

Revisiting the Basic Health Program

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Introduction

State policymakers are focused on increasing access to and affordability of health care coverage—especially in light of the COVID-19 pandemic and the priorities of the new Biden-Harris administration. Recently, state interest has turned to introducing new state-sponsored coverage and adopting the Affordable Care Act (ACA) Basic Health Program (BHP) option.

The BHP is an option, established under [Section 1331 of the ACA](#), that allows states to establish a coverage program for individuals with household income under 200 percent of the federal poverty level (FPL) with federal financial support. To date, BHPs have been established in New York and Minnesota. Both states have seen significant BHP enrollment, due in large part to low consumer premiums and cost-sharing compared with the Marketplace, leading other states to look to the program as a possible strategy to meet their affordability goals.

In particular, the BHP may be attractive for states that are seeking to:

- Address continued affordability concerns, particularly for low-income state residents (e.g., those with a household income up to 200 percent of the FPL), that have been difficult to alleviate in the Marketplace
- Confront health equity and access issues by offering a high-value, state-designed program for low-income residents with reduced out-of-pocket costs
- Provide smooth transition points between coverage programs
- Increase state purchasing power across Medicaid and Marketplace programs
- Obtain access to dedicated federal funding under Section 1331 to support the implementation of a tailored state program

States—both those with existing BHPs and those interested in implementing a BHP—are also interested in expanding eligibility beyond the current 138 percent to 200 percent FPL population. This could be accomplished through statutory reforms to Section 1331 of the ACA, through a Section 1332 waiver, and/or by establishing a buy-in program to allow residents to purchase low-cost BHP coverage.

This brief provides a refresher on the BHP structure as outlined in the ACA, lessons learned from the two states that have implemented the program to date, and considerations for further evolution of the program under legislative or executive action.

Program Refresher and Implementation Considerations

Eligibility. Under Section 1331, states can implement a BHP for individuals whose household income is between 138 percent and 200 percent of the FPL and who would otherwise be eligible to purchase coverage through the Marketplace, including lawfully residing immigrants including those ineligible due the five-year bar.

Program Design. States with BHPs have the flexibility to design the plan structure, benefits, and cost-sharing offered to enrollees and can offer more generous levels of cost-sharing for eligible populations than Marketplace coverage. However, BHP premiums cannot exceed the second-lowest Silver-level (“benchmark”) plan. Cost-sharing must be at least as generous as the equivalent platinum-level plan for enrollees under 150 percent FPL and gold for enrollees between 150 percent-200 percent FPL. States can choose to design the plan to be more “Medicaid-like” in design, with minimal (if any) cost-sharing, or more “Marketplace-like” in design, with modest cost-sharing. States may also consider offering additional services—such as non-medical services to address social determinants of health and/or health equity—depending on available financing. Both states that have implemented the BHP highlight the importance of choosing a benefit package that matches target enrollee needs.

The program design provides an opportunity to improve continuity of care and to use state purchasing power to create a smoother glide path between Medicaid and commercial insurance for individuals transferring between program eligibility levels. The BHP can be designed with no cost-sharing or premium contributions, or it can have tiered consumer contributions based on income, with no or minimal contributions at the bottom of the income spectrum and increasing contributions toward the higher end of the range. This creates a step-based structure to prepare enrollees for cost-sharing on the Marketplace when their household income exceeds 200 percent of the FPL. It is possible that even minimal cost-sharing can impact access to care for low-income enrollees.

Implementing a BHP. States interested in implementing a BHP must submit a [Blueprint](#) to the Centers for Medicare & Medicaid Services (CMS) as an official request for certification. The Blueprint outlines the state’s program design choices and provides a full description of the program’s operations and management in compliance with federal rules. The full process for submission and certification takes approximately one year to complete. Unlike a Section 1332 waiver, which is subject to approval at the discretion of the Secretary of Health and Human Services, if all BHP requirements are met, the Blueprint will be approved and the program may be implemented.

