ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

October 31, 2011

Dr. Donald M. Berwick, Administrator
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: Request for Information Regarding State Flexibility to Establish a Basic Health Program Under the Affordable Care Act

Dear Dr. Berwick:

The Association for Community Affiliated Plans (ACAP) very much appreciates this opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to the *Request for Information Regarding State Flexibility to Establish a Basic Health Program Under the Affordable Care Act*.[1] ACAP is strongly supportive of the Basic Health Program (BHP) as an option for states to provide health care coverage to low-income populations and appreciates this effort on the part of CMS to seek stakeholder input while developing BHP policy.

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 28 states.[2] Our member plans provide coverage to 9 million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationally, ACAP plans serve approximately one-third of all Medicaid managed care enrollees. Safety Net Health Plans currently are developing plans to serve those individuals that will gain new coverage due to insurance expansions enacted by the Affordable Care Act; such plans must be viewed as full partners in meeting the coverage needs of our nation's low-income health care consumers – whether they are eligible for Medicaid, CHIP, the Basic Health Program, coverage in health state-based health insurance Exchanges, or other health care programs.

[1] The Patient Protection and Affordable Care Act (P.L. 111-148) and the Healthcare and Education Reconciliation Act (P.L. 111-152) together are referred to in this letter as the Affordable Care Act (ACA).
[2] ACAP represents safety net health plans that are exempt from federal income tax, or that are owned by an entity or entities exempt from federal income tax, and which serve primarily or exclusively enrollees receiving benefits under a Federal health care program as defined in section 1128B(f)(1) (42 USC 1320a-7b(f)(1)) or a health care plan or program which is funded, in whole or in part, by a State or locality (other than a program for government employees).

Background

As you know, the BHP, established by Section 1331 of the Affordable Care Act, 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, Connecticut, Illinois, Maryland, New Jersey, 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 people, smooth transitions between programs when household income changes, provide consistent health plan choices when members of a given family qualify for different public programs, and offer more affordable coverage options.

ACAP supports the BHP for the following reasons:

- **Affordability:** States will have an opportunity to design BHP to offer coverage at lower premium and out-of-pocket expense than Exchange coverage, which would increase the likelihood low-income individuals would choose to enroll. Recent research by the Urban Institute suggests that if the BHP is implemented in each state and is designed to offer coverage at a lower cost for consumers than Exchange coverage, the national number of uninsured could be reduced by nearly 600,000 individuals.[3]
- **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 low-income and high-needs populations. Employing these plans to cover the BHP population could result in comprehensive medical, behavioral health and substance abuse coverage that retains important enabling services often provided by Medicaid programs, such as transportation, translation, and coordination of social services.
- **Stability**: Depending on program design, BHP can help reduce gaps in coverage as enrollees experience income volatility and move between programs. States could build BHP on the Medicaid health plan platform, which would allow enrollees to remain with the same providers and Safety Net Health Plans and keep similar benefits and cost-sharing structures.
- **Family unity**: If the BHP employs Medicaid Safety Net Health Plans, families whose members are eligible for different programs (including Medicaid, CHIP and the BHP) may remain covered in the same plan. This will be particularly true if Medicaid and BHP participating plans do not participate in the Exchange.

[3] Dorn S., Buettgens M., and Carroll C., Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States. The Urban Institute Health Policy Center. September 2011. Prepared for Association for Community Affiliated Plans.

ACAP has previously informed CMS that we believe that consideration of the BHP option cannot be separated from decisions a state must make about the structure and function of the Exchange. State health policymakers must have sufficient and timely information to make the BHP decision as they develop their Exchanges. In a letter dated May 5, 2011, ACAP urged 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.

The May 5 letter also included more extensive comments that we suggested CMS consider while developing BHP guidance; that letter is attached to this response to the BHP RFI and many of the comments are incorporated in this letter as well.

Response to Request for Information

A. General Provisions

1. What are some of the major factors that states are likely to consider in determining whether to establish a Basic Health Program? Are there additional flexibilities, advantages, costs, savings or challenges for the state and/or consumer that would make this option more or less attractive to states? If so, what are they?

