollars that would otherwise go to subsidizing the purchase of private insurance coverage for those people through exchanges.

WHAT’S THE BACKGROUND?
To understand how the Basic Health Program fits into the continuum of coverage provided by the ACA—and why advocates believe the program is a necessary option for states—it is useful to recall key elements of the law and the complex structure of the nation’s different health insurance programs.

MAIN AVENUES OF COVERAGE: The ACA requires that most people should have signed up for health insurance coverage by early 2014 or face paying a financial penalty. The law provides for two main avenues for expanded

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coverage. The first by encouraging states to extend Medicaid for adults having incomes up to 138 percent of the federal poverty level. The second avenue is through private coverage purchased from new health insurance exchanges, along with federal subsidies to lower premium costs and coinsurance for people with incomes between 100 percent and 400 percent of the federal poverty level. Since eligibility for different forms of subsidized coverage is based on income, access to a particular program or to federal subsidies can change with fluctuations in family income. For example, incomes may rise or fall because of a job switch or a change in working hours. A family's income relative to the federal poverty level will also be different if the family size changes, such as through marriage, divorce, the birth of a child, or when a child reaches adulthood. The result is that as income compared to the federal poverty level changes, individuals or families may move into and out of different types of coverage or become eligible or lose eligibility for subsidies. This phenomenon is called “churning.”

**CHURNING’S EFFECT:** Movement from one type of coverage to another can be very disruptive. Changes in coverage can force people to change their doctors or other health care providers and may require paying more or less in premiums and cost sharing. It has been estimated that, following the coverage expansion in 2014, more than one-third of all low-income adults—about twenty-eight million people—could experience enough of a change in income within six months of enrollment to churn between Medicaid and buying coverage through an exchange, or to move from being eligible for subsides to buy exchange coverage to losing that eligibility.

Moving from Medicaid to private insurance coverage available through exchanges is likely to produce financial consequences for those affected. Medicaid beneficiaries typically pay no premiums and little or no cost sharing (deductibles and copayments) for covered services. On the other hand, people with incomes just above the newly expanded Medicaid cutoff may pay insurance premiums that, even with federal subsidies, can amount to as much as 3 percent of their income—a relatively high share of income for low-income individuals or families. They may also pay higher cost sharing for services than people on Medicaid. As a result, subsidized private insurance coverage obtained through a health insurance Marketplace may still be unaffordable for many low-income people.

Just the possibility of changes in their income may lead some people not to claim the federal subsidies to help buy private coverage through an exchange. These subsidies will be provided in the form of advance payments of an income tax credit and will be paid prospectively based on a person’s projected income. If by the end of a given year the person’s actual income is more than what was projected, he or she must repay the government for some or all of the difference. People may thus be hesitant to take advantage of the subsidies, knowing that increases in their income could mean that they could owe the government money at the end of the year.

The Basic Health Program is aimed, in part, at giving states a way to mitigate problems associated with churning. One analysis, by Ann Hwang and coauthors, estimated that the effect of a Basic Health Program would be to reduce the number of adults who would churn between Medicaid and coverage obtained through an exchange. The authors estimated that 1.8 million fewer US adults would churn between coverage programs if all states had Basic Health Programs.

A second analysis, by Matthew Buettgens and colleagues of the Urban Institute, estimated a comparable effect. If states set up a Basic Health Program and jointly administered it with Medicaid, churning between Medicaid plans and Marketplace plans for those below 200 percent of the federal poverty level would effectively be eliminated. Although there would still be churning for people whose incomes rose above 200 percent of the federal poverty level, and who then had to purchase coverage through a Marketplace, the total number of those churning between Medicaid plans and Marketplaces would fall from 6.9 million to 5.8 million annually—or about 1.1 million fewer people per year.

More people would retain coverage under a Basic Health Program, in part, because that coverage is expected to be decidedly less costly to enrollees than private coverage available through insurance exchanges. According to analysis by the Urban Institute, an adult having income between 138 percent and 200 percent of the federal poverty level would pay an average monthly premium of about $102 for a private insurance plan obtained through an exchange, plus $36 in monthly out-of-pocket costs. Under a Basic Health Program with premium and cost-sharing charges similar to those in Medicaid and the Children’s Health Insurance Plan—which are likely to be the
models many states use to devise their Basic Health Program coverage—monthly premiums and out-of-pocket costs would each average only about $8 (Exhibit 1).

