ACAP
Association for Community Affiliated Plans

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Ms. Cindy Mann, Director
Center for Medicaid, CHIP, Survey and Certification
Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Basic Health Program Option, Section 1331 of the Affordable Care Act

Dear Ms. Mann:

On behalf of the Association for Community Affiliated Plan's 55 Medicaid safety net health plan members, I am writing to urge the Centers for Medicare and Medicaid (CMS) to issue guidance within the next six months on the Basic Health program option so that state policymakers can factor that option into their Exchange analyses.

ACAP is encouraged that many states are well underway in developing the vision and tools to establish their state Health Benefit Exchange and how it will interface with other public coverage programs, including Medicaid. ACAP member plans are actively engaged in preparation to participate in these new marketplaces, with a specific focus on serving low-income working families and individuals.

As you know, the Basic Health program (BHP), established by Section 1331 of the Patient Protection and Affordable Care Act (ACA), provides states with an option to cover residents with income under 200 percent of the federal poverty level (FPL) through a program offered "outside of the Exchange" beginning in 2014. Discussions about BHP have occurred nationally, coordinated by organizations such as ACAP, as well as in many states, including California, Colorado, Maine, New York, Oregon, Pennsylvania, Rhode Island and Washington. State interest in this option is driven by a variety of factors, including the desire to align coverage for low-income persons, thus smoothing transitions between programs when household income changes and providing consistent health plan choices when members of a given family qualify for different public programs and potentially offering coverage options with lower cost-sharing.

It has become clear that consideration of the BHP option cannot be separated from decisions a state must make about the structure and function of their Exchange. Research reveals that a sizeable majority of the uninsured have incomes under 200 percent of the FPL. If a state opts to offer a BHP, these individuals will access coverage outside the Exchange, thus having a significant impact on the size and composition of the individual market within

the Exchange. State policy-makers therefore must have sufficient information to make the BHP decision before designing the Exchange marketplace. Specifically, we urge CMS, in collaboration with other relevant federal agencies, to promptly issue:

- Detailed data on the tax credits and federal cost-sharing subsidies states can use to determine the financial feasibility of offering a BHP; and
- Detailed guidance on BHP provisions and rules.

Included below are more extensive comments that we hope you will consider as you develop the BHP guidance.

Advantages of the Basic Health Program

As you know, the BHP focuses on individuals with income between 133 and 200 percent of the federal poverty level (FPL). The February 2011 issue of *Health Affairs* includes research co-authored by Professor Benjamin Sommers, MD, PhD, of the Harvard School of Public Health, and Professor Sara Rosenbaum, JD, Chair of the Department of Health Policy at the George Washington University School of Public Health and Health Services, which examines the potential for gaps in health coverage for some Americans under the ACA. They project that 50 percent of individuals below 200 percent of the FPL would experience at least one income change over the course of a year, thereby changing their eligibility for federal tax credits and assistance to afford health coverage. As the authors state, it seems highly likely that many families will face income-related insurance coverage disruptions under health reform.

While the federal tax credits and cost-sharing subsidies will provide working families and individuals with critical assistance for purchasing health coverage, the BHP may offer comparative advantages for low-income populations who would otherwise be eligible for Exchange subsidies, including:

- **Affordability:** BHP could be designed to offer coverage at lower premium and out-of-pocket expense to members than Exchange coverage, thereby increasing the likelihood low-income individuals would choose to enroll;
- **Quality:** BHP may provide low-income residents the opportunity to enroll with Medicaid Safety Net Health Plans that have a track record and expertise working with vulnerable populations. This could result in better comprehensive medical, behavioral health and substance abuse coverage plus important benefits such as transportation, interpreters, and social needs coordination;
- **Stability**: BHP may help reduce the amount of churn by members between public and private coverage, allowing them to remain with the same providers and Safety Net Health Plans and retain the same or similar benefits and cost structures. At a minimum, it may provide a smoother transition for enrollees whose income changes do push them to another program; and

- **Family unity**: BHP may allow families to remain covered in the same plan, rather than parents and children split between commercial and public coverage. This is particularly true if Medicaid and BHP participating plans do not participate in the Exchange.

