

RESEARCH REPORT

The Basic Health Program

Considerations for States and Lessons from New York and Minnesota

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April 2023





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Acknowledgments

This report was funded by the Robert Wood Johnson Foundation. The views expressed do not necessarily reflect the views of the Foundation.

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The authors thank the state officials and stakeholders that generously shared their insights and experiences about the BHP. We are grateful for the research support provided by Emma Walsh-Alker and appreciate the review and comments on drafts of this report provided by John Holahan, Jessica Banthin, Matt Buettgens, Kevin Lucia, Matt Fiedler, Patti Boozang, and Dan Meuse.

Executive Summary

The Affordable Care Act (ACA) included an option for states to run Basic Health Programs (BHPs) that replace subsidized coverage on the health insurance Marketplaces for individuals with incomes up to 200 percent of the federal poverty level (FPL). Only New York and Minnesota have thus far taken the option to create a BHP, but as of this writing, four other states are considering their own BHPs: Oregon, Kentucky, Illinois, and West Virginia. This brief provides analysis of the BHP, as well as lessons learned from Minnesota's and New York's programs.

Overview of BHPs

The ACA sets minimum requirements for state BHPs. BHP premiums may be no higher than an individual's cost for the second lowest cost silver plan on the Marketplace, and cost sharing must be similar. Like Marketplace plans, BHP coverage must cover the full range of the ACA's essential health benefits. The federal government helps finance the BHP by providing the state with 95 percent of the funds it would have paid in Marketplace premium tax credits (PTCs) for each enrollee.

State policies that reduce Marketplace premiums generally reduce federal BHP payments. However, recent federal rules established a "1332 waiver factor" that mitigates losses for states that lower premiums in the individual market through a reinsurance program supported by a Section 1332 waiver. Federal BHP payments are also sensitive to changes in federal PTC policy.

BHPs in New York and Minnesota

Before enactment of the ACA, New York and Minnesota operated and contributed state funding to coverage programs for low-income people who did not qualify for Medicaid. While these populations would generally be eligible for PTCs, the BHP offered both states an opportunity to continue providing Medicaid-like coverage with additional federal funding.

Both states' BHPs are built on a Medicaid chassis: they are administered by the state agency that operates Medicaid and the state contracts with many of the same managed care plans that cover Medicaid enrollees, which in turn rely on a similar set of providers to deliver services. BHP enrollees in

both states receive more generous benefits than those in Marketplace plans. Premiums in both states' BHPs are also lower than Marketplace premiums, and New York eliminated all BHP premiums in 2021.

State Considerations for Establishing and Maintaining a BHP

A BHP will affect consumers' access to and cost of coverage in different ways, depending on their income level and program eligibility. Individuals eligible for the BHP will generally have more generous coverage at a lower cost, while some who remain in the individual market could pay higher premiums.

Impact for the BHP-Eligible Population

A BHP has the potential to greatly improve coverage for eligible consumers, though the impact depends heavily on a state's available funding, implementation choices, and operational systems.

The increased affordability and generosity of BHP plans in New York and Minnesota, particularly the decision to eliminate premiums for many (or all, in the case of New York) BHP enrollees, likely contributes to the high coverage levels in these states. Further, New York has been able to plow its BHP surplus back into the program to improve affordability and increase provider reimbursement rates.

A BHP can also protect consumers from key sources of financial risk and complexity inherent in Marketplace coverage, such as the reconciliation of advanced PTCs on their annual tax returns, annual premium and PTC fluctuations, and plan choice overload.

At the same time, depending on how a state structures its program and eligibility rules, the BHP can either reduce administrative burdens for people who must shift between coverage programs or generate additional burdens. Handling eligibility for Medicaid, the BHP, and Marketplace coverage through a single integrated eligibility system can reduce administrative tasks for consumers, while segmenting eligibility could increase consumer burdens if coverage transitions are not seamless. Relying on the federally run HealthCare.gov could compound the challenges.

Impact for Remaining Individual Market Consumers

When states switch to a BHP, some consumers eligible for PTCs may face higher premiums or cost sharing. This perhaps unintuitive effect arises because adopting a BHP largely eliminates the benefits of

silver loading for people enrolled in bronze or gold plans. While modeling suggests that resulting coverage losses would be small, this concern has prompted Oregon to consider ways to mitigate the higher premiums for affected enrollees.

In theory, switching to a BHP could also affect individual market premiums by removing a significant number of enrollees from the risk pool. If the BHP population has lower expected utilization than the individual market population, removing it will generally increase premiums, and vice versa. Removing the BHP population could also deter some insurers from participating in the Marketplaces, leaving some regions with limited plan choices. In practice, respondents in New York and Minnesota both reported stable markets with ample insurer participation but acknowledged challenges predicting—and pricing for—the health risk of the population enrolling in BHP and Marketplace plans.

State Fiscal Impact

The cost of a BHP to the state depends in part on the generosity of the coverage provided. But the cost also depends on how the cost of the program compares with federal funding. Where Marketplace premiums are high, BHP funding can support a generous program with little or no state contribution. Where Marketplace and Medicaid costs are similar, 95 percent of Marketplace subsidies may not support a generous program.

Generally, the most important factors in the fiscal viability of a BHP are the level of Marketplace premiums and the difference between provider reimbursement rates paid in the individual market and those under the BHP. If a state has a substantial gap between Medicaid and commercial provider rates and can keep its BHP provider rates on par with Medicaid (or some modest multiple thereof), the state is more likely to be able to rely exclusively on federal dollars to finance its program.

Community Rating and Risk Pools

One unique factor in the New York BHP's strong financial performance may be the state's prohibition on age rating in the individual market. New York's BHP enrollment skews younger than Marketplace enrollment. The result is that the BHP is funded by payments based on premiums for an older population but provides services to a younger population—a strong recipe for a surplus.

Potential Innovations

States have begun to explore how a BHP may interact with other policy options to expand coverage. For example, there has been interest in coordinating a BHP or embedding it within a Section 1332 waiver and in using a BHP as the basis for a public option plan.

BHP Appeal versus Other Coverage Expansion Options

New York and Minnesota have been able to generate and sustain broad stakeholder support for their BHPs. In both states, “strange bedfellow” coalitions of consumer advocates, providers, and health plans supported the BHP at its inception. Seven years later, many of these same stakeholders reported general, though not unqualified, satisfaction with how the programs are working.

Conclusion

New York and Minnesota’s BHPs have both shown great success in making coverage affordable for low-income consumers. However, it is not clear that these states’ experiences are replicable in others. Much depends on state-specific factors, particularly the difference in provider reimbursement rates between Medicaid and the commercial market.

The Basic Health Program: Considerations for States and Lessons from New York and Minnesota

The Affordable Care Act (ACA) included an option for states to create and run a health coverage program to replace subsidized coverage on the health insurance Marketplaces for individuals with incomes up to 200 percent of the federal poverty level (FPL). For states to operate a Basic Health Program (BHP), the federal government will give states 95 percent of the funds BHP enrollees otherwise could have received in Marketplace subsidies.

Only two states—New York and Minnesota—have thus far taken up the option to create a BHP. Both have demonstrated success providing coverage that is more affordable and just as or more comprehensive than Marketplace coverage for individuals in the BHP income range. In recent years, New York has done this without a state contribution to program costs, while Minnesota’s program has required some state funding—two different experiences that may be instructive for other states.

At this time, at least four other states are considering their own BHPs. Oregon appears to be moving toward a BHP as recommended by a state task force legislatively mandated to improve continuity of coverage (Legislative Policy and Research Office 2022b).¹ Kentucky enacted legislation with bipartisan support² to develop a BHP proposal that could, if approved by the legislature, be open for enrollment in 2024.³ Illinois has commissioned a feasibility study for a BHP (IHFS and IDoI 2021), and legislators in West Virginia have also shown interest.⁴

This brief seeks to provide policymakers and stakeholders in these and other states with information and analysis about BHP rules and operations, as well as lessons learned from New York’s and Minnesota’s experiences with the program.

