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Short Paper #2

The Basic Health Option: Considerations for States Implementing Federal Health Reform

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Introduction

The Basic Health Option is a state option under national health reform. While federal guidance regarding implementation of the Option is still to be issued, it is important for advocates to understand this Option and to begin investigating, now, whether it would be a positive feature of health reform in your state. This Short Paper provides an overview to the Option and discusses a number of issues for advocates to consider when deciding whether and how to support state implementation of the Basic Health Option.

In order to understand the Basic Health Option, you need to be familiar with three key concepts in the Patient Protection and Affordable Care Act (ACA). First, the ACA creates **Health Insurance Exchanges** for individuals buying commercial coverage. Only "qualified health plans" as defined in the law are permitted to sell products in the Exchanges. Second, the **insurance products are standardized**, so that every plan must contain a set of **essential health benefits**. There are five "metallic" benefit levels – Platinum, Gold, Silver, Bronze, and Catastrophic – that are geared to the level of point-of-service cost sharing, with platinum covering the highest percentage of the cost of care (90%). Third, people with income below 400% of the federal poverty level will qualify for **premium and cost-sharing subsidies** in the form of tax credits. These limit premiums to a percentage of household income (pegged to the cost of the silver level plan) and substantially reduce cost-sharing if the individual selects a silver plan.[1]

[1] For more information, see: Kaiser Family Foundation, Explaining Health Care Reform: Questions About Health Insurance Exchanges, http://www.kff.org/healthreform/7908.cfm; and Robert Carey, Public Consulting Group, Health Insurance Exchanges: Key Issues for State Implementation, http://www.rwjf.org/files/research/70388.pdf .

What is the Basic Health Option?

The ACA §1331 allows states to offer one or more "Basic Health" insurance plans to low- to moderate-income individuals instead of offering them coverage through a Health Insurance Exchange. Plans must provide at least the essential health benefits, and individual premiums may be no greater than the corresponding Silver plan on the Exchange. Plans may be offered by licensed HMOs, licensed health insurance insurers, or networks of health providers formed for this purpose. It is expected that a state would offer enrollees better value than an individual market plan by using a publicly administered, competitive process to negotiate premiums, cost-sharing and benefits. States electing to offer coverage through the Basic Health Option will receive tax credit subsidies to cover costs for individuals who would have been covered through the Exchange. This provision was introduced by Senator Cantwell of Washington, a state with a similar, successful program.

Who is eligible for Basic Health?

In a state that offers Basic Health, residents under age 65 with income above 133% and up to 200% of the federal poverty level would be eligible, as well as lawfully present aliens with income below 133% and ineligible for Medicaid.[2] That is, the individual must be eligible for a premium tax credit. Basic Health is not available to employees whose employers offer at least the "minimum essential coverage" that is considered "affordable," just as in the Exchange. Moreover, in a state electing the Basic Health Option, eligible individuals may not purchase coverage through the Exchange.

How do premiums and cost-sharing subsidies compare to the Exchange?

Premium subsidies for Basic Health enrollees must be at least as generous as those in the Exchange. One provision in § 1331 suggests that a state may charge slightly higher cost-sharing in Basic Health.[3] However, this provision is inconsistent with another subsection, and appears to be due to a drafting error.[4]

How will the tax credit subsidies be distributed to states?

The federal government transfers to the state 95% of the premium credits and cost-sharing reductions that individuals would otherwise have received if enrolled in the Exchange. This amount considers a variety of factors such as age, income, health status, and geographic

[2] When computing income, a 5% FPL disregard, added in the reconciliation bill, makes the lower threshold effectively 138% FPL.
[3] For those with income below 150% FPL, § 1331(a)(ii) states that the maximum actuarial value of the Basic Health plan must be 90% (platinum plan level), and for those above 150% the maximum is 80% (gold plan level). The respective exchange percentages are 94% and 87%, and there is also a reduction of the out-of-pocket limit.
[4] The conflict is with § 1331(d)(3)(A), which references the cost-sharing subsidies under § 1402 (relating to Exchanges). The U.S. Department of Health and Human Services (HHS) could address this conflict by requiring states to use the same cost-sharing levels for Basic Health as in the Exchange.

differences in average spending for health care. This methodology is designed to offset any additional risk borne by serving this population through a separate program.[5]

What are the features of Basic Health plans?

