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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?

The Affordable Care Act employs two main strategies for expanding health insurance coverage—first, by extending Medicaid to millions of additional low-income people, and second, by allowing better-off people to purchase private health insurance with federal subsidies through new state-based health insurance exchanges. But the law also provides for additional means of expanding coverage, including allowing states to run a so-called Basic Health Program beginning in 2014.

Under such a program, states could offer public health insurance to people whose incomes are too high to qualify for Medicaid but are also below 200 percent of the federal poverty level (in 2012, that means less than \$46,100 for a family of four).

To help pay for this program, which would probably resemble Medicaid, states could draw on a portion of the federal dollars that would otherwise go to subsidizing the purchase of private insurance coverage for those people through exchanges.

Proponents of the Basic Health Program idea maintain that it would make coverage more affordable for low-income people and save money for some states. But others worry that the program could undermine the viability of the new state insurance exchanges and, rather than saving money, expose states to fi-

nancial risk. Meanwhile, federal officials have not yet provided many details for states about how the program will be operated.

This policy brief explores the issues surrounding the Basic Health Program and outlines options for states.

WHAT'S THE BACKGROUND?

To understand how the Basic Health Program could fit into the continuum of coverage provided by the Affordable Care Act—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 Affordable Care Act requires most people to have health insurance coverage beginning in 2014 or pay a financial penalty. As noted, the law provides for two main avenues for expanded coverage, the first through Medicaid for adults having incomes up to 138 percent of the federal poverty level, which in 2012 is about \$15,415 for an individual and \$31,810 for family of four. The second avenue is through private coverage purchased from new state-based 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.

138%

Federal poverty level

States can extend Medicaid eligibility to adults having incomes up to 138 percent of the federal poverty level starting in 2014.

“The Basic Health Program may pose a viable means under which states can offer their citizens coverage that is more affordable than that available on the private health insurance market.”

These income eligibility standards may be a useful way of determining which people should be in certain programs or should be eligible for federal subsidies. But individuals’ or families’ incomes can fluctuate, which means that their eligibility for programs or subsidies may change. Incomes may rise or fall because of a job switch or a change in working hours; what’s more, if a family’s size changes, for instance through the birth of a child, the family’s income in relationship to the federal poverty level will also be different.

As a result, 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, sometimes forcing people to change their doctors or other health care providers, to possibly pay more or less in premiums and cost sharing, and to experience other effects. It has been estimated that, once coverage is expanded in 2014, within six months of enrollment, more than one-third of all low-income adults—about 28 million people—may experience enough of a change in income to churn between Medicaid and buying coverage through an exchange, or to move from being eligible for subsidies to buy coverage through an exchange 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 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 will people on Medicaid. As a result, subsidized private insurance coverage obtained through a health insurance exchange may still be unaffordable for many low-income people.

It is also possible that people worried about changes in their income may decide for still other reasons 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 the person’s actual income is more than 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 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 these ill effects of churning, if only somewhat. One analysis by Ann Hwang and coauthors published in *Health Affairs* 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 exchanges. Without a Basic Health Program, the authors estimated, 58.2 percent of people with incomes below 400 percent of the federal poverty level would not experience an income-related eligibility change for a full year.

By contrast, with a Basic Health Program, 62.5 percent of people would have stable income eligibility. Those percentages mean that, in numerical terms, 1.8 million fewer US adults would churn between coverage programs if all states had Basic Health Programs.

A second analysis, by Matthew Buettgens, Austin Nichols, and Stan Dorn 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 exchange plans for those below 200 percent of poverty would effectively be eliminated, this study said.

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 exchanges, the total number of those churning between Medicaid and exchanges would fall from 6.9 million to 5.8 million annually—or about 1.1 million fewer people per year.

WHAT’S IN THE LAW?

To create a Basic Health Program, the Affordable Care Act 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,

4 points

Estimated churn reduction

A Basic Health Program would reduce the percentage of people nationwide churning between Medicaid and the exchanges by about 4 percentage points per year.

newborn, and pediatric care; and prescription drugs. (See the [Health Policy Brief](#) published on April 25, 2012, for more information on essential health benefits.)

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. For example, the enrollee's monthly premium cannot exceed what it would have been had the enrollee purchased the second-lowest cost "silver" plan in the insurance exchange. If a state's Basic Health Program is run 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).