Financing. Under Section 1331, states that operate a BHP receive federal funding equal to 95 percent of premium tax credits that would otherwise have been provided to (or on behalf of) enrolled individuals if those individuals had enrolled in Marketplace qualified health plans (QHPs). Federal funds are paid prospectively on a quarterly basis to a BHP State Trust Fund with future reconciliation.¹

Unlike Section 1332 waivers, Section 1331 funding is not at the discretion of CMS and the Department of Treasury. States that meets all program requirements are entitled to receive the funding. This type of federal funding offers stability that is unavailable for health care affordability proposals that rely on Section 1332, which are required to meet federal deficit neutrality requirements (putting the state at financial risk if Marketplace enrollment increases as a result of the 1332 waiver).

Section 1331 explicitly states that the BHP State Trust Fund can be used only to reduce premiums and cost-sharing or to provide additional benefits for BHP eligible enrollees.

Interaction of Federal Policy and the BHP Funding Methodology

Cost-Sharing Reduction Payments. The original BHP funding methodology included the equivalent of premium tax credits plus cost-sharing reduction (CSR) payments paid on the Marketplace. In 2017, CSR reimbursements to QHP issuers were eliminated,² and states began to allow carriers to increase premiums for silver-level QHPs—for which federal premium tax credits are calculated—to offset the lost federal CSR payments (dubbed “silver-loading”).

After the elimination of CSR payments, the CSR component of quarterly BHP payments for New York and Minnesota was halted by the federal government, significantly impacting the states’ BHP revenues. The states filed legal action in 2018, which caused CMS to replace the formula for the CSR portion of BHP payments based on how silver-loading had impacted premiums across the states, implementing a “premium adjustment factor” of 18.8 percent. In 2020, the Department of Health and Human Services (HHS) further revised the BHP payment methodology to implement an additional 97.04 percent “metal-tier selection factor,” or a 3 percent reduction in overall BHP payments in response to increased consumer use of increased subsidies as a result of silver-loading to purchase Bronze and Gold-level plans. Both adjustment factors remain in place today.

¹ Funding methodology and payment rates are expressed per eligible individual enrolled in a BHP standard health plan for each month of enrollment, and payment rates may vary based on category/class of enrollee.

² The Attorney General concluded that HHS lacked authority to make CSR payments as long as Congress had not appropriated funds for the payments.

State Reinsurance Programs. In 2018, Minnesota’s newly implemented state reinsurance program had the intended effect of reducing Marketplace premiums, but the unintended impact of reducing federal funding for its BHP. When approving the state’s Section 1332 reinsurance waiver and the pass-through savings, CMS rejected a request for equivalent savings to be passed through to the state under the BHP methodology, stating that the Section 1331 statute did not expressly authorize the pass-through of BHP savings. States considering a BHP and a reinsurance program should consider the implications of a reinsurance program on the available federal funding for the BHP.

Potential Impact of the American Rescue Plan Act of 2021. The American Rescue Plan, passed in March 2021, includes significant enhancements to federal financial assistance on the Marketplace by raising the generosity of premium tax credits for individuals between 100 percent-400 percent of the FPL and, for the first time, allows those above 400 percent of the FPL to qualify for federal subsidies. Importantly, the subsidy increases are *temporary* through 2022; however, Congress may consider making them permanent in future legislation.

Because the BHP funding methodology is based on equivalent Marketplace subsidies, states with BHPs will see a marked increase in 2021 and 2022 funding. This will likely cause programmatic changes in Minnesota and New York as the states decide how to use additional funding, and it may increase the attractiveness of the BHP for states considering implementing the program.

Impact on the Marketplace. Once a BHP is implemented, individuals under 200 percent of the FPL must be covered through the BHP rather than subsidized QHPs. Under CMS rules, the BHP removes eligible individuals from the individual market and creates a separate risk pool.

