



The Basic Health Program as a Critical Component of Successful Health Care Reform

States face a number of significant issues to address the requirements of The Patient Protection and Affordable Care Act (ACA) in designing state-based health insurance exchanges. This statement of principles reflects the views of Molina Healthcare on the design of health insurance exchanges. The principles revolve mainly around issues related to the needs of low-income exchange-eligible populations. The principles advocate that states give immediate and serious consideration to the adoption of a Basic Health Program as the ideal alternative to the health insurance exchange to cover the lower-income segments of the exchange-eligible population.

Principles for Health Care Reform

Molina believes that states should give substantial weight to the special circumstances of low-income populations as they design and implement health care reform and health insurance exchanges. Health plans and providers that have traditionally served Medicaid beneficiaries have vast experience in delivering effective health programs and benefit packages for low-income populations that make them uniquely qualified to play a significant role under health reform. States should leverage the success and expertise of such health plans and providers by maximizing their use and availability for this population.

With respect to low-income families and individuals, Molina recommends the following health care reform design principles:

- Individuals receiving subsidized coverage should have access to health plans with experience serving culturally diverse, low-income populations.
- States should recognize the unique social and health care needs of low-income populations and design coverage options that address their special circumstances.
- States should be committed to providing the highest quality of care and adopt coverage approaches that have proven effective for low-income populations.
- Low-income individuals should have access to affordable coverage with the lowest possible premiums and finely tuned cost sharing.
- State health care reform strategies should promote continuity of care, stable coverage, and the same health plan options for family members.
- **States should understand that forcing culturally diverse, low-income populations into largely commercial health insurance exchanges will result in care disruption and higher costs of health care for these populations.**

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Low-Income Populations and Exchanges

In addition to expanding the Medicaid program uniformly to 133% of the Federal Poverty Level (FPL), the ACA will make new health insurance options available through health insurance exchanges. In the individual market, the exchange-eligible population can be broken down into two groups: persons with incomes above 400 percent FPL; and, low- and moderate-income individuals with incomes between 133 and 400 percent FPL that will receive federal subsidies when purchasing insurance through the exchange.

According to the Congressional Budget Office, two-thirds of individuals purchasing coverage through exchanges will fall into the second group and be eligible to receive subsidies. The American Academy of Actuaries has found that **in every state well over half of the uninsured have incomes below 200 percent FPL** and that between 25 and 30 percent of the uninsured have incomes between 100 and 200 percent FPL.¹

Individuals with incomes below 200 percent FPL, who will comprise a disproportionate number of persons eligible for coverage through the exchanges, have more in common with Medicaid and CHIP populations than with populations commercial insurers typically serve. These individuals have unique social and health care needs that states should consider as they design health insurance exchanges and other coverage options for this population under health care reform. For example:

- Parents at this income level are more likely to have a child enrolled in Medicaid or CHIP.
- Family members may be receiving other Federal or State benefits such as Earned Income Tax Credit (EITC) and Women, Infants, and Children (WIC) benefits.
- Low-income patients are accustomed to receiving care from community-based providers, including safety net health centers, clinics and hospitals.
- Low-income individuals may require or benefit from enhanced services, such as targeted patient education and outreach, case management, or language assistance, such as is provided by managed care organizations serving the Medicaid and CHIP populations currently.
- Even with subsidies, low-income individuals may find it financially challenging to pay premiums and cost sharing under the exchange.
- Low-income adults that will be eligible for health care subsidies for the first time are uninsured at very high rates and have greater health care needs than other uninsured groups.²
- Eleven percent of childless adults with incomes between 100-200% FPL report they are in fair or poor mental health, compared to just 6 percent of childless adults above the poverty line.²
- “Churning” due to income fluctuation will be a major issue for the low-and moderate-income populations. It is estimated that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will.³
- Income fluctuation for low-and moderate-income individuals carries both financial and health care consequences.

The design of the health insurance exchanges and other coverage options must begin with a profound appreciation of the special needs of the low-income population, particularly those under 200% of FPL and as such, health insurance exchanges should be designed and implemented in a manner that addresses these needs or the very success of the exchange could be jeopardized.