Basic Health states are required to negotiate for certain plan features: innovation features (such as care coordination, incentives for use of preventive services, and patient-centered decision making), consideration of differing health care needs and resource differences, managed care attributes, and performance measures focusing on quality of care and improved outcomes. States are encouraged to offer a choice of plans and may have regional compacts with other states. Coordination with Medicaid and Children's Health Insurance Program (CHIP) is required to maximize efficiency and continuity of care. Basic Health plans are only available to Basic Health enrollees.

How does a person enroll in Basic Health?

The ACA §1413 provides for streamlined, coordinated enrollment procedures that apply to Medicaid, CHIP, a state Basic Health program, and subsidies in the Exchange. A single enrollment form will serve as an application for all these programs.

Benefits of Adopting the Basic Health Option

The Basic Health Option is an important avenue for providing affordable health coverage for people with income just above Medicaid levels. Because it is state-run, it has built in public accountability – a feature that may or may not exist in the Exchange, depending upon the form it takes in your state. A state using Basic Health will be able to offer:

- ***Affordability.*** The Basic Health Option allows a state to reduce costs and improve benefits for enrollees. Low-income consumers will likely find the Basic Health Option more affordable than the Exchange and more likely will insure themselves. This is because a state's bargaining power can allow it to stretch its dollars further than an individual buying coverage in the commercial market. The ACA requires that any state savings must be applied to reduce enrollee premiums and cost-sharing further, or to provide additional benefits.[6] States will receive substantially more per capita than they currently spend on Medicaid, making it possible for them to achieve such savings. This would tend to reduce

[5] §1331(d)(3) requires the Secretary to determine the amount to transfer to the state on a per enrollee basis, taking into account all relevant factors necessary to determine the value of premium tax credits and cost-sharing reductions that would have been provided, including the age and income of the enrollee, whether the enrollment is for self or family, variance in health care spending based on geographic differences in average spending for health care, and the health status of the individual. It is to be based on the experience of other states, with a particular focus on enrollees with income below 200 percent of FPL. The Chief Actuary of CMS, in consultation with the Treasury Secretary, are to certify whether the methodology used meets the necessary requirements, based on data from the state in question and comparable states. Note that as of this writing, the federal agencies have not yet issued guidance on this methodology.

6 Section 1331(d)(2) provides that "amounts in the [state's federal subsidy] trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State."

the "cliff" between Medicaid and the Exchange for people who experience increases in income. The reduced cost will likely draw more people into coverage than the Exchange would at lower income levels where people are exempt from the individual mandate. A more affordable plan will not only benefit low-income enrollees; it will also reduce the number of uninsured whose costs are shifted to the rest of the market through charity care and other mechanisms.

- ***Family Unity.*** A state can facilitate coverage of adults and their children under one umbrella rather than splitting families between the Exchange and other state-administered programs, when children's income eligibility levels exceed those of their parents. This promotes the concept of a "health home" for families.

- ***Continuity of care.*** A state may be able to enhance continuity of care when a person crosses the income boundary from Medicaid to Basic Health, if the state is able to purchase coverage through the same health plans for both programs.

- ***Coverage for immigrants.*** In setting premiums for lawfully present immigrants who are not covered under Medicaid, their actual income is considered rather than deeming a minimum income level.[7]

- ***Address health disparities.*** Basic Health programs may be shaped to address the needs of populations at risk of health disparities and those with special needs, whereas the Exchange market is less likely to do so.

- ***Spending on health care services.*** An additional safeguard in the ACA requires a state-contracted plan operating under the Basic Health program to have a Medical Loss Ratio (MLR) of at least 85%, the same minimum as the large group market. (By comparison, the MLR may be as low as 80% in the Exchange for individual/small group products.) This limits administrative and other non-healthcare costs.