What emerges is a complex picture. On the one hand, the BHP gives certain states—generally those with high Marketplace premiums and Medicaid reimbursement rates significantly below Marketplace rates—a cost-effective pathway to help some of their most vulnerable residents. On the other hand, federal funding may not cover the full costs of the program in states with different market conditions. New York’s especially positive experience may result partly from unique rating rules for its individual

market. At the same time, implementation of a BHP is likely to increase costs for some marketplace plan enrollees with higher incomes, though these effects can be mitigated with state expenditures. Alternatively, the increase may be deemed a worthwhile trade-off to improve insurance affordability for people with lower incomes. And, depending on how it is implemented, a BHP could improve continuity of coverage for consumers losing Medicaid, or the additional coverage transition between Medicaid and the Marketplace could increase consumers' administrative burdens.

Understanding how these factors play out in a given state and balancing the pros and cons will require robust actuarial analysis and careful consideration of the state's specific goals, market conditions, and operational capabilities.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. Through the US Health Reform—Monitoring and Impact project, which began in May 2011, Urban researchers are using microsimulation modeling to project the cost and coverage implications of proposed health reforms, documenting the implementation of national and state health reforms, and providing technical assistance to states. More information and publications can be found at www.rwjf.org and www.urban.org.

Research Approach

To assess the BHP, we analyzed federal and state laws, regulations, and subregulatory guidance and reviewed published research evaluating the programs. We also conducted structured interviews with federal and state officials and representatives of consumers, insurers, and health care providers in New York and Minnesota. These interviews were conducted between July 21 and September 16, 2022.

Overview of BHPs

The BHP is authorized by Section 1331 of the ACA. Under Section 1331, states may enroll individuals up to 200 percent of FPL (for 2023, \$27,180 for an individual or \$55,500 for a family of four)⁵ not eligible for other coverage into the BHP in lieu of Marketplace coverage. Like the Marketplace, the BHP

covers individuals below 133 percent of FPL who are ineligible for Medicaid because of the “five-year bar,” which excludes lawfully present immigrants who have resided in the US for less than five years.⁶

Under Section 1331, states may not set BHP premiums higher than an individual’s cost for the second lowest cost silver plan on the Marketplace. For individuals under 150 percent of FPL, the BHP must cover at least 90 percent of their costs (equivalent to a platinum-level Marketplace plan); for those between 150 and 200 percent of FPL, the BHP must cover at least 80 percent of their costs (equivalent to a gold-level plan). Like Marketplace plans, BHP coverage must cover the full range of the ACA’s essential health benefits.

The federal government helps finance BHPs by providing a state with 95 percent of the funds that would have been paid in Marketplace premium tax credits (PTCs) for each enrollee. Because the size of PTCs is closely tied to Marketplace premiums, a state’s federal BHP payments depend heavily on its Marketplace premiums. The federal funds are deposited into a BHP trust fund, which states may only use to cover premiums, cost sharing, and benefits for BHP enrollees.⁷ States may not use the federal funds to cover administrative costs.⁸

Evolving Federal-State Relationships

Although the ACA was enacted in 2010 and authorized the BHP option to begin in 2014 (at the same time as the Marketplaces), the Centers for Medicare & Medicaid Services (CMS) did not publish rules or guidance for states on the BHP until 2014, well after states had made initial implementation decisions. This delay may have deterred some states from establishing a BHP at the time. New York and Minnesota initially enrolled many BHP-eligible individuals into their state-based Marketplaces, then transitioned them to the BHP in 2015. Federal rules outlined the process by which federal officials would review and approve state “blueprints” to establish a BHP, delineated eligibility and enrollment requirements and minimum standards for benefits, and described the methodology for calculating federal payments to states and the factors CMS would use to make annual adjustments.⁹ The rules also set forth the framework for states to establish and maintain the BHP trust fund and placed limits on allowable expenditures.¹⁰

The federal government has changed its BHP payment methodology over time, in part to respond to state and national policy changes, but it has continued to peg payments to the level of Marketplace premiums. State policies that reduce premiums in the Marketplace may have the unintended effect of reducing federal BHP payments, whereas state policies that increase premiums in the Marketplace would increase federal BHP payments. For example, in 2018 Minnesota became one of several states to

use a Section 1332 waiver¹¹ to support a reinsurance program that reduces premiums for individual market plans, including those sold on the ACA Marketplaces. This in turn reduces federal spending on advance premium tax credits (APTCs), which are pegged to the cost of the second lowest cost silver plan in the Marketplace, allowing the state to draw down federal pass-through funding under Section 1332. However, in Minnesota, the reinsurance program interacted with the BHP in a way that undermined its benefit: by reducing premiums, the reinsurance program reduced the base amount CMS used to calculate BHP payments. When the state pursued its Section 1332 waiver, it asked to be held harmless from this interaction, but CMS denied this request. This resulted in a loss of more than \$350 million in BHP funding between 2018 and 2020.¹²

CMS's decision was not compelled by Section 1332, which merely requires that waivers "not increase" the federal deficit. Indeed, the Biden administration recently finalized regulations to reverse this policy by introducing a 1332 waiver factor for BHP payments that would allow states that lower premiums in the individual market (i.e., through a reinsurance program) to receive a pass-through of those savings to help fund the BHP.¹³ New York and Minnesota provided statements supporting this change.¹⁴

Separately, in 2017, the Trump administration eliminated federal funding for the cost-sharing reduction (CSR) payments that insurers received to finance plans with reduced cost sharing for low-income Marketplace enrollees, which also eliminated the CSR portion of BHP payments.¹⁵ Insurers in most states, working with their insurance regulators, were able to adjust for the sudden loss of CSR payments by increasing silver plan premiums to account for the higher actuarial values of CSR variants (a practice called silver loading), which allowed them to draw down more federal premium tax credits.

However, this did little to offset the loss of the CSR portion of the BHP payments in New York and Minnesota, where people who would otherwise be eligible for high-value CSR plans were instead enrolled in the BHP, so silver premiums and tax credits increased little from silver loading. According to state officials, New York's BHP payments were reduced by roughly 25 percent. Both states sued the federal government for the loss of federal funding, resulting in a partial fix. Specifically, the federal government agreed to reimburse the two states for their lost funds for BHP-eligible consumers in plan year 2018 and establish a premium adjustment factor to BHP payments to account for the silver-loading practices adopted in other states.¹⁶ The premium adjustment factor does not, however, make up for the fact that the presence of a BHP in these states greatly reduces the benefits of silver loading for consumers at higher incomes, as will be discussed in greater detail.

Federal BHP funding is also sensitive to changes in PTC policy. The premium tax credit enhancements provided under the American Rescue Plan Act of 2021 (and extended through 2025 under the Inflation Reduction Act of 2022) resulted in an additional \$750 million in federal funding for New York's and Minnesota's BHPs.¹⁷

BHPs in New York and Minnesota

Before enactment of the ACA, New York and Minnesota operated and contributed state funding to coverage programs for low-income people who did not qualify for Medicaid. New York's program (called Family Health Plus) covered individuals up to 150 percent of FPL and immigrants ineligible for Medicaid because of the five-year bar. Minnesota's legacy program (called MinnesotaCare) covered individuals with incomes up to 275 percent of FPL. While these populations would generally be eligible for APTC, the BHP allowed both states to continue providing Medicaid-like coverage, now with additional federal funding.

For New York, the prospect of a BHP was made even more attractive because a 2001 state Supreme Court decision, *Aliessa v. Novello*, required the state to fully fund Medicaid coverage for income-eligible legal immigrants.¹⁸ Minnesota transitioned its legacy program to the BHP in 2015, retaining the moniker MinnesotaCare. New York's program transitioned to the BHP (now called the Essential Plan) in two phases: (1) in 2015 lawfully present immigrants under 100 percent of FPL who were not eligible for Medicaid were shifted to the BHP; (2) in 2016 the program opened to eligible Marketplace enrollees (between 138 percent and 200 percent of FPL). During this transition period, the state provided funding to fully cover premiums for Marketplace enrollees up to 150 percent of FPL. "New York's implementation philosophy was that no one should be worse off after the ACA than pre-ACA," said one official.