1. “Critical Issues in Health Reform –State Characteristics,” American Academy of Actuaries, November 2009. www.actuary.org/pdf/health/state_characteristics_nov09.pdf, accessed January 25, 2011.
2. “Childless Adults Who Become Eligible for Medicaid in 2014 Should Receive Standard Benefits Package,” Center on Budget and Policy Priorities, July 6, 2010, <http://www.cbpp.org/cms/?fa=view&id=3229>, accessed February 11, 2011.
3. “Issues in Health Reform: How Changes In Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges,” Benjamin D. Sommers and Sara Rosenbaum, Health Affairs, February 2011

Basic Health Program

Section 1331 of the Affordable Care Act (ACA) provides states with an option to create a “Basic Health Program” for low-income individuals, in lieu of receiving coverage through the health insurance exchange. For states electing this option, participating individuals would choose a health plan under contract with the state rather than one offered in the insurance exchange. Individuals eligible for the Basic Health Program would not have an option to enroll in the exchange and must enroll in this Basic Health Program to receive subsidized health coverage. As designed, Basic Health participants would receive richer benefits and have lower cost sharing than they would if enrolled in the exchange. **While federal guidance is still under development, the Basic Health Program option is likely to be an ideal alternative to the health insurance exchange for covering low-income individuals.**

ACA establishes the following requirements for the Basic Health Program option.

Eligibility

Individuals with income between 133 and 200 percent FPL who are not eligible for Medicaid and do not have access to affordable employer-sponsored coverage may enroll in the Basic Health Program. Individuals eligible for the Basic Health Program will not be eligible for premium subsidies and reduced cost sharing through the exchange. The Program may not be opened to other groups that do not meet these eligibility requirements.

Benefits and Cost Sharing

The Program would be required to cover, at a minimum, essential health benefits defined under ACA. The level of benefits and limits on cost sharing must at least equate to what individuals would have received had they purchased a Platinum level plan (for individuals with income up to 150 percent FPL) or a Gold level plan (for individuals with incomes between 150 and 200 percent FPL) in the exchange. However, the monthly premium for the Basic Health Program cannot exceed the monthly premium that the eligible individual would have been required to pay if he or she had enrolled in the second lowest cost Silver level plan available through the exchange.

Competition and Choice of Plans

States must establish a competitive procurement process, including negotiating premiums and cost sharing with the health insurers. To the maximum extent feasible, States will need to make available multiple health plans to individuals covered under the Program. In selecting health plans, ACA instructs states to consider:⁴

- (1) Innovative features such as care management and care coordination;
- (2) Incentives for use of preventive services, and establishment of patient /doctor relationships that maximize patient involvement in health care decision-making; and
- (3) Specific performance measures and standards for coverage of providers that focus on quality of care and improved outcomes, in addition to requiring providers to report measures and standards.

Health plans that participate in the Basic Health Program are required to have a medical loss ratio of at least 85 percent.

Financing

A state would receive federal funds to operate the Basic Health Program equal to 95 percent of the cost of the premium and cost-sharing subsidies that would have gone to providing coverage for this group in the exchange (based on the second lowest cost Silver level plan). These funds, combined with the member’s share of the premium, would be used to pay health insurers for the Basic Health Program. Funds transferred by the federal government must be deposited into a trust fund and may only be used to reduce premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in the program. For example, if funds were sufficient, a state could eliminate premiums altogether

4. “The Basic Health Program Option under Federal Reform: Issues for Consumers and States”, Stan Dorn, Urban Institute and State Coverage Initiatives, Robert Wood Johnson Foundation, March, 2011

for the Basic Health enrollees. This would mean real savings for participants who otherwise, if enrolled in the exchange, would be required to contribute between 2 and 6.3 percent of income towards premiums.

Design Approaches

A state would have more flexibility in the benefit design than under Medicaid. Designed properly, a state Basic Health Program could provide more affordable and comprehensive coverage for low-income populations than the health insurance exchange and could also add some finely tuned cost sharing to reduce the cost to the state and encourage appropriate care seeking behavior. While it could offer the Medicaid benefit package with minimal cost sharing, it would be more beneficial to design a plan with income-appropriate co-pays and cost sharing that would steer participants to more cost effective care, such as primary care rather than emergency room care and generic drugs rather than brand name drugs.

Given the income level of participants, the cost sharing should be lower than in the health insurance exchanges, more finely tuned to reduce unnecessary or costly utilization, encourage needed preventive and other care, and avoid the adverse impact of blunt, uniformly applied cost sharing on necessary utilization and health outcomes for low-income populations that has been well documented in the RAND Health Insurance Experiment.⁵ The RAND studies have shown that copayments led to a much larger reduction in the use of medical care by low-income adults and children than by those with higher incomes. RAND also found that copayments led to reductions in medical care that the researchers rated as being “effective,” as well as in care viewed as being “less effective.” The RAND studies found that copayments did not significantly harm the health of middle- and upper-income people but did lead to poorer health for those with low incomes, defined as those under 200% of FPL. Finally, the inability to afford copayments not only had serious health consequences but also led to the use of more expensive forms of medical care. **All of the documented adverse effects of cost-sharing on low-income populations would be far greater in the health insurance exchanges than in a well-designed Basic Health Program.**