   Affordability for Low-Income Individuals. ACAP believes that one of the primary advantages to states of implementing the BHP is the potential for the program to be designed to offer coverage at lower premium and out-of-pocket expense to members than coverage in a qualified health plan in the Exchange, thereby increasing the likelihood low-income individuals would choose to enroll. We recognize that the Exchange paired with advance premium tax credits and cost-sharing reductions will drastically reduce the cost of coverage currently available to people in the existing individual market, and we remain firmly supportive of the Exchange and federal subsidies as a coverage option for individuals seeking health insurance.

   Still, recent research published by the Urban Institute demonstrates that should a state implement a program with out-of-pocket spending requirements that mimic those of the Children's Health Insurance Program (CHIP), adults with incomes between 138 and 200 percent of the FPL would see their average annual premium payments drop from $1,218 in the Exchange, with subsidies, to $100 in the BHP. Cost-sharing would decline from $434 per year in the Exchange to $96 each year in the BHP. The BHP could thus reduce annual health care costs for low-income adults

by an average of $1,456. The Urban Institute report provides context for these numbers by stating that the described covered adults would earn between $1,252 and $1,815 per month in pre-tax income.[4]

ACAP recognizes that the more affordable coverage is, the more likely low-income people are to enroll in coverage; such coverage will decrease the rate of uninsurance in that state and reduce bad debt and charity care for providers.

Reduction in Administrative Burden. ACAP also believes that as roughly 30 million new individuals gain coverage in 2014 via a combination of Medicaid, BHP and Exchange expansions, states must consider how to reduce their own administrative burden. Data demonstrate that most income volatility occurs among individuals with income below 200 percent of the FPL; a public BHP built on a Medicaid or CHIP platform could result in a substantial reduction in churn on and off of public coverage and reduce the administrative burden on state Medicaid agencies of frequent eligibility redeterminations.

2. What are key considerations for states in placing responsibility for a Basic Health Program within the state organizational structure?

Several Medicaid safety net health plans, along with providers, consumer advocates and state policymakers, have expressed a deep interest in having potential of their states implement BHP. As states conduct analysis and implement Exchange-enabling legislation, policymakers need timely information regarding BHP financing to make an informed choice about the BHP opportunity. ACAP urges CMS to codify section 1331 as soon as possible, and we appreciate CMS' efforts thus far to seek stakeholder input to guide BHP policymaking. In particular, we believe CMS should address several key considerations by:

Establishing 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 CMS should provide states with an expedited proxy of estimated premium and cost-sharing subsidies available to individuals via the Exchanges. We encourage CMS, in collaboration with other federal agencies, as appropriate, to establish either a funding estimated or a reasonable method states can use to estimate BHP funding. This will allow states to fully assess feasibility of the BHP. ACAP is 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. Without this information, states face a barrier to thoroughly evaluating

[4] Dorn S., Buettgens M., and Carroll C., Op cit

and making decisions regarding the BHP because they do not have a reliable understanding of the financial implications.

Establishing a "hold harmless" threshold for states. Section 1331 requires the Secretary of the Department of Health and Human Services to adjust the amount of BHP payment for any fiscal year to reflect any error in the determinations for any preceding fiscal year.

We recommend CMS establish a "hold harmless" threshold for states 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.

Tobacco Rating Issue. The Affordable Care Act gives states the option to vary premiums by tobacco use, permitting increases up to 50 percent for smokers. Implementing this option has the potential to reduce federal BHP payments below BHP costs. In a state that allows tobacco rating, federal subsidies in the Exchange do not cover tobacco-related premium increases; instead, such subsidies are based on the non-tobacco-use premium, and the tobacco user must pay the full additional cost. Accordingly, in a state with tobacco-rated premiums, federal BHP payments would be based on a calculation of health care costs that excludes tobacco-related care, but BHP potentially would still need to pay those costs.

We urge CMS not to penalize those states implementing BHP that also vary premiums by tobacco use so that BHP funding continues to be adequate to support a robust program. For example, CMS should provide BHP funding to states as if they did not utilize the tobacco rate band.

Allow Standard Health Plans to Bear Risk for BHP. To address the concerns of states regarding the unknown nature of the cost of BHP enrollees as compared to federal BHP funding, ACAP suggests that states be allowed to share risk with the standard health plans serving the Exchange or allow plans to bear all risk.

Phasing In Repayment of BHP Overpayments. We also recommend that CMS allow states to employ a "payment plan" to repay BHP overpayments when federal BHIP funding estimates are inaccurate. This device will assure states that they will not face a substantial payback all at one time when actual BHP funding amounts are known after the end of the tax year.

