REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-12)
Basic Health Program
(Reference Committee A)

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA, PL 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, PL 111-152) provides states with the option to cover a segment of the population eligible for premium credits and cost-sharing subsidies (i.e., uninsured low-income individuals and families with household incomes that exceed 133 percent of FPL but do not exceed 200 percent of FPL) through an alternate mechanism: a Basic Health Program (BHP). Starting in 2014, states have the option to cover this population in a state-based BHP, which would make these individuals and families no longer eligible for premium tax credits and cost-sharing subsidies for subsidized coverage in health insurance exchanges.

Since the enactment of the ACA, the US Department of Health and Human Services and the states have been taking steps to implement the provisions of the law related to the BHP. In these processes, key issues associated with the BHP have emerged that merit further consideration regarding potential effects on patient care, physician payment and practice, and the patient-physician relationship. This report provides a summary of legislative and regulatory activity pertaining to the BHP; outlines relevant American Medical Association (AMA) policy; highlights the potential impact of BHPs; and discusses continuous eligibility as it relates to Medicaid, the Children's Health Insurance Program (CHIP) and health insurance exchanges.

While the AMA has advocated that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, the Council is concerned that the establishment of BHPs in states will decrease the number of individuals and families receiving premium tax credits and cost-sharing subsidies to purchase coverage through health insurance exchanges. Also, the Council believes that before states establish BHPs, and while BHPs operate on the state level, that the program's impact on the viability and purchasing power of state health insurance exchanges should be assessed.

State BHPs ultimately should ensure patient choice of health plan and physician. In implementing a BHP, the Council finds it especially critical that the goals of longstanding AMA policy be followed addressing network adequacy and opposition to mandatory physician participation in health plans. Also, in states that establish a BHP, physicians will have to be involved in the implementation process, especially with regard to physician payment, continuity of care for their patients, the means through which the program achieves network adequacy, and quality.

States have several options at their disposal to limit patient churn between public programs and private plans, including establishing a BHP for individuals between 133 and 200 percent of FPL. The Council believes that instituting 12-month continuous eligibility across Medicaid, CHIP and the exchange would be an effective mechanism to address churn. Instituting continuous eligibility ensures that individuals and families have 12 months of continuous coverage in the plans regardless of changes in income and without having to reapply for coverage for a year. As a result, the need for a BHP to limit churn may be diminished. The Council reiterates its belief that as patients cycle through various eligibility levels over time, physicians will need to have real-time information regarding what coverage a patient currently has.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-12

Subject: Basic Health Program

Presented by: Thomas E. Sullivan, MD, Chair

Referred to: Reference Committee A
(Thomas J. Madejski, MD, Chair)

Consistent with American Medical Association (AMA) policy in support of health insurance exchanges and providing refundable and advanceable tax credits inversely related to income, the Patient Protection and Affordable Care Act (ACA, PL 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, PL 111-152) calls for the establishment of state health insurance exchanges through which individuals and families can obtain health insurance coverage. Individuals and families with incomes between 133 and 400 percent of the federal poverty level (FPL) are eligible to receive premium tax credits and cost-sharing subsidies to subsidize the cost of coverage purchased in health insurance exchanges.

However, the ACA also provides states with the option to cover a segment of the population eligible for premium credits and cost-sharing subsidies (i.e., uninsured low-income individuals and families with household incomes that exceed 133 percent of FPL but do not exceed 200 percent of FPL) through an alternate mechanism: a Basic Health Program (BHP). Starting in 2014, states have the option to cover this population in a state-based BHP, which would make these individuals and families no longer eligible for premium tax credits and cost-sharing subsidies for subsidized coverage in health insurance exchanges.