Although the law gives states considerable leeway in designing a Basic Health Program, most approaches under consideration build on existing state programs. The Urban Institute estimates that at least 600,000 more people would have health insurance if all states offered a Basic Health Program because such insurance coverage is likely to be decidedly less costly than private coverage available through insurance exchanges.

According to the analysis, an adult having income between 138 percent and 200 percent of poverty 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).

ELIGIBILITY REQUIREMENTS: To qualify for the Basic Health Program, a state resident must be under age 65, 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). As noted, the person's income must be greater than 133 percent of poverty but less than 200 percent. (Legal immigrants who have incomes below 138 percent of poverty but who do not have the five-year lawful residency required for Medicaid are eligible for the Basic Health Program.)

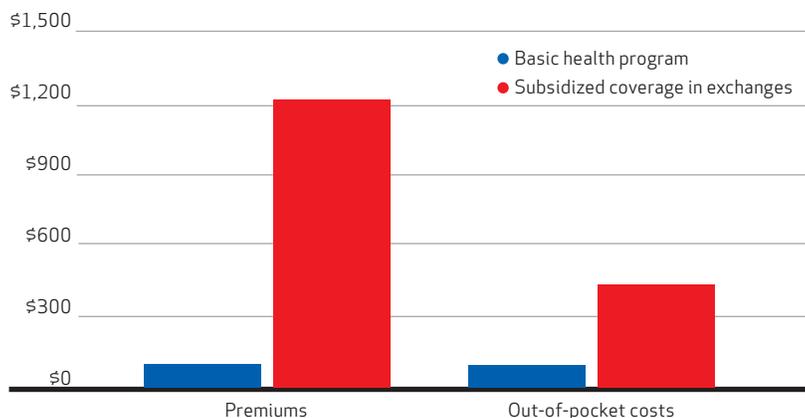
To fund the Basic Health Program, the federal government will give states 95 percent of the federal premium tax credits and cost-sharing subsidies that would have been spent on individuals had they been enrolled in a private health insurance plan purchased through a state exchange. If these federal dollars 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.

The federal government is supposed to make a determination before the fiscal year begins about how much money it should give the state, based on projected enrollment and other factors. Then, when the year is over, payments to the state may be adjusted if it turns out that the initial estimates were incorrect.

Although states have the option to offer a Basic Health Program, they are not required under the law to do so. At least eight states have conducted analyses to explore creating the programs. Washington, which already had a similar state program in place, passed legislation to enact a Basic Health Program that complies with the terms of the Affordable Care Act. Massachusetts also passed such "enabling" legislation, and California will consider a bill to establish one during an upcoming special session of the state legislature beginning in December 2012 or January 2013. Seven other states have passed legislation requiring an analysis of the prospect.

EXHIBIT 1

Estimated Average Annual Costs for Insurance Coverage for Low-Income Adults



SOURCE Stan Dorn, Matthew Buettgens, and Caitlin Carroll, "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States," Urban Institute, September 2011. **NOTES** Results show effects as if policies were fully implemented in 2011. Results were derived from the Health Insurance Policy Simulation Model developed by the Health Policy Center and the Urban-Brookings Tax Policy Center at the Urban Institute.

WHAT ARE THE ISSUES?

Although the Basic Health Program offers potential benefits to both the state and to 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 state health 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 that way rather than purchase subsidized private health insurance coverage through the state exchange. That, in turn, will mean that fewer people will receive coverage through an exchange.

In fact, nationwide, a third of the people expected to be eligible to purchase private health coverage through exchanges, and receive federal subsidies to do so, have incomes below 200 percent of the poverty. This large group of people—an estimated 7.5 million—could thus be eligible for a Basic Health Program if their states set them up.

VIABILITY THREATENED: If the result of creating a Basic Health Program is that the population of people buying coverage through a given state's insurance exchange is too small, the exchange's viability could be threatened. For the exchange concept to work financially, there needs to be a broad pool of people purchasing coverage through the 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.

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.

There are other concerns about the existence of a Basic Health Program cutting into the size of the population that would buy coverage through exchanges. Under the law, states have the option of running their exchanges in an "active purchaser" model that allows them to negotiate with health plans to obtain the most affordable premiums. However, if fewer people will be covered through a state's exchange because of the existence of a

Basic Health Program, the state may have less negotiating power with health plans.