Both states' BHPs are built on a Medicaid chassis: they are administered by the state agency that operates Medicaid (in New York, Medicaid, the Children's Health Insurance Program, BHP, and the Marketplace are all housed within the Department of Health), and the state contracts largely with the same managed care plans that cover Medicaid enrollees, which in turn rely on a similar set of providers to deliver services. In New York, initial provider reimbursement was set between the Medicaid rate and Medicaid plus 25 percent, but in 2021 the state provided funding for BHP plans to increase provider reimbursement (New York State 2021).¹⁹ In Minnesota, provider reimbursement rates for BHP enrollees are generally close to Medicaid rates.²⁰ BHP enrollees in both states also receive additional benefits not covered through Marketplace plans, such as eyeglasses and nonemergency medical

transportation for children in Minnesota, and dental and vision coverage for adults in New York. New York also recently enacted legislation to add coverage of long-term care services and supports to its BHP benefit package (New York State of Health 2022).

Even though federal rules require only that BHP premiums “not exceed” after-APTC Marketplace premiums, BHP premiums have typically been lower. The same was true before the American Rescue Plan increased APTC. For 2023, Minnesota BHP enrollees pay between \$0 to \$28 per month, depending on income.²¹ New York’s BHP never imposed a deductible and eliminated all premiums for BHP enrollees beginning in June 2021 (New York State 2021). Marketplace enrollees at similar income levels could pay up to \$45 per month (table 1).

TABLE 1
Expected Premium Contributions for Basic Health Programs and Marketplace Coverage with APTC, Select Incomes

	2020 (pre-ARP)		2023 (with ARP)	
	150% FPL	200% FPL	150% FPL	200% FPL
Single individual				
New York Essential Plan	\$0	\$20	\$0	\$0
MinnesotaCare	\$37	\$80	\$0	\$28
Marketplace with APTC	\$65	\$136	\$0	\$45
Married couple				
New York Essential Plan ^a	\$0	\$40	\$0	\$0
MinnesotaCare	\$74	\$160	\$0	\$56
Marketplace with APTC	\$117	\$271	\$0	\$122

Sources: Randall Chun, “MinnesotaCare” (Saint Paul: MN House Research, 2022), <https://www.house.mn.gov/hrd/pubs/mncare.pdf>; Minnesota Department of Human Services, “MinnesotaCare Premium Estimator Table” (Saint Paul: State of Minnesota, 2022), <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4139A-ENG>, “DHS Announces MinnesotaCare Premium Reductions for 2021 and 2022,” Bulletin 21-21-06, May 20, 2021, <https://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs-329458.pdf>; New York Department of Health, “Attachment H—EP Benefits and Cost-Sharing Chart” (Albany: New York State, 2020), https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20H%20-%20EP%20Benefits%20and%20Cost-Sharing_2.pdf; New York State of Health, “Essential Plan at a Glance” (Albany: New York State, 2021), https://info.nystateofhealth.ny.gov/sites/default/files/Essential%20Plan%20At%20A%20Glance%20Card%20-%20English_1.pdf.

APTC = advance premium tax credit; ARP = American Rescue Plan Act of 2021; FPL = federal poverty level.

^a New York’s Essential Plan offers only self-only coverage. The figures here are the combined premiums for two separate plans.

Similarly, while Section 1331 permits cost-sharing expenses to be moderately higher in the BHP than in the Marketplace, both states make cost sharing lower. New York requires no cost sharing for most services for individuals under 150 percent of FPL and has no deductible and little cost sharing between 150 and 200 percent of FPL.²² Minnesota’s BHP plans have an actuarial value of 94 percent, meaning that enrollees bear, on average, 6 percent of the cost of covered services.²³ This is the same as the Marketplace actuarial value for enrollees with incomes up to 150 percent of FPL. It is considerably

more generous than the 87 percent actuarial value available in the Marketplace for individuals between 150 percent and 200 percent of FPL. Also, children and pregnant individuals in Minnesota's BHP are exempted from any cost sharing.

State Considerations for Establishing and Maintaining a BHP

A BHP will affect consumers' access to and cost of coverage in different ways, depending on their income level and program eligibility. Individuals eligible for the BHP will generally be better off, while some who remain in the individual market could pay higher premiums.

Impact for State Insurance Markets

The main goal of a BHP is to help consumers with incomes up to 200 percent of FPL by increasing affordability and reducing administrative complexity. New York and Minnesota have succeeded in this goal to a substantial extent. But a BHP can also affect higher-income consumers, primarily by influencing premiums in the individual market, from a practice known as silver loading, discussed further below. These changes can reduce affordability by reducing PTCs for certain non-BHP-eligible consumers. Thus, a BHP can create both winners and losers. States could mitigate affordability losses by pairing the BHP with state policies that benefit non-BHP-eligible consumers. Adopting a BHP may also have an opportunity cost—consuming state fiscal resources that could otherwise be used to increase affordability through some other mechanism.

IMPACT FOR THE BHP-ELIGIBLE POPULATION

A BHP has the potential to greatly improve coverage for BHP-eligible consumers, though the impact depends heavily on a state's available funding, implementation choices, and operational systems. A BHP might also reduce consumers' choice of providers, but this does not seem to have happened in New York or Minnesota.

POTENTIAL FOR LOWER OUT-OF-POCKET COSTS AND EXPANDED BENEFITS

Section 1331 generally requires that BHP coverage be at least as affordable and comprehensive as a subsidized Marketplace plan for consumers at the same income level. Federal law requires that premiums be no greater than what an individual at the same income would pay for a silver plan after

APTC. Cost sharing can be slightly less generous but still generous. BHP plans must cover the same essential health benefits as Marketplace plans.

In practice, both premiums and cost sharing for BHP enrollees in New York and Minnesota have generally been lower than they are for individuals enrolled in the Marketplace at the same income level in other states. New York's percentage of uninsured residents was cut in half after implementation of the ACA, an achievement state officials attribute largely to the BHP. In 2021, New York calculated that BHP enrollees saved at least \$1,600 per year, compared with their premiums and out-of-pocket expenses in a Marketplace plan (without the American Rescue Plan PTC enhancements in place).²⁴ Marketplace plans may also lack benefits that Medicaid routinely covers, such as adult dental care. Both New York and Minnesota have been able to offer plans with additional benefits not offered by most Marketplace plans.

The increased affordability and generosity of BHP plans may contribute to the high coverage levels in these states. In 2021, New York's uninsured rate for people between 100 and 199 percent of FPL was 9.3 percent, while Minnesota's rate was 11.2 percent—both well below the national average of 16.8 percent.²⁵ A key reason may be that both state BHPs have eliminated premiums for many (or all, in the case of New York) of their enrollees. There is strong evidence that even a very small premium poses a barrier to low-income individuals' ability to obtain coverage (Fiedler 2022; see also Dague 2014; McIntyre, Shepard, and Wagner 2021). "From a consumer standpoint," said one advocate, "we have seen the relief on people's faces when they are eligible for [Minnesota's BHP] versus the exchange."

It is not guaranteed, however, that other states can replicate the affordability and comprehensiveness of these states' BHP plans. In New York, federal BHP payments far exceed what is needed to match the generosity of plans in the Marketplace. The ACA requires that BHP trust fund dollars be spent only on improving BHP coverage; New York has therefore plowed its surplus back into the program by lowering premiums and cost sharing while increasing benefits and provider reimbursement in order to expand enrollees' access to services. In Minnesota, the picture is more complicated. While BHP coverage is more affordable than most of the state's Marketplace options, Minnesota has had to contribute state funds to finance the program. In other states considering a BHP, increasing affordability depends on specific state conditions or the state's willingness to provide state funding. If a state is willing to provide funding, it has other options to increase affordability, such as a state subsidy. These issues are discussed in greater detail below in the section on state fiscal impact.