Since the enactment of the ACA, the US Department of Health and Human Services (HHS) and the states have been taking steps to implement the provisions of the law related to the BHP. In these processes, key issues associated with the BHP have emerged that merit further consideration regarding potential effects on patient care, physician payment and practice, and the patient-physician relationship. This report provides a summary of legislative and regulatory activity pertaining to the BHP; outlines relevant AMA policy; highlights the potential impact of BHPs; discusses continuous eligibility as it relates to Medicaid, the Children's Health Insurance Program (CHIP) and health insurance exchanges; and presents policy recommendations.

LEGISLATIVE AND REGULATORY ACTIVITY

The ACA gives states the option to establish a BHP starting in 2014 to cover uninsured low-income individuals and families with household incomes that exceed 133 percent of the FPL—the income threshold for Medicaid eligibility—but do not exceed 200 percent of FPL. A state BHP also would cover lawfully present immigrants who are ineligible for Medicaid coverage and have incomes that do not exceed 133 percent FPL. Such immigrants include those who have been lawfully present in the United States for less than five years.

There is the potential for a state BHP to cover additional populations, depending on congressional or state actions. For example, children with household incomes between 133 and 200 percent FPL

who currently receive coverage under CHIP could become eligible for BHP coverage if Congress does not fund CHIP beyond 2015. Additional children could become eligible for BHP coverage if Congress changes the current maintenance-of-effort requirements for Medicaid and CHIP. There have also been discussions to shift other Medicaid-eligible adults into BHP coverage if their incomes are above 133 percent FPL but do not exceed 200 percent FPL, including pregnant women, the medically needy and individuals with HIV/AIDS.

If a state elects to implement a BHP, then populations eligible for BHP coverage would not be eligible to receive premium tax credits and cost-sharing subsidies for subsidized coverage in the exchange. Instead, state BHPs would receive 95 percent of what the federal government would have otherwise spent on premium tax credits and cost-sharing subsidies for this population for coverage purchased in the exchange.

Impact of BHP on Eligibility for Coverage in the Individual Market

	Without BHP	With BHP
Up to 133% FPL	Medicaid Coverage	Medicaid Coverage
Above 133% FPL, up to 200% FPL	Exchange coverage, subsidized with premium tax credits and cost-sharing subsidies	BHP Coverage
Between 200% and 400% FPL	Exchange coverage, subsidized with premium tax credits and cost-sharing subsidies	Exchange coverage, subsidized with premium tax credits and cost-sharing subsidies

* The above chart excludes the coverage by a BHP of lawfully present immigrants who are ineligible for Medicaid coverage and have incomes that do not exceed 133 percent FPL.

To operate a BHP, a state would contract with health maintenance organizations, health insurers or networks of health care providers to provide at least the essential health benefits package required by the ACA to BHP enrollees. Premiums under a BHP cannot exceed the premium of the silver plan in the exchange—a plan with an actuarial value of 70 percent that provides the essential health benefits package—with the second-lowest cost. This helps to ensure that BHP enrollees pay no more in premiums than they otherwise would have paid in the exchange. There are also cost-sharing limits for BHP enrollees. The ACA also requires states "to the maximum extent feasible" to offer multiple health plans under BHP, referred to as "standard health plans," to ensure health plan choice.

The AMA has already been involved in the regulatory process to implement the provision of the ACA concerning the BHP. In October 2011, the AMA provided comments in response to a request for information by the Centers for Medicare and Medicaid Services, regarding state flexibility to establish a BHP under the ACA. In its comments, the AMA highlighted the key issues for physicians and patients pertaining to the BHP, including the impact of BHPs on the viability of state health insurance exchanges, health plan choice for patients, network adequacy, physician payment, and physician and consumer protections. HHS is expected to issue additional rules and guidance on the BHP in the coming months.

RELEVANT AMA POLICY

The AMA proposal for expanding coverage advocates providing individuals with refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits. These individual tax credits would allow patients to purchase coverage of their own choosing (Policies H-165.920[3] and H-165.865, AMA Policy Database).

In addition, the AMA has long advocated for tax credits over public sector expansions as a means of providing coverage to the uninsured (Policy H-165.920[14]).