Recommendations for Advocacy with States to Adopt the Basic Health Option

- A state electing the Basic Health Option should design the program so as to improve continuity and quality of care. The state should develop a way for people to transition from Medicaid to Basic Health and from Basic Health to the Exchange without experiencing gaps in coverage or disruptions in care, with attention to maintaining the "health home" concept. Advocates should point out that the Basic Health Option can improve continuity of care and coverage by maintaining state-based coverage for a larger group of state residents (i.e., 0-200% FPL). While the details will need to be clarified, a state can minimize coverage gaps and problems as people cross the income boundaries in a variety of ways; federal guidance is needed on which of the above options would be permissible:

[7] In the Exchange, lawfully present immigrants' premiums are calculated as if they have income no less than 100% FPL, whereas in BH, premiums are calculated based on actual income. A state may also extend its Basic Health program to other immigrants, using its own funds for subsidies.

- Adopting 12-month continuous eligibility across Medicaid, Basic Health and the Exchange.

- To preserve continuity of care when an enrollee's income decreases to Basic Health levels, the state should be permitted to pay the enrollee's premium for their Exchange plan for the period of time necessary to transition to the new plan. The transition from Basic Health to Medicaid could be similarly handled.

- At the state level, incentivize plans – and especially providers – to participate in Medicaid, Basic Health and the Exchange, so families can continue coverage with the same providers. This might involve combining Basic Health and Medicaid purchasing to encourage plans and provider networks to participate in both. States could also "deem" plan participation across programs: if a plan meets the Medicaid requirements for "qualified health plans," it could be deemed qualified in the Exchange and Basic Health.

- Ensure that the Basic Health Option provides enrollees with adequate access to care. Provider payment rates may be lower than those in commercial plans, so states must be committed to ensure adequate provider participation, using the strategies discussed above. This will require strong network adequacy safeguards in its contracts, and the ability and commitment to enforce the contract if problems arise.

- Determine the best way to administer the Basic Health program, whether by the Medicaid or CHIP agency or by another part of state government. It will be important to advocate for the consolidation of agencies or otherwise ensure that eligibility determinations can be done expeditiously to avoid gaps in coverage as people cross from one coverage source to another, and to unify purchasing. If the state maintains separate agencies to run Medicaid, CHIP, and Basic Health, advocates will need to ensure that this does not cause delays due to the need for communication back and forth, differing determination systems,[8] duplicative data requests, and the potential for confusion on the part of enrollees. A single family might then need to deal with requests from multiple agencies seeking the same information for different family members and varying notices and appeals procedures. Multiple agencies with overlapping functions are likely to increase a state's administrative costs. These costs would need to be managed within the available federal funding, or else the state could be required to tap its own revenue sources to cover the difference.

- States will want to understand the financial considerations involved in implementing the Basic Health Option. They will be able to use their Exchange planning grants to study the option. They might, for example, compare recent population survey or census data to estimate the number of people who would be in the Basic Health pool, determine what expected per capita costs would be, and project the subsidy revenue, considering the risk-adjustment methodology described in §1331. The state should then estimate its ability to manage the program within this budget. Washington State's experience with its Basic

[8] As currently allowed, a state may administer its CHIP program separately from Medicaid. Under the ACA section 1413, effective January 2014, a single enrollment website must link to all agencies and various streamlining and coordination requirements will apply.

Health program suggests that costs per person will be significantly lower than for private individual market plans, but this comparison will need to be refined when more is known about the essential health benefit package.

- The state should also evaluate its anticipated savings, which can be used to reduce cost-sharing and increase benefits for Basic Health enrollees. One use of Basic Health is to leverage a state's purchasing power to offer better coverage than what a person can buy for the same money in the Exchange. Advocates should aim to ensure that the scope of benefits for the Basic Health group (as well as the expansion Medicaid group) is aligned with the state's existing Medicaid program, but recognize that states will need to manage within the amount of funding received. Competitive purchasing is thus integral to achieving this goal. A publicly-accountable governing body should be put in place to oversee the Basic Health benefit package.

