The Basic Health Plan Option under Federal Health Reform: Considerations for Oregon

What Is The Basic Health Plan Option?

Section 1331 of the Affordable Care Act (ACA) allows states to establish a Basic Health Plan (BHP) that would offer subsidized health coverage beginning in 2014 to individuals who meet the following criteria:

- Citizens or lawfully present individuals under age 65 who: have income between 139%-200% of the federal poverty level (FPL); are ineligible for Medicaid; are not offered Employer Sponsored Insurance that meets the ACA's affordability standards.
- Lawfully present individuals with incomes below 139% FPL who are ineligible for Medicaid because of immigration status.

Note: If the state implements a BHP, BHP-eligible Oregonians cannot receive premium tax credits and cost sharing subsidies for commercial plans purchased through the Exchange.

Structure and Federal Funding

States that establish a BHP will receive federal funds equal to 95% of the premium tax credits and cost-sharing subsidies the state's BHP enrolled population would have otherwise received through the Exchange.[1] The BHP must offer federally mandated "essential health benefits" through a managed care or similar system, at a medical-loss ratio of at least 85%, with consumer cost sharing no greater than what enrollees would have paid in other Exchange coverage.[2] States must also establish a competitive procurement process for selecting health plans.[3] Once these requirements are met, states have wide latitude in addressing a number of complex design elements, ranging from their benefits and cost sharing structure, to the myriad options for implementation.[4]

Considerations for Oregon Regarding the Basic Health Plan Option

Potential Opportunities:

1. **Improve continuity, affordability and coverage.** Depending on its design as well as plans and provider participation, a BHP has the potential to offer more affordable and comprehensive coverage than the Exchange for populations from 139% to 200% of the federal poverty level, but at a cost to the state. In addition, the Urban Institute estimates that a significant proportion of "churn" under the ACA (people moving involuntarily between coverage options or plans) will stem from movement between being eligible for Medicaid to being ineligible for subsidized coverage. A BHP option could increase participation, continuity and access to care among this highly price-sensitive target population.[5,6,7]

   Finally, some have suggested that a BHP could be used to provide coverage to undocumented immigrants. However, the law clearly states that "eligible individuals" must meet the criteria stated above. Therefore, coverage for undocumented immigrants under a BHP would have to be funded with 100% state only dollars.

Potential Risks/Challenges:

1. **Cost implications.** The ACA does not provide money to states to set up a BHP and disallows the use of federal Exchange establishment grants for this purpose, so Oregon would need to identify a revenue source for start-up funds. Furthermore, the federal government has not yet issued details about BHP operational issues that have a significant impact on state responsibilities and costs and is not expected to do so until later in 2013, at the earliest. These include the:
    - availability of federal dollars for state administrative costs;
    - manner in which federal payments will be calculated; and
    - process for correcting over- and under-payments to the state, particularly as states will be responsible for the difference in the cost of overpayments if they are miscalculated.
2. **Lower commercial Exchange enrollment could hurt Exchange sustainability.** BHP implementation would result in fewer Exchange members, with estimates for reduction in enrollment as high as one-third.[8] This could negatively affect the Exchange's sustainability and its ability to leverage quality improvements and lower premiums. Reduced commercial enrollment could impact carriers' willingness to participate in the Exchange.
3. **Commercial premiums impact BHP funding.** BHP funding is tied to tax credits and cost sharing assistance, which are tied to premiums in the Exchange. To the extent that the Exchange successfully contains or reduces premiums, BHP payments will also be held down. As a result, BHP payments could decline over time. In addition, premium tax credits will be linked to annual income, which historically has risen slower than medical costs.
4. **Risk sharing.** Risk sharing policies between Exchange plans and BHP plans would need to be carefully considered to mitigate any possible effects the BHP may have on Exchange premiums.

Conclusion

While a BHP has some potential to provide low and middle-income consumers with an affordable and comprehensive coverage option, Oregon has not currently pursued this option because of the complexity of its design, the limited federal guidance on financing, administration, and certification, the lack of funding for set-up and ongoing administration, and uncertainty of its interplay with the Exchange.

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[1] ACA §1331 (d)

[2] ACA §1331(a)-(c)

[3] The statute requires that the State-based "competitive process" for procuring plans to consider: innovation; health and resource differences of enrollees and access to local health providers; encouragement to contract with managed care plans; and performance measures to encourage the provision of quality of care and improved health outcomes. ACA §1331(c).

[4] Dorn, S. The Urban Institute. State Coverage Initiatives. *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States.* March 2011.

[5] Benjamin, E. and Slage, A. Community Services Society of New York. *Bridging the Gap: Exploring the Basic Health Option for New York*. Revised January 2012.

[6] Dorn, S.

[7] Buettgens, M., Nichols, A., and Dorn, S., The Urban Institute, *Churning Under the ACA and State Policy Options for Mitigation: Timely Analysis of Immediate Health Policy Issues.* June 2012.

[8] Bachrach, D., Dutton, M., Tolbert, J., and Harris, J. Kaiser Family Foundation. *The Role of the Basic Health Program in the Coverage Continuum: Opportunities, Risks, and Considerations for States.* March 2012.