However, the AMA has advocated that state governments be given the freedom to develop and test different models for improving coverage with patients with low incomes (Policy D-165.966). The AMA also has supported eligibility expansions of Medicaid with the goal of improving access to health care coverage to otherwise uninsured groups (Policies H-290.974 and H-290.986), and specifically supports the elimination of categorical requirements and implementation of uniform eligibility for all persons below the poverty level (Policy H-290.997). AMA policy supports physician participation in the Medicaid program to ensure access to care (Policy H-290.982[12]). The AMA supports Medicaid payment for physician providers to be at minimum 100 percent of the RBRVS Medicare allowable (Policy H-385.921), and advocates allowing physicians to tax defer a specified percentage of their Medicaid income (Policy H-290.982[12]). Of note, AMA policy states that the medical care portion of the Medicaid program should be financed with federally issued tax credits to allow acute care patients to purchase individual coverage (Policy H-165.855[1]). Council on Medical Service Report 1-A-12 proposes modifications to this policy.

AMA policy also supports the general concept of creating a health insurance exchange, and advocates principles for the operation of health insurance exchanges (Policy H-165.839). Council on Medical Service Report 6-I-11 established additional policy addressing health insurance exchanges, including advocating that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. Policy H-165.838 states that insurance coverage options offered in a health insurance exchange should be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollee access to out-of-network physicians.

POTENTIAL IMPACT OF A BASIC HEALTH PROGRAM

A number of states are considering creating a BHP. Although federal guidance and regulations on the BHP are forthcoming, states have considerable latitude as to how they construct and design their BHPs. Options currently available to states include establishing a stand-alone BHP to offer coverage similar to Medicaid, combining funding from BHP, Medicaid and CHIP to create a single program for all low-income individuals, and allowing BHP enrollees to choose between coverage similar to Medicaid or private health plans that are also offered in the exchange. Different designs of BHPs will impact patients differently. Offering coverage similar to Medicaid in a stand-alone BHP or a program combined with Medicaid and CHIP would likely offer BHP enrollees cost savings when compared to what they would have paid for subsidized coverage in the exchange. However, this cost savings would likely be at the expense of physician and health plan choice. How states choose to design their BHPs also will determine how the programs will impact patient churn. A stand-alone BHP program would add another level of churn between Medicaid and the exchange, whereas a BHP as part of a single program for all low-income individuals would raise the income threshold at which churn would become more likely from 133 to 200 percent of FPL. Similarly, the issues physicians will face in BHP implementation will vary based on BHP design. Low physician payment levels and the possibility of mandating physician participation in BHPs are possible provisions impacting physicians.

The establishment of a BHP in a state will also affect the size and risk profile of its exchange. The Urban Institute estimates that implementing BHPs would cause the percentage of nonelderly individuals receiving individual coverage in the exchange to decrease from 6.5 to 5.1 percent. In

its examination of both the small group and individual markets of the exchange, the Urban Institute projects that the percentage of individuals covered would fall from 9.8 to 8.2 percent. It has also been projected that a BHP would reduce the population that receives subsidies in the health insurance exchange by approximately half.

With respect to the impact of BHPs on exchange risk levels, the Urban Institute projects that adults eligible for BHP would have on average lower health care costs than other adults in the individual market. Therefore, establishing a BHP could take younger, less costly individuals out of the individual market risk pool, which includes the exchange. This estimate would not be applicable if states choose to shift other Medicaid-eligible adults with incomes eligible for BHP into the program, including women with breast or cervical cancer, individuals with tuberculosis and the medically needy. The Council notes that having a less healthy risk pool in the individual market could affect exchange viability and health plan premiums.

Establishing a BHP also may be advantageous to state budgets. Projections by the Urban Institute, Milliman and other entities find that federal BHP payments will exceed baseline costs of providing individuals eligible for the BHP coverage similar to Medicaid and CHIP. States can achieve savings by shifting adults from Medicaid, a program jointly funded by the federal government and the states, to BHP, which is entirely federally financed. States are weighing these potential cost savings with the estimated rise in premiums in their health insurance exchanges.

