



OLR RESEARCH REPORT

January 26, 2012

2012-R-0048

BASIC HEALTH PROGRAM

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You asked for information about the Basic Health Program, an optional state health insurance program for low-income individuals who do not qualify for Medicaid established in the Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152). Specifically, you requested (1) a summary of the program's provisions in the federal law, (2) how the benefits offered under it fit with the ACA's essential health benefits, and (3) whether the program could be considered one of the plans available in the state's health insurance exchange.

For a detailed summary of the insurance-related provisions in the ACA, see OLR Report [2010-R-0255](#).

SUMMARY

The ACA established the Basic Health Program (BHP) that, beginning in 2014, allows states to offer subsidized health insurance coverage to low-income individuals who are ineligible for Medicaid. If a state elects to offer BHP coverage, consumers meeting the program's eligibility would not have the option of getting their coverage through a state's health insurance exchange. Consequently, they would not be eligible for the ACA's premium subsidies or tax credits, which are available to people who purchase their coverage through an exchange. (States are expected to create exchanges and Connecticut has done so in [PA 11-58](#)).

States that offer BHP coverage must purchase it through contracts with individual providers or health plans. To offset the state's costs, the federal government provides 95% of what it would have spent on tax credits and subsidies for out-of-pocket costs had these individuals purchased their insurance through an exchange.

The benefits available under a state BHP plan must be at least as rich as those in the essential health benefits (see OLR Report [2012-R-0022](#) for a summary of what these benefits include). But a state's BHP can be more generous.

Because a BHP plan replaces any benefits that might be available to individuals in a state's exchange, it would not be an exchange plan, but rather, an alternative to one.

PA 11-58 directs the Sustinet Health Care Cabinet to advise the governor and the Office of Health Reform and Innovation on developing an integrated health care system for Connecticut, including the feasibility of implementing the BHP.

BASIC HEALTH PROGRAM (BHP)

The ACA requires the secretary of the U.S. Department of Health and Human Services (HHS) to establish a Basic Health Program under which a state may enter into contracts to offer one or more "standard health plans." Individuals participating in the BHP are ineligible for coverage through a state's exchange. By law, a standard health plan provides at least the essential benefits package and, when that coverage is offered by a health insurance issuer (e.g., HMO), it must have a medical loss ratio of at least 85%. (This generally means that the insurer must spend at least 85% of enrollee premiums on direct health care services.)

Eligibility

If a state elects to have a BHP, it must be made available to individuals who:

1. are ineligible for Medicaid;
2. are under age 65;
3. have household income between 133% and 200% of the FPL (for a family of three in 2012, this would be income between \$25,390 and \$38,180) or if a qualified alien (in U.S. legally but for less than five years), have income up to 133% of the FPL; and

4. are ineligible for “minimum essential coverage” or cannot afford their employer’s coverage.

“Minimum essential coverage” can include government-sponsored health care (e.g., Medicaid); employer-sponsored coverage; individual market plans; a grandfathered health plan; or “other coverage”, such as a state health benefits risk pool.

An family’s employer sponsored-coverage is considered unaffordable if it costs more than 9.5% of family income and the insurance has an actuarial value (AV) of less than 60% (i.e., the consumer must pay more than 40% of his or her health care expenses through a combination of premiums, deductibles, and coinsurance) (26 USC § 5000A (f) and 42 USC § 18051 (e)).

Cost Sharing

The ACA provides that a BHP plan’s monthly premium for an individual enrollee and the individual’s dependents may not exceed the premium amount that the individual would have to pay had he or she enrolled in “the applicable second-lowest-cost silver plan” offered by a state exchange. (In a silver level plan, the plan covers 70% of the AV of the essential health benefit.)

The law further caps overall cost sharing. For someone with income up to 150% of the FPL (currently \$28,635 for a family of three), total cost sharing may not exceed the cost sharing for someone enrolled in a “platinum” plan, which covers 90% of the AV of the essential health benefits. For someone with a higher income, total cost sharing cannot exceed that required under a “gold” plan (which covers 80% of the AV (42 USC § 18051(a)(2)).

Benefit Delivery and Coordination

The ACA requires a state’s BHP to establish a competitive process for contracting with health plans, including negotiating premiums, cost sharing, and benefits that go above and beyond the essential benefits.

The law requires states, when negotiating with potential health plan “offerors,” to include innovative features, including (1) providing care coordination and care management, especially for individuals with chronic conditions; (2) offering incentives for using preventive services; and (3) establishing relationships between providers and patients that maximize patient involvement in decision-making.

States must also:

1. consider and make suitable allowances for differences in (a) enrollees' health care needs and (b) local availability of, and access to, providers;
2. contract with managed care systems or systems that offer attributes of managed care that are feasible in the local health care market; and
3. establish performance measures that focus on care quality and require the contractors to report to the state on the measures and make the information available to enrollees.

To the extent possible, states implementing a BHP must make multiple standard health plans available to individuals to ensure choice. They must coordinate the administration of BHP benefits with benefits provided under Medicaid (HUSKY A, C, and D in Connecticut), the State Children's Health Insurance Program (HUSKY B in Connecticut), and other state-administered health programs (e.g., Charter Oak Health Plan) to maximize program efficiency and improve continuity of care (42 USC § 18051 (c)).

Funding

The ACA requires the HHS secretary to transfer funds to states that operate BHP standard health plans. The amount transferred equals 95% of the premium tax credits and cost sharing reductions that the federal government would have spent if BHP enrollees had received tax credits and subsidies for out-of-pocket costs through the exchange.

States must establish special trust funds to deposit the federal funds. These funds can be used only to reduce the premiums and cost sharing, or to provide additional benefits for individuals enrolled in standard health plans. No trust fund money can be included in determining the amount of any non-federal funds for purposes of a state meeting any federally funded program's matching or expenditure requirement (42 USC § 18051(d)).

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