REDUCED COMPLEXITY AND FINANCIAL RISK

A BHP can protect consumers from key sources of financial risk and complexity inherent in Marketplace coverage: the reconciliation of APTCs on their annual tax return, annual premium and APTC fluctuations, and plan choice overload.

- **APTC reconciliation.** Consumers receiving APTCs must file a tax return and reconcile what they received in tax credits with what they were entitled to on the basis of their actual income. Consumers who underpredict their income at the start of the year risk owing money to the IRS. Individuals who are paid hourly, have irregular or multiple sources of income, or experience changes in their household composition can face the most difficulty accurately projecting their income, increasing the risk that they will owe money at tax time. The reconciliation is also complicated, creating risks of confusion and mistake.
- **Premium and APTC fluctuation.** Each year, a Marketplace enrollee's premium contribution may change based on the plan options available and the cost of the second lowest cost silver plan available to them. This cost can change, sometimes dramatically, from year to year. If the cost of the second lowest cost silver plan declines significantly relative to the price of the enrollee's existing plan, an enrollee can face significant premium increases if he or she does not return to the Marketplace to shop for a less expensive option.
- **Plan choice overload.** In the FFM, the average enrollee's selection of plans has jumped from 25.9 in 2019 to 113.6 in 2023.²⁶ Too many health plan choices can lead to consumer confusion and frustration and, ultimately, poor enrollment decisions. In many states, the number of plan choices now offered on the Marketplace has increased beyond a point that is productive for consumers.

Individuals in the BHP are not required to reconcile their subsidies or take other actions at tax time, eliminating this source of risk and complexity.²⁷ Further, for the BHPs in New York and Minnesota, state officials have determined benefits, cost sharing, and premiums (or in New York's case, no premiums), reducing premium fluctuation and choice overload as sources of financial risk and administrative burden.

COVERAGE TRANSITION OPPORTUNITIES AND RISKS

Many individuals with incomes at or near FPL experience fluctuations in income that can lead to eligibility changes and put them at risk for coverage gaps. A modest increase in income can result in a loss of Medicaid coverage, and transitions into Marketplace plans can be challenging because of administrative and affordability barriers. In most states, individuals who lose Medicaid must complete a

new application for Marketplace subsidies. If found eligible, they must then choose among plans that, depending on their income, can come with substantial premiums and deductibles. (These affordability challenges have been mitigated by the APTC enhancements in the American Rescue Plan and Inflation Reduction Act, but those enhancements are set to expire after 2025). Individuals losing Medicaid, furthermore, generally have a short time to complete the Marketplace application without experiencing a coverage gap (Levitis and Corlette 2022). Only a small fraction of consumers losing Medicaid successfully enroll in Marketplace coverage, and most of those do experience a gap in coverage (Buettgens, Nichols, and Dorn 2012; MACPAC 2022).

The BHP provides what is effectively a middle layer of coverage between Medicaid and the Marketplaces, creating a “bridge” between Medicaid and the commercial insurance market. Depending on how a state structures its program and eligibility rules, this can either reduce or generate administrative burdens for people who must shift between coverage programs.

A key to reducing burdens is providing seamless transitions between Medicaid and BHP coverage. Structuring the BHP to rely largely on existing Medicaid eligibility systems and the delivery systems of Medicaid managed care plans can ease transitions in coverage and care for individuals under 200 percent of FPL. Both New York and Minnesota have state-based Marketplaces with IT systems across Medicaid, the Children’s Health Insurance Program, the BHP, and the Marketplace that can provide real-time eligibility determinations for individuals applying for coverage. In addition, New York offers 12 months’ continuous coverage for Medicaid enrollees and is implementing the same for BHP enrollees.²⁸ And both New York and Minnesota have maintained continuous eligibility for Medicaid and BHP enrollees throughout the COVID-19 public health emergency. By contrast, Marketplace enrollees who have a change in income or household midyear are required to report it to the Marketplace within 30 days, in order to receive a new determination of eligibility for financial assistance.

However, even with an integrated state-based Marketplace, facilitating seamless transitions is easier said than done. Some stakeholders identified this as a greater challenge in Minnesota than in New York (see, for example, CSEAC 2021).

Minnesota officials also noted that differences in federal rules for Medicaid, BHP, and Marketplace eligibility and enrollment have “made [the BHP] a very difficult program to administer.” The state has sought to better align its BHP eligibility and enrollment with Medicaid rules, but the BHP statute limits flexibility to do so (Chun 2022). To the extent these transitions are not smooth, adopting a BHP may increase administrative burdens by further segmenting eligibility.

Other states considering a BHP, such as Oregon and West Virginia, rely on the federally run platform, HealthCare.gov, to operate their Marketplaces. This likely makes it harder to achieve a single, streamlined eligibility and enrollment process. However, CMS has signaled to Oregon that it will be able to accommodate a BHP (Legislative Policy and Research Office 2022b). Nonetheless, there are limits to how much the federal platform can be integrated with a state’s Medicaid systems or otherwise adjusted to meet a state’s needs. Given these constraints, Oregon officials have set a goal of 2025 to transition to a state-based Marketplace, if approved by the legislature (Legislative Policy and Research Office 2022a).

POTENTIAL DECLINE IN PROVIDER CHOICE

As discussed in greater detail, the financial benefit of a BHP generally depends on BHP plans reimbursing providers at lower rates than qualified health plans. This creates a risk that fewer providers would participate in BHP plans, potentially hurting consumers’ access to care. Stakeholders in both New York and Minnesota report that this has not been a problem. One consumer advocate in New York observed, “The fact of the matter is our [Marketplace] and Medicaid plans really don’t seem that different [in terms of provider network].” But network adequacy could be an issue in other states adopting a BHP, especially if provider participation is a substantial problem in their Medicaid programs.

Impact for Remaining Individual Market Consumers

Implementing a BHP could result in higher costs or market instability for some consumers who purchase individual market insurance on or off a Marketplace, but there are options for states that want to mitigate these risks.

REVERSAL OF APTC AFFORDABILITY GAINS FROM SILVER LOADING

Switching to a BHP will generally result in some remaining APTC-eligible consumers facing higher premiums or cost sharing. This perhaps unintuitive effect arises from the practice of silver loading.

Following the federal government’s decision in 2017 to cease making CSR payments to insurers, most states began requiring insurers to adjust premiums for on-Marketplace silver plans to make up for the lost CSR payments.²⁹ Under silver loading, the on-Marketplace silver premium is effectively the weighted average of the insurer’s cost of providing coverage under the various silver plan CSR variants (table 2), based on how many consumers enroll in each one. This has the effect of increasing silver premiums relative to other tiers.

TABLE 2

Variants in Cost-Sharing Reductions under the Affordable Care Act

Income range (% of FPL)	Actuarial value of silver plan ^a (%)
100–150	94
151–200	87
201–250	73
251 and above	70

Source: Affordable Care Act, Pub. L. No. 111-148 § 1402 (2010).

FPL = federal poverty level.

^a Percentage of total average costs for covered benefits that a plan will cover.

Higher silver premiums, in turn, generally *improve* affordability for APTC-eligible consumers over 200 percent of FPL. APTCs are pegged to the premium for the second lowest cost silver plan in the market but can be used to purchase bronze or gold coverage. Consumers can use their augmented PTCs to purchase a bronze or gold plan at a lower net price than would otherwise be possible. Silver plans often remain the best value for consumers with incomes under 200 percent of FPL, because they are eligible for the 94 percent and 87 percent silver plan variants).³⁰ These enrollment decisions compound the benefit of silver loading by increasing the share of silver enrollees with high-value silver variants, which in turn further increases APTC. The increased APTC allows many consumers to purchase zero-premium bronze and sometimes even gold plans (Fiedler 2021). Although this was likely not the intended consequence of the decision to cut off CSR funding, total federal spending for Marketplace coverage is higher than it would have been if CSR payments had continued. Silver loading has increased benchmark premiums by an estimated 28 percent (Fiedler 2021).