Allowing Use of BHP Funds for State Administrative Costs. We also recognize that in addition to the concerns about BHP funding articulated above, states are

concerned about the source of administrative funding for the BHP. The statute directs states to establish a trust fund for the deposit of federal BHP funds received and specifies that the amounts in the trust may only be used to reduce the premiums and cost-sharing of or to provide additional benefits for, eligible individuals enrolled in standard health plans within a BHP.

Therefore, we respectfully request CMS to interpret the statute broadly and allow federal subsidy dollars to be used for state administrative costs. This is a fundamental, threshold issue for most states, given current constrained state budgets. If states are unable to use federal funds to administer a BHP, they may be unlikely to exercise the option, regardless of the benefits to consumers.

Permitting BHP in States with a Federally-Operated Exchange. ACAP believes that if a federally operated Exchange operates within a state, the state should 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.

Allowing States to Employ 12-Month Continuous Eligibility in BHP. ACAP is promoting continuous eligibility in the Medicaid program to provide stability to Medicaid and Medicaid enrollees as well to state-based Exchanges. In comments to CMS regarding *Medicaid Eligibility Changes under the Affordable Care Act of 2010* (CMS-2349-P; 76 Fed. Reg. 51148 (Aug. 17, 2011)), we urge CMS to allow states to implement 12-month continuous eligibility for adults in Medicaid without requesting a waiver. Section 1331 is silent on the issue of continuous eligibility; therefore we urge CMS to allow states to implement 12-month continuous eligibility for BHP enrollees as well. Such a policy will provide stable coverage and access to care to low-income health care consumers, and will reduce the administrative burden to states of conducting unnecessary eligibility determinations, thereby promoting efficiency and streamlining.

Permitting 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 BHP. 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.

Treating the BHP as a Public Program with Regard to the Health Plan Excise Tax. The Affordable Care Act is funded in part by an assessment on the health insurance industry beginning in 2014, which provides a limited exemption for plans that "serve a critical purpose for the community," including nonprofit health plans that receive more than 80 percent of their income from government programs, specifically Medicaid, Medicare and SCHIP. Section 9010(c)(2)(C)(iii) exempts nonprofit entities

> "more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act."

Most ACAP Safety Net Health Plans are included in this exemption, which will allow them to use their revenues to better serve their mission of providing high quality care to low income enrollees. As described below, many Safety Net Health Plans hope to serve the BHP. BHP revenues, however, are not explicitly mentioned in section 9010(c)(2)(C)(iii). The tax appears to be structured so that plans are exempt from the whole tax as long as at least 80 percent of their revenues come from the three mentioned public programs. If these revenues drop below 80 percent, the plans are no longer exempt and all their revenue is subject to the tax. Analysts currently estimate the tax to be as high as 3 percent of plans' revenues. Thus, the current exemption may represent a barrier to having Safety Net Health Plans serve the BHP. If these plans that currently serve the Medicaid program do not serve the BHP, continuity of coverage for low-income enrollees may be severely impacted.

ACAP urges CMS to rule that BHP revenues should be included as part of the public programs that target low-income, elderly, or disabled populations in the calculation of the 80 percent "trigger." If a state combines BHP, Medicaid and CHIP dollars into a single program that serves all low-income adults up to 200 percent FPL, uses a single set of health plans and furnishes benefits and cost-sharing that meet requirements of Titles XIX and XXI, then the BHP is essentially an extension of those programs. Section 9010 explicitly distinguishes between the underlying federal funding streams and the "program" that provides the nonprofit health plan with revenue, and specified that the "program" furnishing the plan with revenue must target low-income, elderly, or disabled populations under these titles. We argue that so long as the program does so, an individual served by the program can have the applicable revenues count within the 80 percent allotment, regardless of the source of federal funding (if any) that ultimately reimburses the program.

ACAP believes this interpretation furthers the Congressional intent which was to protect the Safety Net Health Plans and the individuals they serve. 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 Affordable Care Act's health insurer fee. This is consistent with the Affordable Care Act'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.

4. Are states that are exploring the Basic Health Program considering implementation for 2014, or for later years? What are the key tasks that need to be accomplished, and within what timeframes, to implement the Basic Health Program in a timely fashion? What kinds of business functions will need to be operational before implementation, and how soon will they need to be operational? Are there opportunities to leverage existing systems and increase efficiency within the State structure? To what extent have States begun developing business plans or budgets relating to Basic Health Program implementation?