States also may realize positive outcomes, including:

- **Fewer uninsured**: If the BHP is designed to offer coverage at a lower cost for consumers than Exchange coverage, a larger number of residents may access coverage; and
- **Reduced administrative burden**: If the BHP is designed to streamline eligibility with Medicaid, CHIP and the Exchange, any resulting reduction in churn on and off of public coverage also may reduce the administrative burden on state Medicaid agencies.

Timing of State Decisions on Basic Health and Exchange Policies

Several Medicaid safety net health plans, along with providers, consumer advocates and state policymakers, have expressed a deep interest in the potential of their state implementing the BHP. As states conduct analysis and implement Exchange-enabling legislation, policymakers need information to make an informed choice about the BHP opportunity. Specifically, we ask CMS to provide the following for states:

- **Establish a proxy for BHP funding**. BHP funding available to states is related to how subsidies for commercial Exchange coverage are calculated. While it may be too early to give exact figures, in the next few months states will need an expedited proxy of estimated premium and cost sharing subsidies available to individuals via the Exchanges. We encourage CMS, in collaboration with other appropriate federal agencies as appropriate, to establish an estimated subsidy level or identify a reasonable method states can use to make such estimates which will determine BHP funding, allowing states to fully assess feasibility of the BHP. ACAP recognizes that federal agencies have many important timelines to meet. However, we are concerned that *not* providing this information to states within the next few months could threaten states' efforts to implement the BHP option and make sound decisions about the structure of their Exchanges. Currently, states face a barrier to thoroughly evaluating and making decisions regarding the BHP because they do not have a reliable understanding of the financial implications.

- **Establish a "hold harmless" for states**. We recommend CMS establish a "hold harmless" for states in order to minimize their financial risk from implementing the BHP. For example, a hold harmless threshold set at a certain percentage would protect states in case the federal funding estimates for the BHP are inaccurate. This

could be particularly important in the early years of the BHP and Exchange when there will be greater uncertainty of the risk profile and utilization patterns of enrollees.

Structural and Programmatic Recommendations

Medicaid, BHP and Exchange regulations and statute allow for considerable flexibility for states to determine the structure and scope of their programs. Safety Net Health Plans are prepared to work with state policymakers to design the BHP in ways that best align the three programs and meet the needs of low-income residents. We ask you to consider the following recommendations to facilitate our goals.

- **Permit flexibility in risk pool structures.** Characteristics of the markets and risk pools will likely vary considerably across states. Each state will need to assess the potential impact on risk pools due to establishment of the BHP. For these reasons, ACAP recommends that federal regulations provide states with the flexibility to determine whether their residents are best served by merging the BHP market with the Exchange marketplace and/or Medicaid program.

- **Allow states to leverage existing public program policies and structures.** The BHP regulations should explicitly allow states to use their current Medicaid or Children's Health Insurance Program (CHIP) policies and structures given the similarity in the population that would be enrolled. For example, states should have the option to establish a BHP by amending existing Medicaid or CHIP contracts. Contract amendments could accommodate new BHP rules and we urge CMS to work with states to facilitate this. In addition, states should have the option to use existing Medicaid or CHIP accreditation, licensing, and reserve standards for the BHP.

  By allowing states to use their existing Medicaid and CHIP infrastructures, BHP becomes a "turnkey" start-up that could minimize administrative costs, enhance seamless interface with other public coverage options, and minimize confusion among potential members and providers.

- **Include essential community providers in BHP networks.** Safety Net Health Plans have a unique relationship with safety net providers, including federally qualified health centers which comprise a significant portion of plans' networks. ACAP strongly supports the ACA's requirement that Exchange plans contract with such providers. We believe this contracting requirement should extend to the BHP.