The potential impact on the remaining Marketplace depends on the share of enrollees under 200 percent of the FPL and their health status. If enrollees joining the BHP have poorer health status than those remaining in the Marketplace, premiums on the Marketplace will likely decrease. The opposite is true if BHP enrollees are healthier than the remaining Marketplace population. Additionally, individuals under 200 percent of the FPL receive the highest cost-sharing reduction subsidies (with plans between 87 percent and 94 percent actuarial values). Removing these individuals from the Marketplace will impact silver-loading practices in the state, therefore lowering the premiums of Silver-level plans and the benchmark plan that is used to determine advanced premium tax credits for all Marketplace enrollees. Reducing available tax credits will not negatively impact enrollees in the benchmark plan, but may impact the purchasing power for individuals using their tax credits to enroll in Bronze and Gold plans. Nationally, [approximately](#) 50 percent of Marketplace enrollees are under 200 percent of the FPL. Income distribution varies by state and states considering introducing a BHP will have to analyze how removing a substantial part of the market will impact Marketplace premiums and enrollment. Smaller state markets will be particularly vulnerable to the impacts of enrollment fluctuation.

The two states that have implemented a BHP to date—New York and Minnesota—had similar, existing programs for low-income enrollees before implementing the BHP. The states also introduced the program early enough in the ACA implementation that their programs did not have a significant impact on Marketplace premiums or enrollment (see page 5 for more information on the New York and Minnesota programs). The migration of a significant portion of the population out of Marketplace coverage as new BHP’s emerge will be largely uncharted territory for states and CMS.

A state implementing a BHP could consider policies to mitigate the impact on the remaining market, including policies establishing state subsidies to ensure that affordability for remaining enrollees is stabilized, particularly for the unsubsidized population (assuming provisions in the American Rescue Plan that provide subsidies to all enrollees regardless of income are not made permanent).

Lessons from Existing Programs: New York and Minnesota

Minnesota: MinnesotaCare

Minnesota was the first state to implement its BHP program, MinnesotaCare, in 2015. MinnesotaCare was built off an existing state program for Minnesotans with household income up to 275 percent of the FPL with pre-existing conditions that was originally funded through a Medicaid 1115 demonstration waiver. The BHP was implemented on a compressed timeline due to related state and federal policy developments surrounding the ACA’s implementation. Despite uncertain enrollment, premium rates, and federal funding in the early years of the program, today the program serves nearly 80,000 Minnesotans and is on stable financial footing. Legislation to expand program eligibility and/or offer a buy-in program has been under consideration in the state for multiple years.

- **Enrollment.** In FY 2020, MinnesotaCare had [77,594 enrollees](#). Enrollment trends show steady enrollment levels since 2016, with expected increases in FY 2021 and FY 2022.
- **Plan Design.** MinnesotaCare offers a single benefit package regardless of income or immigration status. Premiums are set on a sliding scale by household income, ranging from 35 percent to 200 percent of the FPL, at \$4-\$80/month for coverage. For certain groups (individuals under age 21, American Indians, select military members), there are no premiums. MinnesotaCare offers no deductibles and modest copayments, and covers all essential health benefits plus dental, vision, and enhanced behavioral health services.
- **Administration.** The program is administered by the State Medicaid agency. MinnesotaCare shares a single eligibility system with Medicaid and Marketplace programs.
- **Provider Rates.** BHP provider reimbursement rates are similar to those in Medicaid.
- **Looking Ahead.** Minnesota introduced [public option legislation](#) in 2021 that is focused on using the BHP as a platform for a public option, expanding eligibility, and offering small group buy-in to the program.

New York: Essential Plan

New York began implementing the Essential Plan in 2015. The program has seen higher-than-anticipated enrollment, robust carrier participation, and strong federal and state funding. Both the state and consumer advocates are seeking improved affordability and access in the program and are also considering program expansions.