The Council recognizes that some states may be looking to establish a BHP as a way to limit patient churn between Medicaid and exchange plans. It has been projected that half of all adults with family incomes below 200 percent of FPL (28 million individuals) will cycle between Medicaid and an exchange plan due to income fluctuations within a year. In addition, 24 percent are projected to have at least two eligibility changes within a year (Sommers and Rosenbaum, February 2011). The Council has previously noted that the issue of patient churn is one of the most important issues physicians and patients will face once health insurance exchanges become operational and the Medicaid expansion is fully implemented. If not effectively addressed, patient churn could significantly impact the continuity and quality of care of these patients. For physicians, patients churning between plans could impact the ability of physicians to receive payment for the care and services provided, especially if patients churn from one plan in which a physician participates to another plan in which a physician does not.

If a BHP is established in a state, it would effectively raise the income threshold at which churn would become more likely between public programs and private plans to 200 percent of FPL from 133 percent of FPL. Supporters of the BHP have argued that at that income level, it is expected that the overall amount of churn would be lower, since income volatility decreases as income increases. However, Graves, Curtis and Gruber (November 2011) noted that a BHP operating within Medicaid would cause a higher level of churning between a BHP and the health insurance exchange at 200 percent of FPL than there otherwise would have been at 133 percent of FPL. As a result, they found that there would be more overall churning with a BHP in place than otherwise would have taken place under the standard structure of the ACA. In addition, a high level of churning at the 200 percent FPL threshold between a BHP and an exchange plan raises further concerns, because individuals churning at this level would experience more significant changes in the premiums and cost-sharing. Differences between estimates of churning at the 200 percent of FPL threshold may be due to how or whether affordable offers of employer-sponsored coverage are factored into the projections.

ENSURING CONTINUITY OF CARE AND LIMITING PATIENT CHURN

Less than half of state Medicaid and CHIP programs have used 12-month continuous eligibility for child beneficiaries, which would provide 12 months of continuous coverage for children in the programs regardless of changes in income and without having to reapply for coverage for a year. These state policies ensuring continuous eligibility for children will remain through 2019, as the ACA's maintenance-of-effort requirement stipulates that states must not further restrict the eligibility standards, methodologies and procedures that were in effect at the time the ACA was enacted into law.

Analyses of continuous eligibility have shown that such provisions promote continuity of care for patients and prevent disruptions in health insurance coverage, resulting in improved access to care and health outcomes. One of the most notable effects of continuous eligibility provisions is that they limit administrative costs pertaining to the coverage of these populations. With continuous eligibility, state administrative resources can be used more efficiently because resources do not have to be highly dedicated to frequent public program disenrollments and reenrollments. As a result, the idea of guaranteeing a full year of coverage for Medicaid, CHIP and exchange plans is garnering increased support as a leading approach to limit patient churn and ensure continuity of care.

The Council notes that there is a pathway through which continuous eligibility could be ensured for Medicaid, CHIP and exchange plans. The ACA requires that qualified health plans that offer coverage options in health insurance exchanges must have annual enrollment periods during which individuals can enroll or change plans. The HHS final rule in March 2012 addressing the establishment of exchanges and qualified health plans put forward an annual redetermination process for premium subsidies. Likewise, the final rule issued by HHS in March 2012 addressing Medicaid eligibility changes recommended that states adopt at least annual redetermination processes. Therefore, analysts note that continuous eligibility could tie all of these processes together and ensure that most coverage changes would occur between calendar years. As a result, it is expected that enrollment changes that take place during the year would be minimized.