Although states have the option to offer a Basic Health Program, they are not required under the law to do so.

### WHAT’S IN THE LAW?

To create a Basic Health Program, the ACA allows a state to contract with one or more managed care plans or other organizations to offer insurance coverage. This coverage must include at least the state's minimum essential health benefits, which consist of a required package of services, including hospitalization; treatment for physical and mental health conditions; maternity, newborn, and pediatric care; and prescription drugs. (See the Health Policy Brief on essential health benefits for more information.)

Maximum premiums and cost-sharing expenses for Basic Health Program coverage are linked to the private coverage available in a state’s health insurance exchange. On the exchanges, there are different levels of coverage, with bronze being the least expensive and platinum being the most expensive. Under the Basic Health Program, the enrollee’s monthly premium cannot exceed what it would have been had the enrollee purchased the second-lowest-cost “silver” plan in an insurance exchange. If a state’s Basic Health Program is offered by an insurance company, its plan will be required to spend a greater percentage (85 percent) of premium dollars on clinical services and quality improvement compared to plans offered through an exchange (80 percent).

### ELIGIBILITY REQUIREMENTS:

To qualify for the Basic Health Program, a state resident must be under age sixty-five, cannot be eligible for Medicaid, and cannot be offered employer-sponsored coverage that is considered affordable under the law (that is, costing no more than 9.5 percent of household income for self-only coverage). As noted, the person’s income must be greater than 138 percent of the federal poverty level but less than 200 percent. (Legal immigrants who have incomes below 138 percent of the federal poverty level but who do not have the five-year lawful residency required for Medicaid are eligible for the Basic Health Program.) Eligible people in states offering a Basic Health Program can no longer receive federal subsidies for premiums or cost sharing for coverage under an exchange.

### FUNDING:

To fund the Basic Health Program, the federal government will give states 95 percent of the federal premium tax credits and cost-sharing subsidies that would have been spent on people had they been enrolled in a private health insurance plan purchased through a state exchange. If these federal dollars exceed a state’s costs for its Basic Health Program, any surplus funds must be used to reduce premiums and cost sharing for eligible people or to provide additional benefits. Centers for Medicare and Medicaid Services (CMS) will provide quarterly payments to states based on projected enrollment and will reconcile funding at the end of the year based on actual enrollment. Funding may be different than anticipated if more or fewer beneficiaries actually enroll or if changes in beneficiaries’ income over the year change the amount of premium and cost-sharing subsidies that the state receives.

### START DATE:

The ACA provided a start date of January 1, 2014, for the Basic Health Program, but states needed guidance from the federal government about how the program would be implemented before deciding whether to offer such a plan. In February 2013 CMS announced that rules implementing the Basic Health Program would not be finalized until sometime in 2014. Therefore, the program would not be operational until January 2015.
“The Basic Health Program is aimed, in part, at giving states a way to mitigate problems associated with churning.”

Although the Basic Health Program offers potential benefits to both a state and its residents, the calculation as to whether a state should establish one is complicated. Here are some of the issues involved.

**Impact on Exchanges:** The interaction between a Basic Health Program and the insurance exchange created in a given state is likely to be complex. If a state sets up a Basic Health Program, some people will obtain coverage through that program rather than by purchasing subsidized private health insurance coverage through the state exchange.

Nationwide, one-third of the people expected to be eligible to purchase private health coverage through an exchange, and receive federal subsidies to do so, have incomes below 200 percent of the federal poverty level and, therefore, could be eligible for a Basic Health Program if their states set them up.

For the exchange concept to work financially, there needs to be a broad pool of people purchasing coverage through an exchange, in part so insurers can spread the risks and costs of covering a relatively small group of very sick people across a broader group of healthier people. The exchange’s viability could be threatened by creation of a Basic Health Program if the resulting population of people buying coverage through a given state’s insurance exchange is too small. States that have explored creation of the Basic Health Program option have generally found that the remaining pool of people buying coverage through exchanges will still be large enough for the exchange market to work. However, it’s not certain that this would be the case in all states.

The reduction in the exchange population caused by the Basic Health Program could also affect the overall health status of the pool of people buying coverage through an exchange in a way that might affect the level of their health insurance premiums. The smaller population might also affect the state’s ability to effectively negotiate with health plans to obtain the most affordable premiums in states with state-run exchanges.