Reasons for States to Adopt the Basic Health Program

States and low-income individuals could benefit from the Basic Health Program in a number of very significant ways:

- A state could provide Medicaid, CHIP, and Basic Health coverage through the same community and other managed care plans and keep families together, resulting in greater enrollment, more stable coverage, and fewer coverage gaps.
- The Basic Health Program could smooth out the differences between Medicaid benefits, which generally have very limited cost sharing and no monthly premiums, and the benefits and cost sharing under the health insurance exchange.
- The state could design the benefits to reduce the cost to the state and to tune the benefits to the income and the unique needs of the population.
- The Basic Health Program is especially attractive to States that had previously expanded their Medicaid programs beyond federal minimums and/or developed other publicly subsidized programs for individuals with income above 133 percent FPL.
- Health plans that traditionally serve Medicaid and CHIP are well-qualified to serve Basic Health Program members based on experience, cost, readiness, and knowledge of the population.
- The Basic Health Program can provide a state more leverage in its direct purchase of health coverage because it is buying on behalf of additional covered lives, for example, through its Medicaid program.
- The Basic Health Program would also provide needed support to safety net providers remaining viable by retaining their current low-income patients who may otherwise be forced into commercial plans and networks in the health insurance exchange.

5. “Patient Cost-Sharing and Hospitalization Offsets in the Elderly”, Amitabh Chandra, et al, *The American Economic Review*, March 2010 & “The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment” Joseph P. Newhouse et al, RAND Corporation, R-3055-HHS, December 1984

- If CHIP funding is not extended after 2015, the Basic Health Program is a natural fit to absorb a share of these children with minimum service and care disruption.
- States could invest unused Basic Health Program funds into additional services, including ones that are traditionally funded with state dollars. Under the exchange, by comparison, a State would be required to pay for any additional services not defined under the essential health benefits.

Other Considerations

A number of questions have been raised regarding what impact the implementation of a Basic Health Program would have on the health insurance exchange market and State budgets. Some of those questions are addressed below.

What is the potential risk of States experiencing federal subsidy shortfalls?

Forthcoming federal guidance prescribing the methodology for calculating Basic Health subsidies is critical to ensure that the program is adequately funded. The Urban Institute has begun to examine this issue and found that the Basic Health Program can likely be implemented without additional costs to a state. According to the Urban Institute projections, current Medicaid costs for a non-elderly, non-disabled adult will reach \$3,756 in 2015, while 95 percent of the average subsidy will total \$4,940, based on Congressional Budget Office estimates.⁶ Health and Human Services also will be able to provide solid advanced estimates about the federal payments states would receive if they implement a Basic Health Program. This information should let states enter into contracts with health plans that avoid significant financial risk.

How would the adoption of the Basic Health Plan option affect exchange operations?

The impact of adopting the Basic Health Plan option in a given state will vary, based on state-specific demographics of the uninsured, prevailing market conditions, and the strategic goals and financing plans for the exchange. It is unlikely the Basic Health Program will negatively affect the exchange or make an exchange impractical. In fact, Massachusetts runs a separate, commercial-only exchange, Commonwealth Choice, which has had positive market and consumer impacts with no subsidized coverage at all.

It is not yet clear whether removing Basic Health Program enrollees from the exchange would increase or decrease the risk level of the remaining pool of participants. In the event that the level of risk decreases, it will improve the performance of the exchange for remaining participants. In the event that the level of risk increases, the adverse effects can be ameliorated by risk adjustment provisions in ACA. Further, requirements that health plans rate across the entire individual and small group markets also effectively expand the risk pool in those markets, again subject to risk adjustment. In any event, risk selection poses no barrier to the success of the Basic Health Program.

Summary

The Basic Health Program provides a model opportunity for states to cover low-income populations in a cost effective and culturally sensitive manner. The Basic Health Program will reduce the churn of low income individuals in the health insurance exchanges and will reduce both medical and administrative costs to the state as a result. The Program is a near ideal solution for states that had previously expanded their Medicaid programs beyond federal minimums and/or developed other publicly subsidized programs for individuals with income above 133 percent FPL. The funding and cost reduction potential of the Basic Health Program make it an alternative all states should adopt to cover their low-income population below 200% of the FPL.

6. "State Coverage Initiative Webinar: Basic Health Program," sponsored by Robert Wood Foundation, November 17 2010. www.statecoverage.org/node/2649, accessed January 25, 2011.