Basic Health Plan

Overview: Basic Health Plan Option

"The Secretary shall establish a basic health program…under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits…to eligible individuals in lieu of offering such individuals coverage through an Exchange."

Key Elements:

- Eligibility:
  133-200% FPL, offer basic health plan option instead of exchange based subsidies
- Funding:
  95% of the premium tax credits + cost sharing reductions that would have been provided to eligible individuals enrolling in qualified health plans through the exchange.
- Participating Health Plans:
  Entities may include licensed HMOs, health insurance issuers, or a network of health care providers established to offer services under the program. Not linked to qualified health plans under exchange provisions.

Considerations

- Financial advantage or risk to the state
- Capacity/resources
- Coordination with other programs, including Exchange

	Statutory Requirements
Funding	*Amount*: 95% of the premium tax credits + cost sharing reductions that would have been provided to eligible individuals enrolling in qualified health plans through the state. Age, income, family status, and geography may be used to calculate eligible premium amount. Health status may be used to calculate risk adjustment and reinsurance payments. DHHS Secretary responsible for calculating. *Mechanism*: State establishes a trust to pay for basic health plan enrollees *Special considerations*: Segregation of abortion funding (per Sec. 1303) applies
Eligibility	a) State resident b) Ineligible to enroll in Medicaid c) Income 133%FPL>200%FPL OR non-residents under 133%FPL and ineligible for Medicaid d) Not eligible for "minimum essential coverage"** or is eligible for unaffordable ESI e) Under 65 years of age
Eligible entity	States must contract with one or more "standard health plans", which must enroll *only* eligible individuals, provide at least essential health benefits, and have at least an 85% MLR. Entities may include licensed HMOs, health insurance issuers, or a network of health care providers established to offer services under the program.
Benefits	Must cover at least essential health benefits*
Premiums	Must not exceed the amount an individual would have paid (less subsidy) if enrolled in second lowest cost silver plan
Cost Sharing	Must not exceed the cost sharing required for a platinum plan for those 133%<150%FPL and a gold plan for those >150%FPL
Contracting	Basic health plans must establish a competitive bidding process, including negotiating premiums, cost sharing, and benefits added to essential health benefits. Negotiations also must include: (a) *innovation*—care coordination, incentives for prev care, incentivizing appropriate utilization; (b) *health* and resource difference—make suitable allowances for differences in care needs of enrollees and availability of providers; (c) *managed care*—contract with managed care or managed care-like systems (d) *performance measures*—establish specific quality and outcome measures for plans with reporting requirements to the State and making measures available to enrollees
Consumer choice	"A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans."
Limitations	Eligible individuals for the basic health plan are not eligible to participate in the Exchange.
Regionalize	States can negotiate regional compact to include coverage in other states in agreements with issuers of standard health plans.
Certification of Basic Plan	DHHS Secretary certifies that Basic Health Plans are compliant with premium, cost-sharing, and benefit requirements.
DHHS oversight	DHHS will annually review States to ensure compliance with eligibility verification, funding requirements, and quality measures.
Coordination w/ programs	States should coordinate the administration and benefits of the basic health plan with Medicaid, CHIP, and other state-administered health programs
Waiver options	States may apply for a budget neutral waiver beginning in 2017 of the following requirements: qualified health plans, essential health benefits, Exchanges, premium tax credits, individual mandate and employer requirements. The basic health plan provision is not included among the sections eligible for waiver.

* "Essential health benefits" include: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care).

** "Minimum essential coverage" includes Medicare, Tricare, Medicaid, state high risk pool, Peace Corps coverage, CHIP, individual market plans, plans offered in the individual market, grandfathered health plans, and "eligible employer sponsored plans". An eligible employer sponsored plan is a government sponsored plan or a plan offered in the large or small group markets. Regulations to further define "eligible employer sponsored health plan" have not yet been issued.