AMA
AMERICAN MEDICAL ASSOCIATION

Improving the Health Insurance Marketplace

Basic Health Program

The American Medical Association believes that the issue of patient churn—patients cycling between coverage offered by Medicaid, Children's Health Insurance Program (CHIP) and private health plans participating in health insurance exchanges—needs to be effectively addressed by the states and the federal government during the process of implementing the Patient Protection and Affordable Care Act. The AMA recognizes that states have several options at their disposal to limit patient churn between public programs and private plans. The AMA supports the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit patient churn and promote the continuity and coordination of patient care. States may also consider establishing a Basic Health Program (BHP); however, its impact on patient churn is not yet clear.

For states that choose to establish BHPs, the AMA believes that state BHPs should:

- Guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals.
- Offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region.
- Include physician payment rates established through meaningful negotiations and contracts.

The American Medical Association (AMA) has advocated that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes. Resulting from the enactment of the Patient Protection and Affordable Care Act (ACA), states have an additional option at their disposal to cover low-income individuals who are not eligible for Medicaid coverage: establishing a Basic Health Program (BHP). Establishing a state BHP can impact patient care, physician payment and practice, and the patient-physician relationship.

Patient Protection and Affordable Care Act provisions

- The ACA gives states the option to establish a BHP to cover uninsured low-income individuals and families with household incomes that exceed 133 percent of the federal poverty level (FPL)—the income threshold for Medicaid eligibility in those states that choose to implement the ACA's Medicaid expansion—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.

- States have had the ability to implement the BHP since 2015.

- 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.

- 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 second-lowest cost silver plan in the exchange—a plan with an actuarial value of 70 percent that provides the essential health benefits package. 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.

(Continued on page 2)

- 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 that enrollees have a choice of health plans.

Alternatives to establishing a Basic Health Program

The AMA believes that the issue of patient churn between public programs and private health plans is one of the most challenging issues physicians and patients face with the implementation of health insurance exchange and Medicaid expansion. While some states may consider establishing a BHP as a way to limit patient churn between Medicaid and exchange plans, there is not a consensus as to the impact of BHPs on patient churn. Some studies show that the overall amount of churn would be lower with a BHP in place. Other studies have suggested that more churning may occur with a BHP in place. States have options at their disposal to limit patient churn between public programs and private plans, including:

- Instituting 12-month continuous eligibility across Medicaid, the Children's Health Insurance Program and exchange plans. 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.

- Purchasing qualifying health plan coverage offered through health insurance exchanges for their Medicaid beneficiaries. This alternative, outlined by HHS, would enable Medicaid beneficiaries to keep their health plan and physicians, even if their incomes increase to a level at which they are no longer eligible for Medicaid coverage.

- Allowing "bridge plans" to operate in health insurance exchanges. Under this option, HHS has outlined that a state could allow a health insurance issuer that also contracts with the state Medicaid agency to offer QHPs in the health insurance exchange to certain populations.

Strategies to foster healthy markets

The AMA believes that instituting 12-month continuous eligibility across Medicaid, the Children's Health Insurance Program and the exchange would be an effective mechanism to address churning between public programs and private health plans, as well as promote the continuity of care for patients. However, for states that choose to establish a BHP, the AMA supports the following guidelines:

- State 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.

- 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.

- Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts.

- State BHPs should not require provider participation, including as a condition of licensure.

- Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment.

- State medical associations should be involved in the legislative and regulatory processes concerning state BHPs.

- 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.

Visit ama-assn.org/go/marketreforms to view additional pieces in this series

KED:15-0662:PDF:12/15:ST