The prospect that people eligible for a state's Basic Health Program could be subtracted from the population of people eligible to purchase coverage through the state's health insurance exchange could also affect the overall health status of the pool of people buying coverage through the exchange in a way that might or might not affect the level of their health insurance premiums.

The size and extent of any impact 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 exchanges. 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](#) published on August 30, 2012, for more information on risk adjustment.) Another option might 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.

IMPACT ON BASIC HEALTH PROGRAM: 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 the insurance exchanges, 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.

Most analyses assume that the Basic Health Program will utilize a benefit design and payment structure similar to that of Medicaid.

600,000

More people insured

The Urban Institute estimates that at least 600,000 more people would have health insurance if all states offered a Basic Health Program.

"Most approaches under consideration build on existing state programs."

\$16

Total monthly cost

Monthly premiums and out-of-pocket costs would each average only about \$8 under a Basic Health Program similar to Medicaid plans.

“The interaction between a Basic Health Program and the state health insurance exchange created in a given state is likely to be complex.”

One reason is that the Affordable Care Act requires close coordination between Basic Health Programs and Medicaid. It is also 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.

CONTINUITY OF CARE: 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 group of providers contracted to work with the exchange plans but not with Medicaid.

A related issue is how much health care providers would be paid to see and treat patients in a Basic Health Program. Medicaid programs have typically paid providers less money for their services than private insurance plans or even Medicare, so that the networks 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: As previously noted, if a state creates a Basic Health Program, it is likely that there will be many occasions when incomes fluctuate and people move from Medicaid coverage into coverage under the Basic Health Program. Such a circumstance represents churning at the lower bound of income.

However, it is also true that if a state creates a Basic Health Program, it will create a new opportunity for people to move from that program into a health insurance exchange, if and when an individual’s or family’s income

shifts such that it exceeds 200 percent of the federal poverty level. This circumstance represents churning at the upper bound—in other words, at a higher level of income. It is also possible that such people could move from the Basic Health Program to obtaining coverage through an employer. In either case, these people will most likely face higher premiums and cost sharing as they move into this new type of coverage. 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 the federal poverty level.

Whether or not this additional churning occurs may be influenced by the structure of the Basic Health Program. The law does 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 individuals to maintain coverage.

FISCAL BENEFITS AND RISKS TO STATES: The Basic Health Program presents both potential financial advantages as well as 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 receiving 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. Such a situation would arise if federal funding did not cover the costs. This situation could occur 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: The June 2012 Supreme Court decision largely upholding the Affordable Care Act in effect gave states the option of declining to expand their Medicaid programs as the law envisioned. Many states have signaled that they may decline to proceed with the Medicaid expansion. If so, in these states, residents with incomes 100 and 138 percent of poverty would qualify to purchase coverage through exchanges with the aid of federal subsidies but would not be eligible for Medicaid coverage.

It is unlikely that states in this situation would pursue creation of a Basic Health Program, since doing so would create a patchwork system in which individuals or families between 100 and 133 percent of poverty would participate in exchanges; individuals and families between 134 to 200 percent of poverty would be in the Basic Health Program; and then individuals or families with incomes above 200 percent of poverty would also be

purchasing subsidized coverage through exchanges.

OTHER PROGRAM UNCERTAINTIES: States do not know at this point how the federal Department of Health and Human Services (HHS) is likely to implement the Basic Health Program, including in particular how the federal government intends to determine available funding, what the review and reconciliation processes will involve, and how states can cover administrative costs. To date, HHS has not released any guidance to help states decide whether or not to pursue a Basic Health Program. With President Barack Obama's reelection, these regulations may be issued, but no specific timeline has been given.

WHAT'S NEXT?

Currently, only a few states—including Washington, Massachusetts, and California—are taking steps to implement a Basic Health Program. A number of states appear to have held back for the time being, as they await clarification from federal regulators on specific details of the program. More broadly, decisions that states may make about setting up a Basic Health Program will clearly be linked to their plans for expanding Medicaid coverage and establishing health insurance exchanges, which are likely to crystallize now that the elections are over.

The absence of federal guidance also means that time is running out to implement a program to coincide with the launch of the exchanges in 2014. Presumably, states could implement a Basic Health Program at a later date. HHS may also allow states to implement alternative programs to reduce churning. ■

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