Adopting a BHP largely eliminates the benefits of silver loading for state residents. Consumers between 100 and 200 percent of FPL who would otherwise be eligible for a 94 percent or 87 percent CSR plan instead enroll in the BHP. This removes those higher silver variants from the weighted average, leaving the silver premium close to what it would be based on a 70 percent actuarial value. The result is a reduction in APTCs for many of those remaining in the Marketplace, giving them less purchasing power. Those enrolled in silver coverage are generally unaffected, as their silver premiums would also fall. But those purchasing bronze or gold plans would generally see higher net premiums for the same coverage. Those in gold could switch to silver or bronze plans to reduce their premiums, but then they would face higher cost sharing.³¹ Either way, the affordability boost would be gone.

Reducing affordability for some of those remaining in the Marketplace is not necessarily a deal-breaker for BHP—policymakers may conclude that the benefit to lower-income residents outweighs the cost to these higher-income residents, who are more likely to be able to bear higher premium costs.

Indeed, modeling suggests any coverage losses at higher incomes would be small.³² But it has prompted at least one state—Oregon—to consider ways to mitigate the cost for higher-income enrollees (Legislative Policy and Research Office 2022).³³ This could be accomplished with a premium subsidy in a state with a state-based Marketplace and perhaps through other means in a state (like Oregon) that currently relies on HealthCare.gov. Either way, the state would generally bear the cost of such mitigations, given the prohibition on using BHP funds for anything other than benefits for the BHP-eligible population.

EFFECTS ON MARKET STABILITY AND PREMIUMS FOR UNSUBSIDIZED INDIVIDUALS

In addition to the impact on silver plans discussed above, switching to a BHP could affect individual market premiums by removing a significant number of enrollees from the risk pool. If the BHP population has lower expected utilization than the individual market population overall, removing it will generally increase premiums, and vice versa. Removing the BHP population could also deter some insurers from participating in the Marketplaces, leaving some regions with limited plan choices. New York requires insurers that participate in Medicaid to participate in the Marketplace, but few states have a similar mandate.³⁴ Concerns about market stability may be magnified in lower-population states where the remaining individual market would be smaller.

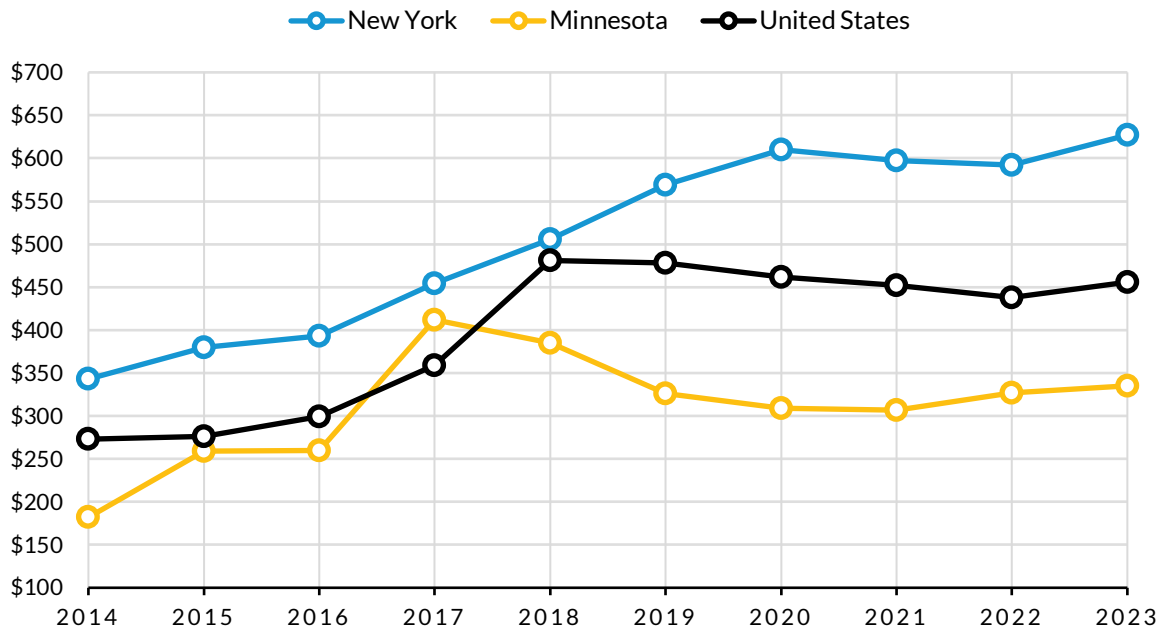
As noted above, APTC-eligible individuals are generally insulated from premium changes, because APTC generally adjusts dollar-for-dollar with market premiums. But individuals who are ineligible for APTC—perhaps because their income is too high or because of immigration status—will be directly affected by any premium changes, for better or for worse. There could also be a small impact on subsidized individuals if a change in overall premium levels changes the differential between the benchmark silver premium and others. But such impacts are likely to be marginal and to move in opposing directions for different types of coverage.³⁵

Before implementing a BHP, New York and Minnesota conducted analyses to assess the impact the program would have on their individual markets. Some stakeholders were concerned that the BHP would siphon away from their fledgling state-based Marketplaces a significant proportion of enrollees, leaving the Marketplaces with smaller, less stable risk pools and higher premiums. In New York, state officials reported that they received projections of a “modest” premium impact. Minnesota’s actuarial estimates suggested the Marketplace would experience a significant decline in enrollment, but that it would not adversely impact premiums because the population eligible for the BHP is generally sicker than higher-income individuals remaining in the Marketplace (Gruber et al. 2013). In practice,

stakeholders in both states acknowledged challenges predicting—and pricing for—the health risk of the population enrolling in BHP and Marketplace plans.

Of the two states, Minnesota’s individual market experienced more instability after transitioning to a BHP, with average premiums for benchmark silver plans increasing dramatically between 2016 and 2017 (figure 1). However, stakeholders and officials in that state place much of the blame on health insurers who had set their initial Marketplace premiums too low, resulting in significant financial losses, rather than the transition to a BHP. When Minnesota implemented its reinsurance program in 2017, individual market premiums declined and have remained relatively stable since (figure 1).

FIGURE 1
Marketplace Average Benchmark Premiums in New York, Minnesota, and the United States, 2014–23



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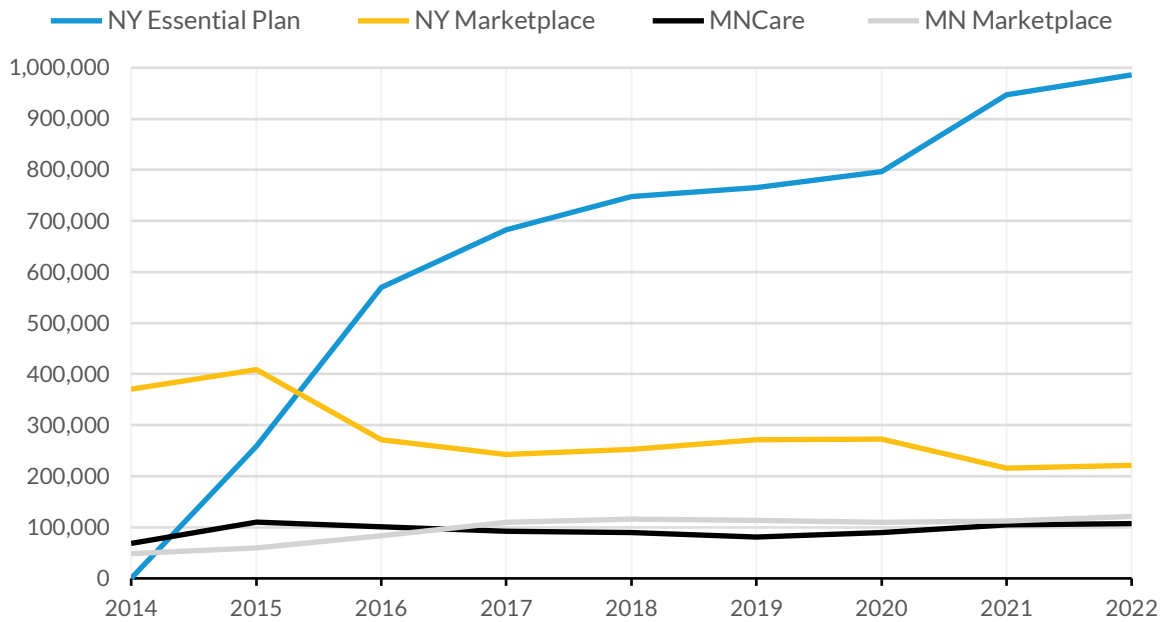
Source: KFF, “Marketplace Average Benchmark Premiums,” <https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums>.