   Simultaneous State Planning. As articulated previously in this letter, ACAP believes that it would be difficult for states to consider the BHP option separately from designing the Exchange. Many uninsured have incomes under 200 percent of the FPL, so if a state opts to offer a BHP, these individuals will access coverage outside the Exchange. Research suggests that the impact on the size and composition of the individual market within the Exchange is negligible, but state policymakers should be able to consider the BHP while designing the Exchange.[5]

   Medicaid Plans as "Turnkey" for BHP. ACAP believes that states will be able to leverage existing Medicaid and CHIP infrastructure to develop the BHP. States should have the option to establish a BHP by amending existing Medicaid or CHIP contracts to accommodate new BHP rules. In addition, states should have the option to use existing Medicaid or CHIP accreditation, licensing, and reserve standards for the BHP.

   A 2008 report by The Lewin Group called *Medicaid Health Plans: A Turnkey Solution for Expanding Health Insurance Coverage* notes that "Several California counties and the State of Massachusetts have chosen to cover low-income uninsured children and low-income uninsured adults, respectively, through programs that are not expansions of Medicaid or SCHIP but that use the delivery platforms for those programs—

[5] Dorn S., Buettgens M., and Carroll C., Op cit

specifically, Medicaid health plans—to provide care." The paper continues to say that

> "There are many reasons for selecting Medicaid health plans for the roles they are playing or are proposed to play in these reform efforts. These include experience in serving low-income, higher need clients; experience working with state government purchasers; administrative experience, including efforts to improve quality and access and control costs; and existing provider networks that include safety-net providers and other providers that have demonstrated an ability and willingness to serve low-income populations."[6]

ACAP suggests that states be encouraged to develop the BHP using the operational platform of plans currently serving the states' public health coverage programs.

5. To what extent have states already begun to assess whether to establish a Basic Health Program? What internal and/or external entities are involved, or will likely be involved in this planning process?

   State Legislation and Discussion. Legislatures in the states of California, Connecticut, New Jersey, Rhode Island, and Washington all have considered or passed legislation requiring those states to either assess the BHP option or work toward implementing the BHP. A number of additional states, including Colorado, Hawaii, Illinois, and Maryland have engaged in discussions regarding the BHP. ACAP has attached to this comment letter a BHP legislative tracker, updated as of October 31, 2011.

6. What guidance or information would be helpful to states, plans, and other stakeholders as they begin the planning process? What other terms or provisions need additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

   Please see A.2. above.

7. How can the Administration provide technical assistance? What form(s) of technical assistance would be most helpful to States?

   Please see A.2. above.

[6] Arora R.S., Chimento L., and Forbes M., Medicaid Healt Plans: A Turnkey Solution for Expanding Health Insurance Coverage. The Lewin Group. July 2007. Prepared for Association for Community Affiliated Plans.

Regulatory Guidance and Dialogue. States are in immediate need of regulatory guidance regarding the BHP. Furthermore, opportunities for dialogue between federal policymakers and stakeholders, including listening sessions and conference calls, would also be a welcome source of technical assistance.

B. Standard Health Plan Standards and Standard Health Plan Offerors

1. What additional standards, if any, should standard health plans participating in a state's Basic Health Program meet? What consumer protections should be included? How should quality and performance be measured?

Medicaid Plans as Standard Health Plans. As previously mentioned in this letter, data demonstrate the high volume of income volatility among people with incomes below 200 percent of the federal poverty level. In the absence of a continuous eligibility policy for adults in all but one state Medicaid program (New York will implement 12-month continuous eligibility for adults in February 2012 as part of an 1115 waiver), many lower-income health care consumers will experience changes in eligibility between Medicaid and the Exchange. In addition, many families will experience "split eligibility," with children covered by Medicaid or CHIP and parents covered by BHP or qualified health plans in the Exchange. Estimates from the Urban Institute indicate that three out of four parents who are eligible for the Exchange will have one or more children who are eligible for CHIP or Medicaid and must enroll in these programs. If a state implements BHP, the numbers of families with split eligibility are likely to be similar.[7]

For both of these reasons, ACAP wishes to note the importance of having Safety Net Health Plans and other Medicaid health plans serve the BHP. As we discuss in A.4., we feel as though it is important for states to select standard health plans that have already built expertise serving lower-income populations through Medicaid and CHIP.

