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The Basics of the Basic Health Program

How "Basic Health" Could Strengthen Oregon's Health Reform Efforts

By Janet Bauer

Oregon's efforts to extend health coverage to all, particularly to low-income Oregonians, could gain from the establishment of a Basic Health Program ("Basic Health").

An option for states to offer under the federal Affordable Care Act, Basic Health may fill a gap in affordable coverage among low-income Oregonians that likely will exist despite a planned expansion of Medicaid and the creation of a state health insurance marketplace or exchange. Additionally, Basic Health could improve available benefits and help individuals keep their doctors, thereby enhancing the health of low-income Oregonians.

This fact sheet explains what a Basic Health Program is, how it could benefit low-income Oregonians, how it might impact Oregon's health insurance exchange and the state's budget, and why Oregon leaders should commission a feasibility study of a Basic Health Program in Oregon this year.

What is a Basic Health Program? Basic Health is an option states have for providing health coverage to low-income residents. Basic Health, which could start in 2015, would function as an alternative to purchasing individual insurance coverage through Cover Oregon — Oregon's new health insurance exchange.[1] The state would contract with one or more health insurers or providers to offer Basic Health coverage.

Why should Oregon consider Basic Health? Oregon should consider Basic Health because some low-income Oregonians likely will struggle to afford the required health insurance in 2014, even with the help of federal tax subsidies provided through Cover Oregon.[2] A Basic Health Program, offering the prospect of substantially more affordable coverage, has the potential to reach these Oregonians who might otherwise go uninsured.

Who could be covered by Basic Health? Basic Health covers residents under age 65 with incomes less than 200 percent of the federal poverty level (FPL) who are not eligible for Medicaid and cannot obtain job-based health insurance.[3] Because Oregon plans to expand its Medicaid program — the Oregon Health Plan (OHP) — to 138 percent FPL as allowed under federal law, a Basic Health Program in Oregon would primarily cover people with incomes between 138 and 200 percent FPL.[4] The FPL varies by family size. To fall within 138 and 200 percent FLP in 2013, a family of three would earn between $26,951 and $39,060 per year.

Some legal immigrants could also benefit from a Basic Health Program. Under federal law, legal immigrants are ineligible for the state Medicaid program, OHP, for the first five years of U.S. residency. Although those being temporarily barred will be able to purchase insurance in Cover Oregon, the subsidies available may not be enough for many with Medicaid-level incomes. Legal immigrants barred from OHP due to their residency period (as well as those with incomes between 138 and 200 percent FPL) would be eligible for Basic Health.[5]

How many Oregonians would a Basic Health Program cover? The Urban Institute estimates that, based on 2011 population figures, 110,000 Oregonians would be eligible for Basic Health and 72,000 of them would enroll. These figures do not include an estimate of the legal immigrants who would be able to participate.[6]

Is there funding for a Basic Health Program? Yes. Funding for Basic Health would come from the federal subsidies that would otherwise be used through the state's health insurance exchange for the Basic Health population. Oregon would receive 95 percent of the value of those premium tax credits and cost-sharing subsidies.[7]

Would people have a choice between exchange or Basic Health coverage? No. If Oregon offered Basic Health, eligible Oregonians would either use Basic Health coverage or purchase unsubsidized insurance outside the exchange. They would not be able to purchase coverage in the exchange.[8]

What kinds of health services would be offered? By federal law, Basic Health coverage must include the essential health benefits required of all plans in the individual and small group markets inside and outside the exchange, but can include additional services.[9]

Basic Health could potentially offer a broader package of health services than those offered in the exchange. States must have a competitive process for selecting Basic Health plans and must negotiate for favorable benefits. Consequently, Oregon Basic Health benefits would tend to be more comprehensive than benefits in Oregon's health exchange, given that the exchange currently lacks a competitive plan certification process.[10]

The Affordable Care Act's contracting requirements complement Oregon's efforts to improve health care delivery through Coordinated Care Organizations (CCOs). In Basic Health contracting, states must negotiate for innovative approaches to delivery of care, including coordinated care and disease management.[11] Oregon is already implementing such strategies through its contracts with CCOs in the Oregon Health Plan.