- **Enrollment.** As of [January 2021](#), the Essential Plan has over 885,000 enrollees. The program saw natural migration from Marketplace to Essential Plan coverage during the COVID-19 pandemic.
- **Plan Design.** The Essential Plan offers four plan products tiered by income and immigration status (two products for enrollees with household income below 138 percent of the FPL and ineligible for Medicaid (including lawfully present immigrants), and two products for those between 138 percent and 200 percent of the FPL). For those under 150 percent of the FPL, the premium is \$0 with no copays and no deductibles. For those between 151 percent and 200 percent of the FPL, the premium is \$20, with modest copays and no deductibles. All essential health benefits are included. For those between 138 percent and 200 percent of the FPL, certain plans offer dental/vision benefits.
- **Administration.** The New York Department of Health, which oversees the state Medicaid and Marketplace programs, administers the program; there is a single eligibility and enrollment system for MAGI Medicaid, CHIP, Marketplace, and the BHP.
- **Provider Rates.** BHP provider reimbursement rates are set by the Medicaid agency and adjusted for BHP member demographics, utilization, benefits, etc. Currently, provider reimbursement rates are at or just above those of Medicaid for the at or below 138 percent of FPL population, and more closely aligned with QHP reimbursement rates for the above 138 percent of FPL population
- **Financing.** According to a 2020 [report](#) from Empire State of Health, the state has accrued a surplus of \$3 billion in the BHP State Trust Fund, largely due to federal funding based on Marketplace premiums in the Marketplace.³
- **Looking Ahead.** New York has proposed BHP design changes, including [expanding program eligibility](#). The state's [final FY 2021-2022 budget](#) will eliminate monthly premiums for BHP enrollees, remove premiums and cost-sharing for vision and dental benefits, establish a fund for enhanced provider reimbursement payments, and create a \$200 million Essential Plan quality pool to promote high quality of care, strengthen provider networks, and incentivize providers.

Other State Studies

New Mexico. New Mexico, together with the Urban Institute, recently [studied](#) the cost and coverage implications of seven health reform options, including a BHP with tiered premiums. The studied design assumed provider reimbursement at Medicaid rates for individuals with household income up to 138 percent of the FPL and at 105 percent of Medicare rates for those between 138 percent-200 percent of the FPL. The study found that a New Mexico BHP would reduce the number of uninsured people by 12,000, which was a smaller effect than that of most other options examined in the report, and that 15,000 people would migrate out of the individual market—resulting in a 1.5 percent premium decline.

³ Notably, the Minnesota BHP does not have a similar surplus. Multiple factors can result in this discrepancy, including the health status of the risk pool, administrative costs, the program size, and the differential between the federal funding available based on premiums, which are [consistently higher](#) in New York than Minnesota.

Opportunities to Evolve the BHP

The Biden-Harris administration is expected to build upon the ACA and expand coverage as a top priority, and a Democratic-led Congress may be favorable to similar legislative reforms. While the BHP is not discussed as often as Medicaid or Marketplace coverage, it can be an important tool for states to provide affordable coverage. States with or considering BHPs are looking for ways to expand the reach of the program and to evolve the program to fit state-specific goals and further advance efforts toward universal coverage.

Potential opportunities to evolve the program rely on either state or federal action, and include: making changes to the underlying Section 1331 statute to expand program eligibility and/or offer funding flexibility (requires Congressional action); using a Section 1332 waiver to expand eligibility for a BHP “look-alike” program (requires state action and HHS and Treasury authorization); or using the BHP as a chassis for a state public option (which states could advance administratively).

Section 1331 Updates to Expand Income Eligibility

Given the success of the BHP in Minnesota and New York, policymakers in those and other states have considered expanding program eligibility above 200 percent of the FPL. Congress could pursue legislative changes to Section 1331 of the ACA to increase the eligibility threshold above 200 percent of the FPL and/or expand other eligibility standards, such as age (the existing statute permits adults 18-64 years of age) and immigration status. These flexibilities would allow states to implement the expanded BHP under a traditional Blueprint application and to leverage BHP State Trust Fund dollars to offer affordable coverage and benefits to an expanded BHP-eligible population. Federal legislation is a vehicle for these program changes.

Basic Health Program Expansion Act. In 2018, Senator Cantwell (and Senator Schumer, Senator Gillibrand, and Senator Stabenow) introduced [Senate Bill 3485](#), the Basic Health Program Expansion Act of 2018, which proposed to:

- Provide states with the option to raise the BHP eligibility cap from 200 percent of the FPL to the state’s CHIP income eligibility level as established under that state’s state plan amendment (usually between 200 percent and 400 percent of the FPL)
- Allow funds from the BHP State Trust Fund to be used to cover state costs associated with developing and implementing a BHP in the first year of Blueprint approval (“startup” funds)

Today, the BHP State Trust Fund, as defined under Section 1331, is limited to subsidizing premiums, cost-sharing, or additional benefits for “eligible individuals,” as defined in Section 1331(e): state residents who are not eligible for Medicaid benefits (that provide essential

health benefits), have a household income between 138 percent and 200 percent of the FPL, are not eligible for other minimum essential coverage, and are under 65, and who would otherwise be eligible to enroll in a QHP under Section 1312. Federal legislative changes could also expand the BHP State Trust Fund’s allowable uses to permit states to cover new populations if a surplus exists.