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 Affordable Care Act's requirement that Exchange plans contract with such providers. We believe this contracting requirement should extend to the BHP.

[7] McMorrow S., Kenney G.M., Coyer C., Addressing Coverage Challenges for Children Under the Affordable Care Act. The Urban Institute. May 2011.

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.

2. What plan design issues should be considered? How likely is it for a state to consider an expanded benefit package beyond the essential health benefits for standard health plans participating in a state's Basic Health Program? What are the advantages and disadvantages of an expanded benefit package for standard health plans compared to qualified health plans?

   Robust Essential Health Benefits Package. ACAP's particular concern with regard to the essential health benefits package, which will govern coverage in the Exchange, BHP and Medicaid expansion, is that it may lack robust essential health care and enabling services that are critical for meeting the needs of vulnerable populations including children, individuals with disabilities, the elderly, and others with special needs. In addition to medical and behavioral health care services, a benefits package for a high-needs population should include transportation, translation, and coordination of social services, among others.

   Because the BHP will exclusively serve a low-income and potentially high-needs population, and also because the BHP is conceived as including innovative features such as care coordination and care management for enrollees, incentives for the use of preventive services, and the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, we highly recommend that HHS encourage inclusion of these critical services when outlining guidance related to benefits.

3. What is the expected impact of standard health plans on provider payments and consumer access?

   Robust Provider Payments. ACAP firmly believes that provider payments in the BHP should be sufficiently robust to provide access to care for all BHP enrollees, and believes that excessively low provider payments could lead to access problems, particularly as newly-eligible Medicaid and Exchange enrollees compete for time with providers.

   Stan Dorn of the Urban Institute recently modeled anticipated payments for adults in BHP compared to current cost to cover similar adults in Medicaid, and wrote that:

> "Mainly because provider payments are higher in private insurance than in Medicaid, federal BHP funding would exceed by an average of 23 percent the baseline cost of providing BHP adults with Medicaid-like coverage. Since all federal BHP funds must be spent on BHP consumers, this excess cannot be 'pocketed' by states. However, it could be used to raise capitated payments or provider payment rates above baseline Medicaid amounts."[8]

ACAP agrees that states and plans should be encouraged to use surplus BHP funding to ensure access to care for enrollees by paying providers and plans adequately.

Actuarially Sound Rates for Standard Health Plans. Furthermore, ACAP believes that states should be required to pay standard health plans serving the BHP rates that are actuarially sound based on the risk profile of BHP enrollees. Actuarially sound plan rates are required of states in Medicaid managed care programs; ACAP has recently requested that CMS clarify and improve the oversight and review of rates, and strongly suggests here that CMS employ the improved process for BHP as well.

C. Contracting Process

1. What innovative features should states consider when negotiating through the contracting process with standard health plans to participate in a Basic Health Program?

   Medicaid Plans as Standard Health Plans. Because of the importance of providing continuity of coverage and access to providers, and of providing unified coverage options to families with split eligibility, as described previously in this letter, ACAP suggests that states should weigh heavily on past service to existing state coverage programs such as Medicaid and CHIP when selecting standard health plans for the BHP.

D. Coordination with Other State Programs

2. What is the expected impact of a Basic Health Program on plans participating in the Exchange in terms of risk profile, enrollment, and premium stability? What is the expected impact on overall coverage?

   Permit Flexibility in Risk Pool Structures. Regarding the size and risk of the Exchange risk pool, the Urban Institute has written the following:

[8] Dorn S., Buettgens M., and Carroll C., Op cit

"… implementing BHP would withdraw subsidy-eligible adults with incomes between 138 and 200 percent FPL from the exchange's individual market.

On average, the proportion of nonelderly residents receiving individual coverage in the exchange would fall from 6.5 to 5.1 percent. Exchange individual markets would thus remain large, even though BHP implementation would significantly reduce the number of tax credit recipients in those markets. Our modeling shows that most unsubsidized participants in the nongroup market, other than those enrolled in so-called 'grandfathered' plans that are exempt from some ACA requirements, will obtain coverage through the exchange. The main causes of this high participation level are slightly lower premium costs and greater convenience of enrollment in the exchange. A number of other researchers have reached similar conclusions.[i]

In terms of the exchange as a whole, including small group as well as individual markets, the proportion of residents covered through the exchange would decline from 9.8 to 8.2 percent, which represents a 16 percent relative decrease. Similar results apply in all states. Even without BHP consumers, exchanges would clearly be large enough to remain stable and to attract insurers on favorable terms.[ii]"[9]

Although the BHP would remove enrollees from the Exchange, these data suggest that the impact on the risk pool would not be dramatic, particularly in states with large populations.