The Urban Institute indicates that Basic Health would be able to offer significantly more affordable coverage than plans sold in an exchange

What would Basic Health coverage cost? Oregon would set premium levels for Basic Health, which by federal law cannot be higher than would be charged in the exchange taking the available tax credits into account.[12] Co-payments and other out-of-pocket costs would also be limited.[13] The requirement for states to negotiate with prospective contractors will foster competitively priced plans in Basic Health.

While additional analysis is needed to accurately assess potential enrollee costs, a study by the Urban Institute indicates that a Basic Health Program would be able to offer significantly more affordable coverage than plans sold in an exchange. The institute estimates that the national

average annual premium for a low-income adult purchasing a Medicaid-like benefit package with the federal subsidy in the exchange will cost a consumer $1,218, while in a Basic Health Program the package will cost $100. The Urban Institute also estimates that national average annual additional out-of-pocket costs — such as costs from co-payments — for the same plan would be $434 in a state exchange and $96 in a Basic Health Program.[14]

The Urban Institute also estimates that federal Basic Health Program funding to states would exceed a state's cost of providing Medicaid-like coverage by 23 percent on average nationally.[15] Since states will be permitted to use the additional funds only within Basic Health, the extra resources could be used to improve covered services, lower out-of-pocket costs or increase payments to health service providers.

Could Basic Health reduce disruptions in care caused by changes in eligibility? Basic Health may help make sure that low-income individuals don't go uninsured, lose health services or lose their providers when they are no longer eligible for OHP Medicaid. This is important since low-income individuals are particularly vulnerable to problems associated with switching insurance coverage.[16]

In 2014, when a person's income rises above the Medicaid eligibility level, the individual will be able to shop for private coverage in Oregon's health insurance exchange. Switching between plans raises the risk of being uninsured during the transition. A Basic Health Program, being administered by the same state agency as the Oregon Health Plan, could readily prevent gaps in coverage for low-income Oregonians when their income modestly fluctuates.

Changing to exchange coverage in Oregon could mean a loss of covered services, such as dental care, because the benefit standards for Cover Oregon plans are lower than the benefits in OHP.[17] By making Basic Health benefits nearly or fully as comprehensive as those offered in OHP, the state would minimize disruption of health services for people who become ineligible for OHP when their income rises above Medicaid limits.

Basic Health may be able to improve care for low-income Oregonians by allowing enrollees to stay with their providers when their source of coverage changes

Similarly, Basic Health may be able to improve care for low-income Oregonians by allowing enrollees to stay with their providers when their source of coverage changes. For instance, Oregon could ensure that the array of providers available through Basic Health is the same or very similar to that offered in OHP. Allowing enrollees to stay with providers familiar with their health can improve health outcomes.

Are there other potential benefits for Oregonians? Yes. Basic Health would remove a potential overpayment risk that those who get premium tax credits in the health insurance exchange will face. Individuals getting advanced premium tax credits may end up having to pay some of it back if they underestimate their income and receive a larger advanced credit than it turns out they are eligible for. Under Basic

Health, individuals do not receive tax credits, so they will not face the risk of overpayment.

How would a Basic Health Program impact Oregon's exchange? A Basic Health program in Oregon would impact Cover Oregon by reducing the number and possibly the makeup of Oregonians getting coverage through the exchange. Exactly how this would affect Oregon's exchange is not clear without further analysis. Findings by the Urban Institute, which should be considered preliminary, suggest that the Basic Health population in Oregon will be more expensive to insure than the overall population purchasing individual coverage. If this turns out to be the case, Basic Health in Oregon could mean lower non-group premiums both in the exchange and in the market outside the exchange. Ultimately, how a Basic Health Program would impact exchange premiums will depend on federal and state policy decisions regarding risk pooling among the groups.