Note: Annual benchmark premium calculated for a 40-year-old in each county, weighted by county plan selections.

New York’s individual market has been more stable. Marketplace enrollment has been flat since 2016, while BHP enrollment has grown steadily, likely driven at least in part by the latter program’s extremely low (and now zero-dollar) premiums and generous benefits (figure 2).

FIGURE 2

Basic Health Program and Marketplace Enrollment, New York and Minnesota, 2014–22



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Sources: New York Department of Health, “Basic Health Program Annual Reports,” https://www.health.ny.gov/health_care/managed_care/essential/; Minnesota Department of Human Services, “Managed Care Enrollment Figures,” https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_141529; KFF, “Marketplace Enrollment,” <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/>.

As part of the planning and design of a BHP in Oregon, the legislature directed the state to analyze the program’s potential to disrupt the individual and small-group insurance markets and to identify any mitigating measures.³⁶ Oregon projects that 32,500 people will transition out of its Marketplace and into a BHP once the state has launched the program. This would leave the Marketplace with a smaller pool of people, potentially resulting in a less stable base for participating insurers to set premiums (Sweeney 2022).

State Fiscal Impact

A key issue for a state considering a BHP is its cost to the state budget. The cost of a BHP depends in part on the generosity of the coverage provided. But the cost to the state depends also—and more directly—on how the cost of the program compares with federal funding. And that in turn depends heavily on Marketplace premiums and on the differential between provider reimbursement rates in the

individual market and Medicaid—which is typically the basis for a BHP. Where Marketplace reimbursements and premiums are high, BHP funding can support a generous program with little or no state contribution. Where Marketplace and Medicaid costs are similar, 95 percent of Marketplace subsidies will generally not support a generous program.

New York and Minnesota have had different experiences from a financing standpoint. Setting aside modest administrative costs, New York's BHP is fully funded by federal payments even after eliminating premiums and expanding benefits, with funds left over for a surplus.

For Minnesota, the experience has been less positive, though recent federal policy changes suggest a better outlook going forward. In state fiscal year 2020, federal BHP payments covered less than 70 percent of BHP expenditures, leaving a gap of over \$100 million, although the BHP continues to charge premiums.³⁷ However, this was before two recent federal policy changes: (1) the change in how the BHP funding methodology accounts for reinsurance, as discussed above and (2) enhanced federal tax credits under the American Rescue Plan and now the Inflation Reduction Act. Minnesota's forecasts for fiscal year 2025, when both of these changes will be in effect, show federal payments fully covering the state's share of the program. And forecasts for fiscal year 2027, when the PTC enhancements are set to have expired, show the state's share at only around \$20 million—around 3 percent of the cost of the program.³⁸

The math is likely to differ across states. An Urban Institute analysis of a potential BHP in West Virginia found that it would be financially viable for the state to implement a BHP with generous benefits that would reduce the uninsured rate by up to 8.9 percent (Buettgens and Ramchandani 2023). Similarly, an Illinois actuarial analysis concluded that the state could reduce the uninsured rate among people under 200 percent of FPL by 13.2 percent, financed solely by federal dollars (not including administrative expenses) (IHFS and IDoI 2021). Conversely, a separate Urban Institute analysis of a potential BHP in New Mexico found that it would cost the state \$90 million per year—a large amount for such a small state (Buettgens et al. 2020). Understanding this variation requires digging into the peculiarities of the markets in each state. States considering BHPs would do well to conduct actuarial or other financial projections to determine the program's potential fiscal impact.

DIFFERENCES IN PROVIDER REIMBURSEMENT RATES AND PREMIUMS ACROSS MARKETS

Generally, the most important factors in the fiscal viability of a BHP are the level of Marketplace premiums and the difference between provider reimbursement rates in the individual market and those paid under the BHP. The prices paid to hospitals and clinicians are the primary drivers of a health plan's premium costs (Anderson, Hussey, and Petrosyan 2019). Ninety-five percent of expected Marketplace

subsidies is not enough to maintain the same level of affordability for BHP enrollees if the BHP relies on a product with Marketplace-level provider reimbursement rates.

If a state has a substantial gap between Medicaid and commercial provider rates and can keep its BHP provider rates on par with Medicaid (or some modest multiple thereof), it is more likely to be able to rely exclusively on federal dollars to finance the program. New York’s Marketplace premiums are significantly higher than the national average, which translates into large BHP payments (Holahan, Wengle, and O’Brien 2022). In New York and in most states, Medicaid reimbursement rates are substantially lower than rates in the individual market. It is not surprising, then, that the state can support a generous BHP using something above Medicaid rates.

On the other hand, if a state’s Marketplace premiums are not much higher than its Medicaid costs, the BHP is likely less financially attractive. This appears to be the story in New Mexico. The high cost estimate for operating a BHP in that state is largely because the state’s low Marketplace premiums did not give the state enough room to take advantage of lower BHP provider reimbursement rates (Buettgens et al. 2020).

Minnesota has Marketplace premiums well below the national average (even after disregarding the state’s reinsurance program), which leaves less space for savings when using something close to Medicaid rates (Holahan, Wengle, and O’Brien 2022) (table 3). Low premiums are especially likely in states where the individual market is dominated by companies that have historically focused on the Medicaid managed care sector. Even when a substantial gap exists, federal funding could be insufficient if, as part of the negotiation leading to a BHP, the state agreed to provider rates not much below commercial rates.

TABLE 3
Average Monthly Benchmark Premiums for a 40-Year-Old Nonsmoker in New York, Minnesota, and the United States, 2019–22

	2019	2020	2021	2022
New York	\$572	\$599	\$595	\$604
Minnesota	\$333	\$312	\$306	\$319
US average	\$468	\$453	\$446	\$438

Source: John Holahan, Erik Wengle, and Claire O’Brien, “Marketplace Competition and Premiums, 2019–2021” (Washington, DC: Urban Institute, 2022), <https://www.urban.org/research/publication/marketplace-competition-and-premiums-2019-2022>.

A state without a substantial gap could still support a BHP with highly affordable coverage by paying for the affordability improvements with state funds. The question for such a state would be

whether a BHP provides more bang for the buck for those state dollars than other affordability mechanisms.

States have several alternative options to support coverage and affordability that require substantial state funding. For example, several states have established Marketplace subsidies that wrap around PTCs or CSRs, but states must generally pay for them from state funds (Levitis and Pandit 2021). State programs can also provide subsidized coverage to individuals ineligible for federal subsidies by reason of immigration status, but again using state funds (Manatt 2021). Finding funding is often the biggest barrier to enacting such measures.

States could also look to Section 1332 waivers to turn premium savings into funding for affordability improvements. But their impact is limited by the statutory deficit neutrality requirement, which prohibits a waiver from increasing total net federal spending. This constraint means that a waiver can seldom finance significant affordability improvements for PTC-eligible individuals, considering the cost of such improvements, and the PTC for any resulting new enrollment would be strictly capped at the amount of savings generated by the waiver. The BHP funding proposition appears more promising, considering the state receives 95 percent of expected APTC *per person* enrolled in the program.