The Council also notes that continuous eligibility for individuals enrolled in Medicaid, CHIP and exchange plans could be achieved through legislative or regulatory avenues. While states still have the option to provide 12-month continuous eligibility for children in Medicaid and CHIP, they do not have the same option for adults. Therefore, there is support for legislation to require 12 months of continuous eligibility for all Medicaid and CHIP enrollees, while others cite a Section 1115 waiver as an avenue through which states could provide continuous eligibility for parents and other adults. Additional federal legislative or regulatory activity would be necessary to permit states to allow for 12 months of continuous eligibility for exchange plans.

DISCUSSION

The AMA has a pivotal role moving forward during the regulatory process addressing the mechanisms through which individuals and families will become covered under the ACA. Many aspects and specifics of the BHP will be determined in this process, with the possibility that additional guidance will be developed concerning states being able to implement continuous eligibility for all Medicaid and CHIP enrollees. Following the enactment of the ACA, it has become apparent that several key issues related to BHP establishment and operation have the potential to impact the continuity and quality of patient care, physician practice and the patient-physician relationship.

While the AMA has advocated that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, the Council is concerned that the establishment of BHPs in states will decrease the number of individuals and families that will receive premium tax credits and cost-sharing subsidies to purchase coverage through health insurance exchanges. Before states establish BHPs, and while BHPs operate on the state level, the program's impact on the viability and purchasing power of state health insurance exchanges should be assessed.

As states move forward in considering establishing BHPs, the Council believes that it is critical for state medical associations to be involved in state-level discussions in the legislative and regulatory arenas concerning BHPs. In states that establish a BHP, physicians will have to be involved in the implementation process, especially with regard to physician payment, continuity of care for their patients, the means through which the program achieves network adequacy, and quality.

State BHPs ultimately should guarantee ample health plan choice and ensure that patient choice of health plan and physician be preserved. Before patients enroll in standard health plan options offered by state BHPs, it will be essential for them to know the health plans in which their physicians are participating. In such an environment, the Council finds it especially critical that the goals of longstanding AMA policy be followed addressing network adequacy and opposition to mandatory physician participation in health plans.

Regardless of how states choose to structure their BHPs, the Council believes that outreach and educational efforts will be essential to ensure that stakeholders, such as physicians and patients, are aware of the program and how it operates, so a smooth transition can be assured when state BHPs become operational. For physicians, additional knowledge about the program will lead to decisions regarding whether to enter into meaningful negotiations and contracts with the standard health plans offered under BHPs.

The Council believes that the issue of patient churn needs to be effectively addressed by the states and the federal government during the process of implementing the ACA. While the Council recognizes that states have several options at their disposal to limit patient churn between public programs and private plans, including establishing a BHP for individuals between 133 and 200 percent of FPL, the Council believes that instituting 12-month continuous eligibility across Medicaid, CHIP and the exchange would be an effective mechanism to address churn. Instituting continuous eligibility ensures that individuals and families have 12 months of continuous coverage in the plans regardless of changes in income and without having to reapply for coverage for a year. As a result, the need for a BHP to limit churn may be diminished. The Council reiterates its belief that as patients cycle through various eligibility levels over time, physicians will need to have real-time information regarding what coverage a patient currently has.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote the continuity and coordination of patient care. (New HOD Policy)

2. That our AMA adopt the following principles for the establishment and operation of state Basic Health Programs:

   a) State Basic Health Programs (BHPs) should guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals. Standard health plans offered within a BHP should provide an array of choices in terms of benefits covered, cost-sharing levels, and other features.
   b) Standard health plans offered under state BHPs should offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region.
   c) Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts.
   d) State BHPs should not require provider participation, including as a condition of licensure.
   e) Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment.
   f) State medical associations should be involved in the legislative and regulatory processes concerning state BHPs.
   g) State BHPs should conduct outreach and educational efforts directed toward physicians and their patients, with adequate support available to assist physicians with the implementation process. (New HOD Policy)

Fiscal Note: Less than $500.

References are available from the AMA Division of Socioeconomic Policy Development.