Would Basic Health impact Oregon's budget? Basic Health would involve some risk to Oregon's budget, but just how much risk is unknown, absent federal rules on how program payments will be calculated. The risk arises from a federal requirement for states to pay back any advanced Basic Health funds that subsequent review finds are overpayments. Basic Health funds will be advanced to states based on an annual estimate by federal officials of the value of the tax credits and cost-sharing subsidies that would have been used in the exchange over the coming year absent a Basic Health Program. The estimate will be updated at year's end based on actual performance. If Oregon receives more than the revised assessment indicates it should have, the state will need to refund the overpayment. If it receives less, additional federal funds will make up the shortage.

When will federal officials issue guidance on Basic Health? For states to set up a Basic Health Program with confidence, the federal Center on Medicare and Medicaid Services (CMS) must establish how it will implement the Basic Health provisions of the Affordable Care Act, including how it will calculate the Basic Health payments to states. CMS has indicated it will issue proposed rules in 2013 and final guidance in 2014, so that programs can begin by 2015.[18]

Basic Health will have a bargaining advantage over exchange co-ops because it will have an assured number of enrollees

Would a co-op plan make a Basic Health Program unnecessary? Several newly-forming health co-ops in Oregon aim to offer affordable plans through Cover Oregon.[19] It's unclear how the cost of such plans will compare to that of Basic Health, though Basic Health will have a bargaining advantage because it will have an assured number of enrollees. The co-ops, however, will compete with other plans for members. As an interim step, since Basic Health cannot begin earlier than a year after the exchange opens, Oregon could assess affordability in the exchange in 2014 and the need for more affordable options for low-income Oregonians.

How can Oregon evaluate the feasibility of a Basic Health Program? To more accurately evaluate the feasibility and potential impact of a Basic Health Program, Oregon needs an econometric analysis that takes into account Oregon's unique health care system and marketplace. In addition to estimating federal Basic Health funding, premium levels and impact on Oregon's exchange, a study could assess factors such as the impact on provider payments and feasibility of delivering Basic Health coverage through Oregon's CCO structure.

A study commissioned in 2013 to assess the feasibility of a Basic Health Program in Oregon is warranted given the potential the option holds for extending affordable health coverage to thousands of low-income Oregonians and improving the quality of their care starting in 2015.

A study of a Basic Health Program in Oregon is warranted given its potential for extending affordable health coverage to thousands of low-income Oregonians

Conclusion

Basic Health could fill a gap in affordable coverage among low-income Oregonians that likely will exist despite a planned expansion of Medicaid and the creation of a state health insurance exchange. To enable sound decision-making about this option, Oregon ought to commission a study to explore the feasibility of a Basic Health Program in Oregon.

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Endnotes

[1] Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148, Section 1331.

[2] Bacharach, Deborah, Melinda Dutton, *The Role of the Basic Health Program in the Coverage Continuum: Opportunities, Risks, and Considerations for States,* The Henry J. Kaiser Family Foundation, March 2012, http://www.kff.org/healthreform/upload/8283.pdf.

[3] Basic Health participants cannot be eligible for Medicaid or CHIP. CHIP is a Medicaid-like program for children with income just above Medicaid eligibility levels and up to 200 percent FPL in Oregon.

[4] Oregon's Medicaid program, Oregon Health Plan, covers adults with incomes up to 100 percent FPL. Participation is limited. The Affordable Care Act allows states to expand Medicaid up to 133 percent FPL. Since five percentage points of income are disregarded under the law, the effective income limit for the Medicaid expansion is 138 percent FPL.

[5] Undocumented immigrants are not eligible for Medicaid and would not be eligible for Basic Health.