COMMUNITY RATING AND RISK POOLS

One unique factor in the New York BHP's strong financial performance may be the state's prohibition on age rating in the individual market. New York is one of just two states that prohibit individual market insurers from using age as a factor in setting premiums (Giovannelli, Lucia, and Corlette 2014). This means that, unlike in most states that have adopted the ACA's rating standards, New York insurers cannot charge older individuals up to three times the premium they charge to a young person. New York's BHP enrollment skews younger than Marketplace enrollment: 36 percent of enrollees in the BHP are 34 or younger, compared with 30 percent in the Marketplace.³⁹ Younger people tend to use fewer services, so the New York BHP's risk pool is likely healthier than the Marketplace's risk pool, lowering overall costs. This increases New York's BHP payments relative to the cost of the program, because the remaining Marketplace population—which determines Marketplace premiums—is older on average than the BHP population.⁴⁰ The result is that the BHP is funded by payments based on premiums for an older population but provides services to a younger population—a strong recipe for a surplus.

REINSURANCE

Minnesota lost a significant amount of BHP funding when it implemented its reinsurance program, as discussed above. The recently finalized changes to the federal payment methodology will likely remove this issue as a consideration.

Potential Innovations

States have begun to explore how a BHP may interact with other policy options to permit innovation. For example, there has been interest in coordinating a BHP with a state innovation waiver under ACA Section 1332 and in using a BHP as the basis for a public option plan, perhaps to extend the benefits of a 1331 to a broader population. Legislation enacted in New York calls for the state to consider options along these lines.⁴¹ While the rules for such efforts are not clear, a few considerations may be helpful:

- A key constraint on combining a BHP with a Section 1332 waiver is that Section 1331 is not a “waivable provision” under Section 1332(a)(2). This means that a Section 1332 waiver cannot change BHP rules. For example, a Section 1332 waiver probably could not be used to increase the BHP income cap above 200 percent of FPL.
- A state could embed a BHP change within a Section 1332 waiver plan. For example, a state could submit a Section 1332 waiver promising that it will terminate or suspend a BHP if and only if the waiver is approved, replacing the BHP with other (perhaps similar) coverage. This could be especially attractive if federal BHP payments exceed the cost of the BHP. A state pursuing such a waiver could receive the expected baseline BHP funding stream as Section 1332 pass-through funding, considering that this funding is standing in for and statutorily tied to PTC spending. But both the statute and Section 1332 guidance are silent on this issue. A state could also establish a BHP as part of a Section 1332 waiver plan. But this seems more challenging, given federal guidance prohibiting Section 1332 waivers that require additional simultaneous federal determinations, such as approval of coordinated Section 1115 waivers.
- Finally, a state with a BHP could create a BHP analog for residents with incomes above 200 percent of FPL as a sort of public option. Doing this through a 1332 waiver could allow the state to collect any resulting savings as pass-through funding, though the savings could quickly be exhausted if enrollment increased. A Section 1332 waiver might also allow greater flexibility regarding the design of the plan and improve seamlessness. Minnesota legislators are considering such an option, with legislation to create a BHP “public option” that would allow higher-income individuals to enroll in the BHP instead of a Marketplace plan.⁴²

States have only just begun to explore these and other options, and much work remains to be done.

BHP Appeal versus Other Coverage Expansion Options

New York and Minnesota have been able to generate and sustain broad stakeholder support for their BHPs. In both states, “strange bedfellow” coalitions of consumer advocates, providers, and health plans supported the BHP at its inception. Seven years later, many of these same stakeholders reported general, though not unqualified, satisfaction with how the program is working.

Each state has its unique blend of market and stakeholder dynamics. However, for states seeking federal funding to expand coverage and make it more affordable to more people, particularly those with lower incomes, the BHP could have broader political appeal than other potential options. Consumer advocates strongly support the BHP in New York and Minnesota because it offers low-income consumers considerably more affordable coverage than what they can obtain through the Marketplace.

Health insurers are more qualified in their enthusiasm for the program. However, many health insurers now offer both Medicaid managed care and Marketplace plans. Insurer stakeholders in New York and Minnesota noted that the BHP offers these insurers an opportunity to retain a greater proportion of enrollees who lose Medicaid eligibility when their income rises; this ability will be of even greater importance once state Medicaid agencies resume eligibility redeterminations after the COVID-19 public health emergency ends.⁴³

Providers are the least likely to support the BHP because their reimbursements are closer to Medicaid than commercial rates. However, some may recognize that the program covers many people who would otherwise be uninsured and unable to pay for care. Further, provider stakeholders in New York and Minnesota applauded the BHP’s lack of deductibles and modest cost sharing. Increasingly high deductibles in commercial insurance have become a dominant source of bad debt for providers,⁴⁴ giving the BHP’s zero-deductible coverage greater appeal.

Conclusion

New York and Minnesota’s BHPs have both shown great success in making coverage affordable for low-income consumers. Although financing has not been as advantageous for Minnesota’s BHP as for New York’s, federal policy changes will improve the state program’s fiscal picture, at least temporarily. However, it is not clear that these states’ experiences are replicable in others. Much depends on state-specific factors, particularly the difference in provider reimbursement rates between Medicaid and the commercial market. States considering adopting a BHP will need to conduct robust analysis to project

the impact of the program on consumers and other stakeholders, including the impact of a BHP on consumers who continue to receive premium subsidies through the ACA's Marketplaces.

Notes

- ¹ Oregon H.B. 4035, 81st Assem. (2022), <https://olis.oregonlegislature.gov/liz/2022R1/Measures/Overview/HB4035>.
- ² Kentucky H.B. 1, 22 R.S. B.R. 1180 (2022), <https://apps.legislature.ky.gov/record/22rs/hb1.html>.
- ³ “Basic Health Program,” Kentucky Cabinet for Health and Family Services, <https://chfs.ky.gov/agencies/dms/member/Pages/bhp.aspx>.
- ⁴ Megan Messerly, “Oregon, Kentucky Dust Off an Obama-Era Policy to Expand Health Insurance,” *Politico*, April 30, 2022, <https://www.politico.com/news/2022/04/29/oregon-kentucky-dust-off-an-obama-era-policy-to-expand-health-insurance-00029111>.
- ⁵ New York and Minnesota use different FPL guidelines to determine eligibility levels for their respective BHPs each year. Minnesota applies 2022 FPL guidelines for 2023 coverage for both the state’s BHP and state-based Marketplace. New York is currently not permitted to align FPL guidelines for its BHP and state-based Marketplace (based on state laws and regulations governing the New York BHP). As a result, income eligibility levels for New York’s Essential Plan reflect the 2023 federal poverty guidelines: \$29,160 for an individual or \$60,000 for a family of four.
- ⁶ The BHP does not, however, cover individuals ages 65 and older (42 U.S.C. 18051(e)(1)(D)). As a result, individuals 65 and older who are not eligible for Medicare or Medicaid generally remain eligible for advance premium tax credits, as in non-BHP states.
- ⁷ 42 U.S.C. 18051(d)(2).
- ⁸ 42 C.F.R. 600.705(d)(2).
- ⁹ 42 C.F.R. §600.1 et. seq.
- ¹⁰ 42 C.F.R. §600.700 et. seq.
- ¹¹ Section 1332 of the ACA permits a state to apply for a state innovation waiver (also referred to as Section 1332 waiver) to pursue alternative strategies for providing residents with access to comprehensive, affordable health coverage while retaining many ACA consumer protections.
- ¹² Minnesota Department of Human Services, “The Cost of Reinsurance to MinnesotaCare,” <https://www.house.leg.state.mn.us/comm/docs/aCFnz-tmJUS03UzSSelyTg.pdf>.
- ¹³ 87 Fed. Reg. 77722 (Dec. 20, 2022), <https://www.federalregister.gov/documents/2022/12/20/2022-27211/basic-health-program-federal-funding-methodology-for-program-year-2023-and-changes-to-the-basic>.
- ¹⁴ Cynthia M. MacDonald (Assistant Commissioner and Minnesota Medicaid Director, Minnesota Department of Human Services), letter to CMS, June 22, 2022, <https://www.regulations.gov/comment/CMS-2022-0092-0005>; New York State of Health, “NY State of Health Comments on the Basic Health Program Federal Funding Methodology (“Proposed Methodology”) for Program Year 2023,” June 24, 2022, <https://www.regulations.gov/comment/CMS-2022-0092-0008>.
- ¹⁵ Juliet Eilperin, Amy Goldstein, and Carolyn Y. Johnson, “White House’s Decision to Stop ACA Cost-Sharing Subsidies Triggers Strong Opposition,” *Washington Post*, October 13, 2017, https://www.washingtonpost.com/politics/white-house-tells-court-it-is-immediately-stopping-aca-cost-sharing-subsidies/2017/10/13/4c404234-b01d-11e7-be94-fabb0f1e9ffb_story.html.
- ¹⁶ CMS, “Final Administrative Order,” August 24, 2018, <https://www.medicaid.gov/sites/default/files/2019-11/final-admin-order-2018-revised-payment-methodology.pdf>.