- Consider the impact on market dynamics. If the Basic Health pool is removed from the Exchange, the Exchange pool for individuals becomes smaller. Be prepared to understand the impact on the Exchange of removing the 133%-200% group. Would it affect which plans choose to participate? Would your state consider participating in a joint Exchange with another state to increase the size of the pool? Is there a concern that the market will be segmented into higher-risk and lower-risk groups? Will the federal government permit pooling of risk across these groups?

- As an alternative to election of the Basic Health option, a state may consider running its own health insurance plan (or plans) within the Exchange, with the goal of providing richer benefits than the silver health plans. In order for this to happen, the state's costs – administrative expenses plus negotiated payment rates – would need to be significantly below the costs of commercial plans in the Exchange. In this alternative, the Exchange pool would include the 133-200% FPL group. The state's Exchange plan could not require those under 200% FPL to enroll in its plans, but those over 200% FPL could opt to participate. The state would be able to receive each enrollee's total subsidy amount, not just the risk-adjusted 95%.[9] Enrollees who cross the 200% FPL threshold would be able to stay in the same plan. A state considering this option would seek to offer better value compared to other plans and would need to avoid adverse selection risks in order to keep benefits affordable. Questions have been raised about whether and how the state would be able to operate as a Qualified Health Plan in the Exchange.

- The ACA does not explicitly state access or network adequacy standards for Basic Health. Network adequacy standards exist for qualified health plans in the Exchange, and the state may also have such standards for regulated insurers. Advocates should seek standards sufficient to guarantee timely and convenient access to services for the Basic Health population by urging CMS and their states to establish such standards by law or contract. The National Health Law Program has collected numerous examples of such standards.

[9] In evaluating the options, it will be important for a state to estimate and compare these amounts.

- The ACA does not specify what recourse a Basic Health enrollee has if s/he is denied services. Advocates should urge HHS to adopt regulations establishing the same appeal rights that exist for those in the Exchange or Medicaid, depending on the circumstances in your state. For adverse actions by health plans, if Basic Health benefits, administration, or service delivery are more aligned with the Exchange plans, it may be most appropriate to use the ACA appeal rules to handle benefit disputes. These rules provide for advance notice of adverse action, continued benefits pending resolution of an internal appeal, and simultaneous expedited external review in advance of a reduction or termination of an ongoing course of treatment in urgent care situations.[10] However, if Basic Health is administered by the Medicaid agency or has a similar benefit structure, it may make more sense to use that appeals process. In addition, it may be helpful to specify in state law that that enrollees are third-party beneficiaries of the state's contract with the health plan in the event that an individual needs to pursue a court appeal.

- In order to ensure that all Basic Health members have fair and adequate access to care, the state will want to ensure that enough plans and providers participate. They may be encouraged to do so if the state uses a risk adjustment system to pay Basic Health plans. Such a system should be accurate enough to ensure against adverse selection.

- The law requires annual review by HHS to ensure state compliance with all requirements, including those related to eligibility verification, the use of federal funds, and quality and performance standards. No regulations exist yet, but it would be important that they effectively oversee spending of federal funds on enrollee benefits, to ensure that states use all savings to reduce enrollee cost-sharing and enhance benefits. State accountability mechanisms should be considered where there are gaps in federal oversight.

- No rules yet exist concerning what happens if a Basic Health plan decides to terminate its contract with the state. This could cause instability in the program. To mitigate such occurrences, standards that allow for notice, transition time, and consumer protections should be provided in federal regulations, state law, and health plan contracts. Ensure that enrollees will easily be able to transition to the Exchange if the Basic Health program needs to cease operating.

[10] 26 CFR §§ 54.9815–2719T, 29 CFR §§ 2590.715–27109, 45 CFR § 147.136 (interim final rules, 75 FR 43330-43364 (July 23, 2010)).

Conclusion

The Basic Health Option is an attractive option for those in the 133-200% FPL income range when the state is an effective purchaser that can offer more affordable and/or comprehensive coverage than that available in the Exchange. Evaluate your state's environment to determine whether and how to advocate for the Basic Health Option. Meanwhile, monitor the NHeLP and other websites for information about the issuance of the Federal guidance that is still needed to determine the impact of the option with more certainty.

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