To mitigate any adverse impact on the Exchange risk pool, however, ACAP suggests that CMS and states consider a number of policy solutions, such as including BHP within risk-pooling arrangements that serve the individual market. Characteristics of the markets and risk pools will likely vary considerably across states and 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.

4. How can eligibility and enrollment be effectively coordinated between the Basic Health Program and other state programs to reduce churning between programs and promote continuity of care?

[9] Dorn S., Buettgens M., and Carroll C., Op cit

Coordination Between Programs. The Urban report reminds us that "many exchange functions will incorporate BHP. For example, all exchanges will process applications that result in BHP enrollment, and exchanges can take on other BHP tasks, such as those involving plan certification and consumer choice."[10] Indeed, the proposed rule called *Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers* requires the Exchange to conduct eligibility determinations for applicants to insurance affordability programs, including the BHP. The Exchange must also, in consultation with Medicaid, CHIP, and the BHP agencies, ensure that those agencies provide eligibility determinations for the Exchange, premium tax credits, and cost-sharing reductions.

Therefore, the statute and proposed Exchange rule envision – and ACAP supports – a highly-coordinated approach to eligibility and enrollment for the BHP, Medicaid, CHIP and the Exchange. We also recognize the value of having states administer BHP under an existing agency, such as Medicaid and CHIP, and (as described previously in this letter) employ existing Medicaid and CHIP plans as standard health plans, as this approach may provide the best opportunity to smooth changes in eligibility and prevent gaps in coverage.

5. How could establishing a Basic Health Program affect the ability of an entire family to be covered by the same plan?

   Medicaid Plans as Standard Health Plans Can Cover Entire Families. As we write previously in this letter, we feel that if the BHP employs Medicaid Safety Net Health Plans as standard health plans, families whose members are eligible for different programs (including Medicaid, CHIP and the BHP) may remain covered in the same plan. This will be particularly true if Medicaid and BHP participating plans do not participate in the Exchange.

   Furthermore, we feel that it is important to cover families in one plan for several reasons. For example, parents will be required to learn only one health plan's procedures, and some plans employing family practitioners will allow parents and children to be seen together, creating efficiencies at the family level. Also, for long-term political viability, the reformed health care system needs to move toward consumer-friendliness – allowing all families to share coverage would be a substantial step in that direction.

6. Are standard health plans likely to also participate in other coverage programs, such as the Exchanges, Medicaid, or CHIP? Should this be encouraged, and if so, how could CMS and states encourage it?

[10] Dorn S., Buettgens M., and Carroll C., Op cit

Safety Net Health Plans Intend to Serve Medicaid, CHIP, BHP and the Exchange. Safety Net Health Plans currently participate in Medicaid and CHIP and are planning to do so in 2014 and beyond; most of ACAP's members have indicated that serving the 2014 Medicaid expansion is their top priority.

Many Safety Net Health Plans are also very strongly considering whether and how to serve the Exchange (as an independent qualified health plan, CO-OP, or subcontractor for a larger plan, for example). In some cases, if a state implements BHP, some Medicaid-focused plans will forego becoming a qualified health plan, while others will pursue service to Medicaid, BHP and the Exchange.

ACAP feels strongly, for the reasons articulated throughout this letter, that Medicaid and CHIP health plans should be encouraged to participate in the BHP.

E. Amount of Payment

1. The statute specifies that amounts in the trust fund may only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within a Basic Health Program. What options are States considering for reducing premiums and cost-sharing, or providing additional benefits? What, if any, guidance is needed on this provision?

   BHP Funding Should be Used to Reduce Enrollee Cost Sharing and Increase Provider Payments. We wrote in our answer to question B.3. that anticipated BHP payments to states (as calculated by the CBO) exceed by an average of 23 percent the baseline cost of providing BHP adults with Medicaid-like coverage. Because section 1331 requires that all BHP trust fund dollars be used for health care services and for reducing premiums and cost-sharing, it is logical that states will use most of this surplus for this purpose. ACAP feels strongly that efforts to increase the affordability of coverage will reduce the uninsurance rate and will benefit states, enrollees, and providers. We strongly support this use of surplus federal BHP funding.