- ¹⁷ CMS, “Biden-Harris Administration Extends Millions in Funding to Minnesota for MinnesotaCare, Its Basic Health Program, Key Connection to Coverage Supported by American Rescue Plan,” Press Release, November 10, 2021, <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-extends-millions-funding-minnesota-minnesotacare-its-basic-health>; CMS, “Biden-Harris Administration Extends Hundreds of Millions of Dollars to New York’s Essential Plan, Its Basic Health Program, Key Connection to Coverage Supported by American Rescue Plan,” Press Release, November 10, 2021, <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-extends-hundreds-millions-dollars-new-yorks-essential-plan-its-basic>.
- ¹⁸ *Aliessa v. Novello*, 2001 WL 605188 (N.Y. Ct. of App. 2001).
- ¹⁹ Information about BHP provider reimbursement rates is gathered from interviews with New York state officials and affected stakeholders.
- ²⁰ MN Stat. § 256L.11 (2022).
- ²¹ Minnesota Department of Human Services, “MinnesotaCare Premium Estimator Table,” State of Minnesota, 2022, <https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-4139A-ENG>. Minnesota’s BHP premiums were also generally lower than post-APTC premiums before APTCs were increased by the American Rescue Plan Act (Chun 2021).
- ²² “2023 Invitation for Participation in NY State of Health,” New York State of Health, May 4, 2022, <https://info.nystateofhealth.ny.gov/2023invitation>.
- ²³ MN Stat. § 256L.03 (2021).
- ²⁴ “Health Insurance Coverage Update,” New York State of Health, September 2021, https://info.nystateofhealth.ny.gov/sites/default/files/Health%20Insurance%20Coverage%20Update%20-%20September%202021_0.pdf.
- ²⁵ “Uninsured Rate for the Nonelderly by Federal Poverty Level,” KFF, 2021, <https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-federal-poverty-level-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- ²⁶ 87 Fed. Reg. 78206, 78281 (Dec. 21, 2022).
- ²⁷ There is an unrelated “true-up” between the state and the federal government, in which preliminary trust fund contributions based on projections are adjusted on the basis of actual enrollment. But this process has no impact on individuals and is invisible to them.
- ²⁸ New York State of Health, “Basic Health Plan Program Amendment,” November 22, 2022, <https://info.nystateofhealth.ny.gov/2022BHPblueprintamendment>.
- ²⁹ Sabrina Corlette, Kevin Lucia, and Maanasa Kona, “States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments,” Commonwealth Fund blog, October 27, 2017, <https://www.commonwealthfund.org/blog/2017/states-step-protect-consumers-wake-cuts-aca-cost-sharing-reduction-payments>.
- ³⁰ To qualify for a CSR plan, eligible individuals must enroll in a silver Marketplace plan.
- ³¹ We are unable to estimate the magnitude of the higher premiums that some Marketplace enrollees above 200 percent of FPL would have to pay if they switched from gold to silver or bronze plans, as the impact would be state-specific.
- ³² Oregon estimates that roughly 900 APTC-eligible individuals would drop qualifying health plan coverage as a result of the decrease in PTCs for those just above 200 percent of FPL. Another 4,200 APTC-eligible individuals might switch to a less expensive plan (Legislative Policy and Research Office 2022).

- ³³ See also House Bill 4035 Joint Task Force on the Bridge Health Care Program, “Final Recommendations to the Oregon Legislative Assembly,” December 2022, <https://www.oregonlegislature.gov/lpro/Publications/Joint%20Task%20Force%20on%20the%20Bridge%20Health%20Care%20Program%20-%20Report%20and%20Recommendations%20Dec.%202022.pdf>.
- ³⁴ New York Executive Order No. 167, “Ban on Insurers That Withdraw From New York State of Health, New York’s Official Health Plan Marketplace,” June 9, 2017. <https://www.governor.ny.gov/sites/default/files/atoms/files/EO%20%23167.pdf>.
- ³⁵ For example, suppose a consumer’s expected contribution for a benchmark silver plan is \$200 per month. If the monthly benchmark premium were \$700, the consumer would qualify for APTC of \$500 per month. If bronze and gold plans cost \$600 and \$800, respectively, these consumers would pay \$100 or \$300. If all premiums increase by 10 percent (to \$660, \$770, and \$880), the benchmark silver plan consumer’s APTC would rise to \$570 (\$770 – \$200), leaving the consumer’s cost at \$200. But the bronze consumers’ cost would fall \$10 to \$90 (\$660 – \$570), and the gold consumers’ cost would increase \$10 to \$310 (\$880 – \$570).
- ³⁶ Oregon H.B. 4035 (2022), <https://olis.oregonlegislature.gov/liz/2022R1/Measures/Overview/HB4035>.
- ³⁷ Specifically, federal payments to Minnesota’s BHP in state fiscal year 2020 totaled \$271 million, while the program spent \$396 million. For 2020, the state covered the difference by spending down its BHP trust fund. See “BHP Trust Fund—November 2022 Forecast,” Minnesota Department of Human Services, December 6, 2022. https://mn.gov/dhs/assets/BHP_Trust_Fund_Feb22_tcm1053-520078.pdf.
- ³⁸ “BHP Trust Fund,” Minnesota Department of Human Services.
- ³⁹ “Health Insurance Coverage Update: Impact of ARPA Subsidies,” New York State of Health, July 2022, <https://info.nystateofhealth.ny.gov/sites/default/files/NY%20State%20of%20Health%20Insurance%20Coverage%20Update%2C%20July%202022.pdf>.
- ⁴⁰ “At a Glance: 2020 Open Enrollment Report,” New York State of Health, <https://info.nystateofhealth.ny.gov/sites/default/files/2020%20NY%20State%20of%20Health%20Open%20Enrollment%20Report.pdf>.
- ⁴¹ New York SFY 2023 Enacted Budget (passed through the NYS Assembly Education, Labor and Family Assistance Bill on April 9, 2022), https://nyassembly.gov/leg/?default_fld=%0D%0A&leg_video=&bn=A9006-C&term=2021&Summary=Y&Actions=Y&Memo=Y&Text=Y.
- ⁴² Minnesota H.F. 11 (2022), https://www.revisor.mn.gov/bills/text.php?number=HF11&version=4&session=1s92&session_year=2021&session_number=0.
- ⁴³ The United States declared a public health emergency caused by the COVID-19 pandemic in January 2020. Congressional relief legislation enacted in March 2020 required states to provide continuous coverage for Medicaid enrollees in exchange for enhanced federal financing for the duration of the public health emergency. The Consolidated Appropriations Act of 2023 winds down that enhanced federal funding and enables states to resume Medicaid eligibility redeterminations and renewals effective March 31, 2023. A projected 18 million people could be disenrolled from the program.
- ⁴⁴ Caroline Hudson, “Insured Patients Become Top Reason for Bad Debt at Providers,” *Modern Healthcare*, August 23, 2022, https://www.modernhealthcare.com/finance/insured-patients-become-top-reason-bad-debt-providers?adobe_mc=MCMID%3D75758763439609248431748364585760504897%7CMCORID%3D138FF2554E6E7220A4C98C6%2540AdobeOrg%7CTS%3D1661360832&CSAuthResp=1%3A%3A1024080%3A7461%3A24%3Asuccess%3AE580A29027653DFB8DC545E21941D3B0.

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