Utilizing a Section 1332 Waiver to Create an Expanded BHP

If Congress does not amend [Section 1331](#) of the ACA, another option to expand the BHP is to leverage a Section 1332 waiver to migrate individuals under a predetermined income (or other) eligibility to a new, expanded BHP.

Under the Section 1332 waiver application, the state may seek pass-through funding for the equivalent of tax credits for individuals who are currently participating or are expected to participate in the Marketplace under the pre-waiver eligibility criteria. The state may choose to make participation in the program a choice or mandatory for eligible individuals who choose to enroll.

Under a waiver, the BHP and BHP expansion populations could be segregated by Section 1331 and Section 1332 financing (as discussed in more detail below). Alternatively, the state could apply for a broad Section 1332 waiver to cover both the Section 1331-eligible population and the Marketplace-eligible population into one program with a new financing mechanism. This option would be of particular interest for states developing a program with eligibility up to 400 percent of the FPL or states implementing the BHP for the first time that are interested in expanded eligibility.

Waiving ACA Provisions. Section 1332 waivers cannot be used to waive Section 1331, but they can waive related provisions to help facilitate BHP expansion (or a state could submit a 1332 waiver request to create a BHP-like program if it met 1332 requirements). As an example, [Section 1312](#) of the ACA⁴ could be waived to update a state’s Marketplace eligibility to include only those above the new BHP expansion eligibility threshold (e.g., over 300 percent of the FPL)⁵ to facilitate moving these enrollees from Marketplace to BHP coverage. This is necessary for an expanded BHP program where the BHP is the only choice for enrollees under the program’s eligibility criteria (i.e., an individual under the income threshold cannot choose Marketplace or BHP coverage).

Meeting Section 1332 Guardrails and Securing Financing. Section 1332 waivers are required to meet four guardrails ensuring that (1) coverage after the waiver will be at least as

⁴ Section 1312 sets three standards for individuals who are “qualified” to enroll in a QHP: resident in the state; not incarcerated; and a U.S. citizen or national, or otherwise lawfully present in the U.S.

⁵ A BHP expansion without an income eligibility threshold that replaced the entirety of the Marketplace may require waiving additional ACA provisions (Section 1301 and Section 1311).

comprehensive as the existing Marketplace coverage; (2) plans will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as **affordable** as the provisions existing Marketplace coverage would provide; (3) plans will **maintain coverage** of at least a comparable number of residents to that which the existing Marketplace would provide; and (4) plans will not increase the **federal deficit**.

Under current guidance, deficit neutrality is one of the hardest guardrails to comply with because significant enrollment increases will impact the level of federal spending on subsidies. To meet this guardrail, a state could apply for capped/global pass-through funding for the BHP expansion population currently enrolled in Marketplace coverage. Theoretically, there could be some enrollment estimate adjustments in future years based on trends/benchmark states to account for the potential increase in new enrollees or if the state-designated eligibility level eliminates all tax credit-eligible populations in the Marketplace.

While a capped payment would address deficit neutrality issues, states seeking this type of waiver would be at financial risk for significant BHP expansion enrollment compared to the number of enrollees on the Marketplace for which the state receives pass-through funding. Enrollment of individuals who are currently Marketplace-eligible but are unenrolled is likely, given that BHP expansion premiums and cost-sharing levels would be significantly lower than existing individual coverage offerings. This discrepancy could be mitigated by changes in consumer costs (e.g., increased premiums and/or cost-sharing for enrollees), enhanced subsidies under the [American Rescue Plan Act of 2021](#)⁶, and cost containment. The cost of a BHP expansion program and projected federal pass-through funding would need to be modeled prior to implementation.