The size and extent of any impact on premiums is difficult to predict because the population of people likely to be eligible for the Basic Health Program is expected to be generally younger and poorer than the population that would still be buying coverage through an exchange. These two characteristics work in opposite directions on risk and premiums: Lower income is associated with poorer health status and higher risk, while younger age is associated with better health status and lower risk. Until a given state has actually operated both programs for a while, it might be impossible to know what the effect of premiums would be.

Officials in some states have considered ways to mitigate problems related to shifting health status and risks, including having risk-adjustment mechanisms that apply not just to coverage purchased through exchanges but also to the Basic Health Program. (See the Health Policy Brief on risk adjustment for more information.) Another option would be to consider all enrollees in the Basic Health Program and the exchanges as a common pool, and thus have premiums level across the two groups. CMS considered allowing this approach but chose to exclude Basic Health Program members from the individual market’s risk pool.

**Impact from the Exchanges:** There are also concerns about the impact flowing the other way—from a state’s exchange to its Basic Health Program. Since the federal government will give states 95 percent of the premium and coinsurance subsidies that it would provide if the population were enrolled in plans under an insurance exchange, that means that the premiums charged through the exchange will determine the amount of federal funding provided to the Basic Health Program. Thus, the lower the premiums on policies sold through the exchange, the lower the dollar value of the subsidies and the less federal funding available to the state for its Basic Health Program.

**Continuity of Care:** Most analyses assume that the Basic Health Program will use a benefit design and payment structure similar to that of Medicaid. It is assumed likely that states electing to set up Basic Health Programs would sign contracts with Medicaid managed care organizations to supply services to the people who will enroll in these plans. Such a close alignment with Medicaid would provide the greatest continuity of care to people churning between Medicaid and the Basic Health Program as their income and eligibility shifted. Under such an arrangement, a Medicaid enrollee who shifted into his or her state’s Basic Health Program at some point would be highly likely to be able to keep the same doctors, rather than having to switch to a new doctor.
group of providers contracted to work with the exchange plans but not with Medicaid.

However, some observers raise concerns about continued reliance on Medicaid networks. Medicaid programs have typically paid providers less money for their services than private insurance plans or even Medicare, so that the groups of physicians who will agree to see and treat patients on Medicaid are typically smaller than networks serving other insured groups. It is possible that the rates that a Basic Health Program would pay providers would fall somewhere above Medicaid rates but less than those of private plans, but at this point, no one really knows.

If providers are paid at rates comparable to those of Medicaid to see and treat Basic Health Program patients, some observers question whether there will be enough interest on the part of providers to participate. If there isn’t, it’s not clear that the existing corps of safety-net providers who serve the current Medicaid population will have enough additional capacity to serve the Basic Health Program enrollees as well.

**EFFECT ON CHURNING:** Churning between public insurance and private insurance obtained through the exchange or from an employer will still occur with creation of a Basic Health Program, but it will occur at a higher income level. Individuals or families whose income shifts to exceed 200 percent of the federal poverty level will lose coverage under the Basic Health Program. Exchange subsidies decline as incomes increase, so such families receive less help with insurance costs on the exchange than lower-income families. The evidence suggests that the number of people losing coverage at 200 percent of the federal poverty level may be greater than the number who lose coverage under Medicaid when their incomes exceed 138 percent of poverty.

Whether or not this churning occurs may be influenced by the structure of the Basic Health Program. The law and CMS’s regulations do not require cost sharing or benefits to be constant for all enrollees in the Basic Health Program, regardless of their level of income. If states gradually increase cost sharing as enrollees’ income increases, then the contrast between the Basic Health Program and the exchange plans may not be as significant, making it easier for people to transition to obtaining coverage through an exchange and to handle any additional costs.

On the other hand, if states do not gradually increase cost sharing as income increases, then the contrast between the out-of-pocket costs of enrolling in a Basic Health Plan and an exchange plan may be significant and make it difficult for people to maintain coverage.