[6] Dorn, Stan; Matthew Buettgens; Caitlin Carroll. *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States,* The Urban Institute, September 2011, http://www.urban.org/UploadedPDF/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households.pdf. OCPP email communication with Matthew Buettgens on February 19, 2013 clarified that earlier modeling by the Urban Institute resulting in somewhat different state figures published in March 2011 has been subsequently updated in the study cited here.

[7] Details about how program payments to states will be calculated have yet to be established by CMS, including whether the calculation is based on estimated enrollment of the eligible group in the exchange or on expected enrollment in a Basic Health Program, figures that are affected by plan affordability.

[8] Affordable Care Act Section (e)(2).

[9] Affordable Care Act, Section 1331(a)(2)B and 1302(b). Under the Affordable Care Act, plans in the individual and small group markets, whether inside an exchange or outside, must include Essential Health Benefits (EHB) services in these categories: emergency services, hospitalization, out-patient care, preventive and wellness care and chronic disease management, rehabilitative and habilitative services and devices, prescription drugs, laboratory services, maternity and newborn care, pediatric care including vision and oral care, and mental health and substance use disorder services.

[10] Affordable Care Act, Section 1331(c)(1).

[11] Affordable Care Act, Section 1331(c)(2)(A).

[12] Affordable Care Act, Section 1331(a)(2)A.

[13] Affordable Care Act, Section 1331(a)(2)A(ii). Basic Health plans must pay at least 90 percent of the cost of services, on average, for people with income below 150 percent FPL and at least 80 percent of the cost of services, on average, for people with income between 150 and 200 percent FPL.

[14] Dorn, Stan; Matthew Buettgens; Caitlin Carroll. *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States,* The Urban Institute, September 2011. A Medicaid benefit package with CHIP-level cost-sharing was assumed. The study, whose state-level findings should be considered preliminary, found that an average annual adult premium through an Oregon exchange would cost $1,181 and through an Oregon Basic Health Program $100. Estimated average annual out-of-pocket costs through an Oregon exchange were $548, and $112 through Basic Health.

[15] Ibid. Modeling showed federal Basic Health Program funding exceeding Oregon's cost to operate a Basic Health program by 24 percent.

[16] Research shows that family income fluctuates frequently across what will be the new Medicaid income eligibility threshold of 138 percent FPL. Changes in income are found to be more common at that level than at 200 percent FPL — the upper eligibility threshold of a Basic Health Program. Also relevant is that low-income individuals have a harder time shouldering costs for services not covered than those with higher incomes. Sommers, Benjamin D; Sara Rosenbaum. *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges,* Health Affairs, 30:2, February 2011. Study found that 50 percent of individuals with incomes below 200 percent FPL would change eligibility within 12 months with an effective Medicaid income limit of 138 percent FPL. Also, Buettgans, Matthew; Austin Nichols and Stan Dorn. *Churning Under the ACA and State Policy Options for Mitigation,* Urban Institute, June 2012. http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf. Study found income fluctuations were 16 percent lower across a 200 percent FPL threshold than one at 138 percent FPL.

[17] By federal law, starting in 2014, all health plans must offer an essential health benefit (EHB) package as defined by the state according to federal guidelines. Oregon's proposed EHB plan does not include some services that will be available to newly-eligible individuals in OHP in 2014. Services not in the EHB package but covered under OHP include, but are not limited to, adult dental, private duty nursing and non-urgent medical transportation. http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-oregon.pdf; https://apps.state.or.us/Forms/Served/he9035.pdf.

[18] United States Department of Health and Human Services, *Questions and Answers: Medicaid and the Affordable Care Act,* February 2013, http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf

[19] *Oregon's Health CO-OP* and *Freelancer's CO-OP of Oregon* plan to offer coverage through Cover Oregon in 2014. http://www.orhealthco-op.org/about-us/; http://www.thelundreport.org/resource/freelancers_co_op_of_oregon_selects_dawn_bonder_as_executive_director