CMS and the Department of the Treasury have discretion about whether to approve 1332 waivers (unlike Section 1331 BHP Blueprints) even if state waivers meet all the statutory requirements.

Program Design and Operations. Notably, extending the BHP expansion to include new eligibility groups would require operational changes.

One crucial operational decision is regarding which risk pool the BHP expansion enrollees would belong in and the implications for the existing program risk pools. There are two potential designs related to the risk pool that may require federal waivers:

- **Separate BHP Expansion Group Risk Pool.** A state expanding the BHP could choose to keep the original Section 1331-eligible population in the current risk pool and establish a separate risk pool for the BHP expansion population. A separate risk pool allows for contracting and financing to be fully severed from the original Section 1331-eligible

⁶ Note that the American Rescue Plan Act of 2021 expands tax credit eligibility to people over 400 percent of the FPL for 2021 and 2022. If this provision is made permanent, eligibility for tax credits on the Marketplace would exist regardless of income. This means the Marketplace is likely to remain intact regardless of New York's determination of a maximum income level for the BHP expansion.

population. However, the size and health status of the risk pool will impact affordability of the BHP expansion product. If enrollment is low and health utilization is volatile, it could result in higher costs.

- **Combined BHP/BHP Expansion Risk Pool.** It could be feasible to combine the new enrollees with the existing risk pool to avoid further segmenting the coverage market and increasing the size of the pool. The health care status, health care usage, and expenses of the BHP expansion population in a combined pool may impact rates for the Section 1331 BHP population—either positively or negatively—and the state would want to understand this potential impact.

Under both of these scenarios, as with the introduction of a traditional BHP, the implications for segmenting the individual market risk pool should be considered. Combining the BHP/BHP expansion risk pool with the individual market may also be an option under a Section 1332 waiver. Combining the BHP(s) with the individual market would have very complex operational and program design considerations. CMS and the Department of the Treasury may not consider this option viable, but it could alleviate the potential impact of a BHP expansion on the remaining individual market.

Offering BHP Look-Alike as a Public Option

Finally, the BHP could serve as a chassis for a state-sponsored public option plan, similar to Medicaid buy-in designs considered by several states.⁷

Under this model, the state could use a new or existing BHP as a basis for providing a buy-in product. The product could be offered on or off the Marketplace, depending on the state's target population and goals. An off-Marketplace buy-in would offer lower-cost coverage but would not be eligible for tax credits unless the state received a pass-through waiver. This model differs from the option above because it would be a voluntary choice and the state could determine a premium and cost-sharing contribution for enrollees.

An on-Marketplace product would be eligible for tax credits but would need to meet QHP requirements, meaning that the program design would differ from the existing BHP. However, the state could use existing contracting, provider networks, and potentially BHP-level provider rates to offer a lower-cost QHP product.

If the premium for a BHP-based public option lowers the benchmark premiums, the state could apply for pass-through funding under a Section 1332 waiver. The pass-through funding can be used to invest in the program and/or provide coverage for individuals ineligible for the traditional BHP or Marketplace subsidies.

⁷ For more information see the SHVS/Manatt Health Issue Brief, "[State Medicaid Buy-Ins: Key Questions to Consider.](#)"

Conclusion

The BHP is a long-standing option for states under the ACA that can serve as an important tool for offering low-cost coverage with little or no premiums and minimal cost-sharing and address ongoing affordability and equity concerns for low-income state residents. Two states that have taken up the option – Minnesota and New York – offer a compelling proof of concept.

The BHP offers a direct pathway with federal financial support for states to design a coverage option for residents with household income under 200 percent of the FPL, outside the constraints of the existing Marketplace structure or Section 1332 waiver parameters. States interested in the BHP should design the benefits package to meet enrollee needs, and should consider and potentially mitigate the impact of implementing a BHP on the existing Marketplace.

States can also consider opportunities to expand the BHP to include people at higher income levels or eligibility categories with federal legislative action to update the statutory language of Section 1331, through approval of a Section 1332 waiver to expand the BHP, or through a public option/buy-in program allowing residents to purchase state-sponsored BHP coverage.

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