**FISCAL BENEFITS AND RISKS TO STATES:** The Basic Health Program presents both potential financial advantages and financial risks to states. Some states have already chosen to enroll the same populations who would be eligible for the Basic Health Program in Medicaid instead. For example, in 2011 California spent $225 million to provide Medicaid coverage to recent legal immigrants who did not qualify for Medicaid coverage that would be paid for in part with federal matching funds. In addition, some states have programs that provide direct services to uninsured residents at considerable costs. Reducing the number of these uninsured people, or shifting populations from Medicaid to a Basic Health Program that could be supported with even more generous federal subsidies, could reduce state expenditures for providing health services for these types of populations.

However, it is also possible that states could face additional expenditures as a consequence of setting up a Basic Health Program. States cannot use federal funding to pay for administrative activities needed to set up and run the Basic Health Program and would need to identify other revenue streams to cover those costs. In addition, federal funding may not cover allowable costs under the program if the reconciliation process that adjusts federal funding based on the actual income of enrollees reduces the amount of money available to the state from the federal government. It is also possible that premiums charged in the exchange—the basis of determining the amount of federal subsidies—will be too low to create a Basic Health Program that is attractive to both enrollees and providers. States may find it necessary to contribute state money to improve the product.

**INTERFACE WITH MEDICAID EXPANSION:** As described above, the premise of the Basic Health Program is that it will provide a bridge between an expanded Medicaid program and coverage under the exchange. The June 2012 Supreme Court decision, while largely upholding the ACA, in effect gave states the option of declining to expand their Medicaid programs as the law envisioned. Twenty-five states had chosen not to proceed with the Medicaid expansion as of December 2013, according to the
Kaiser Family Foundation. It is unlikely that states that have chosen not to expand Medicaid would pursue creation of a Basic Health Program.

**Final Rule (Finally!):** States interested in establishing a Basic Health Program were hampered by considerable delays in issuing guidance about the program requirements, including a one-year delay in the effective date of the program from January 1, 2014, until January 1, 2015. The delay not only produced uncertainty for states considering establishment of a program but also created additional complications and administrative burden. Because of the delay in the effective date, interested states could not set up a Basic Health Program that would have begun operation at the same time as the exchanges and Medicaid expansion. Instead, states are faced with the prospect of establishing and enrolling people in exchange plans in 2014 and then establishing and re-enrolling eligible people into a Basic Health Program in 2015.

CMS did not finalize its regulations and funding methodology for the Basic Health Program until March 2014. Under those regulations, states that want to establish a Basic Health Program would submit to CMS a Basic Health Program Blueprint that identifies the benefits, premiums, and cost sharing under the program. The Blueprint must also specify the contracting process and requirements and describe how the state would promote coordination with other insurance affordability programs such as Medicaid, the Children’s Health Insurance Program, and the exchanges. In setting up the Basic Health Program requirements, CMS relied heavily on definitions and procedures already established for either Medicaid or the exchanges. States are given the flexibility to choose whether to align the Basic Health Program more closely with Medicaid or the exchange and would be required to offer residents a choice of two plans by different providers. States are not able to establish enrollment caps or waiting periods; nor may they limit access to the Basic Health Program to certain geographic areas. The Blueprint must be certified by CMS for a state to offer the Basic Health Program but certification does not create an obligation, for the state to offer a program.

CMS will calculate payments to the state based on rates that reflect the average premium and cost sharing for groups of people with common characteristics including age, geographic location, and income. CMS interprets the restrictions on use of the Basic Health Program funds in the law as prohibiting use of those funds for administration of the program. That interpretation means that states would have to provide separate funding to support the administrative functions necessary to operate the program. However, CMS does note in the final rule that if premiums collected from enrollees are not deposited into the trust fund into which the federal government deposits its payments to the state, then those premium dollars are not subject to these restrictions.

**What’s Next?**

Currently, only a few states have shown an interest in implementing a Basic Health Program. Some states have studied the option, and seven states—California, Massachusetts, Minnesota, New York, Oregon, Rhode Island, and Washington—and the District of Columbia are part of a discussion group sponsored by CMS on topics related to the Basic Health Program, including funding, eligibility, and enrollment.

In the final rule, CMS estimated that a total of three states would create a Basic Health Program over the next five years. Minnesota has already signaled its intent to establish a program for 2015, and New York and Oregon remain interested. More is expected to be known about the program in those states, and potentially others, through the development and submission of the required Blueprints, which CMS will post on its website.
RESOURCES


Dorn S., Buettgens M., Carroll C., "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States," Urban Institute, September 2011.


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