- **Ensure the adequacy of rates to BHP participating plans.** We recommend that CMS ensure that states' rates to health plans are actuarially sound based on the risk profile of the BHP enrollees.

- **Treat the BHP as a public program.** We request that CMS use the full extent of its authority to issue guidance stating that nonprofit safety net health plan revenue from the BHP program is not counted as commercial income with regard to the ACA's health insurer fee. This is consistent with the ACA's treatment of public program revenues for nonprofit Medicaid safety net health plans. Alternatively, if CMS determines this is beyond the scope of its authority, we urge the agency to work with Congress to address this via future legislation.

- **Permit flexibility in scope**. States should be permitted to implement a BHP on a regional basis and not be required to make it available statewide, still taking care to ensure BHP plans do not "cherry pick" certain populations. For example, states may wish to leverage their existing Medicaid managed care or CHIP programs to create a Basic Health program. However, their Medicaid managed care programs may only operate in certain regions of the state because it may not be feasible to have health plans or networks in other regions.

  States also should be permitted to implement a BHP for specific categories of individuals between 133 and 200 percent of the FPL. As an example, some state Medicaid programs include pregnant women up to 185 percent of the FPL, but no other categories of individuals at this income level. A state may wish to offer the BHP program to this vulnerable population because it may be relatively more affordable and have more comprehensive benefits as compared to coverage offered in the Exchange in some states.

- **Permit BHP in states with a federally-operated Exchange.** If a state opts to have a federally operated Exchange, we recommend that the state retain the option to establish a BHP. While the Exchange and BHP programs are tied together by their funding sources, we recommend that CMS treat these as distinct decisions by state officials and work with any state interested in implementing the BHP.

- **Allow states to establish consistent quality standards.** We recommend that states have the flexibility to align the quality standards across their Medicaid, BHP and Exchange programs. We believe this would ensure that all residents have access to high-quality plans, regardless of the specific program for which they are eligible. Further this would be the most transparent, least confusing way to ensure consumers can compare plans, and would avoid additional administrative expense associated with administering different standard and performance measures.

Enrollee eligibility and transitions

Safety Net Health Plans have extensive experience with the problem of "churning" and the adverse impact on the quality of care for Medicaid, CHIP, Medicare Special Needs Plans and

enrollees in other public programs. One of the benefits of the BHP is that it can improve enrollment, retention and access to care for low-income adults. Families would have stability of coverage, and churn between public and private coverage could be significantly reduced for these vulnerable families. A BHP could help to reduce churning by implementing the following eligibility policies.

- **Standardize the health coverage eligibility period.** To ensure financial stability of a state's BHP program, we recommend that the BHP utilize the same requirement for reporting income and changes in circumstances as those to be used by the Exchange and/or Medicaid. States should be allowed to establish an annual eligibility determination period for the BHP and Medicaid. Consistency is imperative for the efficiency of the systems that will be used and for all stakeholders involved, including enrollees.

- **Minimize disruptions during enrollee transitions.** To realize the benefits of the BHP, as individuals become ineligible for the BHP and eligible for Medicaid or subsidized Exchange coverage, the termination of the BHP and start of other coverage should be coordinated so individuals and families do not experience coverage gaps. Safety Net Health Plans encourage HHS to work with states to establish a "safe harbor" of coverage which would allow individuals and families in transition to continue to receive benefits under the BHP until they are enrolled in Medicaid or subsidized Exchange coverage.

- **Allow states to cover administrative costs of operating the program from the BHP program funding.** States will incur costs associated with administering an effective BHP program. We recommend that states be permitted to use BHP funds to support their administrative costs.

We appreciate your consideration of our recommendations and we look forward to working with the Department to ensure low-income residents have access to affordable, high-quality health care services.

Sincerely,

MA Murray

Margaret A. Murray
Chief Executive Officer

Cc:
Joel Ario, Director, Office of Insurance Exchanges, Center for Consumer Information and Insurance Oversight