   Furthermore, as articulated previously, this surplus should also be used to shore up provider and plan payments.

3. The statute specifies that in developing the financial methodology for the Basic Health Program, the determination of the value of the premium tax credits and cost-sharing reductions should take into consideration the experience of other states. What information would be most helpful to inform this methodology? Should implementation of the Basic Health Program be postponed until other states' experiences are available?

Use State Medicaid and Washington BHP Experience to Inform BHP Implementation. As we have written earlier in this letter, it is critical that states begin to develop plans for BHP as they design the Exchange. We strongly discourage CMS and states from postponing implementation of the BHP until state experiences with the Exchange are known. The State of Washington has operated a BHP similar to the program described in section 1331 for many years; CMS and other states should look to the experiences of Washington State for data to inform development of additional BHPs. In addition, many states, including Minnesota, New York, and Washington, DC, have expanded Medicaid, CHIP or state-only coverage to adults at higher income levels than traditional Medicaid. CMS and states should look to these state experiences for data regarding cost and utilization of this population.

F. Eligibility

1. What education and outreach will be necessary to facilitate a helpful consumer experience?

   Require Broad Outreach to and Communication with Diverse Populations. ACAP believes that states and their partners should be required to provide extensive, culturally- and linguistically appropriate outreach to diverse populations regarding the BHP and other affordable coverage options. This includes those populations whose eligibility will alternate between Medicaid, BHP and subsidized coverage through the Exchanges as their income fluctuates, those who are likely to be Medicaid-eligible but unenrolled, and those from broad linguistic and cultural backgrounds.

   The Navigator program established in the Affordable Care Act to serve an outreach and education function for the Exchange should be prepared to provide information regarding BHP to enrollees in states that implement the program.

G. Secretarial Oversight

1. What process should the Secretary use to certify or recertify Basic Health Programs? How should this process be similar to or different from Exchange certification?

   Simple State Plan Template and Process. ACAP recommends that the Secretary employ a simple and transparent state plan process to allow states to articulate critical programmatic functions and changes over time, and the federal government to provide oversight.

2. What should be considered when developing an oversight process for the Basic Health Program?

Oversight of Actuarially-Sound Rate Setting. As described in B.3. ACAP believes that states should be required to pay standard health plans serving the BHP rates that are actuarially sound. **ACAP has requested that CMS provide oversight and review of standard health plan rates**, and strongly suggests here that CMS employ the improved process for BHP as well.

Oversight of Risk Adjustment Processes. In addition, because ACAP has suggested that the BHP be included in risk mitigation programs as articulated in HHS guidance related to the individual insurance market, **ACAP urges HHS to develop a process by which both the federally-certified and state risk adjustment processes are overseen by an objective entity.** This oversight process should provide health plans with an opportunity to appeal risk adjustment decisions, when necessary.

Once again, ACAP would like to commend CMS for its efforts to move forward with guidance regarding the BHP. We appreciate your consideration of our response to this solicitation. ACAP is prepared to assist the agency with additional information as needed. If you have any additional questions please do not hesitate to contact Jennifer Babcock at (202) 204-7518 or jbabcock@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer

---

[i] See, e.g., for California, Peter Long and Jonathan Gruber, "Projecting The Impact Of The Affordable Care Act On California," *Health Affairs* 30(1) (2011): 63–70; David Auerbach et al., *The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in California* (prepared by the Rand Corporation for the Council of State Governments, 2011). See also Deloitte Center for Health Care Solutions, *Health Insurance Exchanges: A Strategic Perspective* (2011).

[ii] See discussion in Dorn, op cit. Insurers' interest in the exchange will be affected by the nature of the exchange's participating members, not just their number. However, it is not clear how this would play out under the ACA. As explained below, BHP-eligible consumers may have average costs lower than other individual market enrollees. However, we do not know whether adverse selection will operate more severely with (a) the lowest-income tax credit recipients, who have higher subsidies and lower penalties for uninsurance but less disposable income; or (b) higher-income tax credit recipients, who will receive less generous subsidies but have higher disposable income and will be charged greater penalties for uninsurance. In addition, some private insurers may want to avoid low-income consumers who are particularly subject to income fluctuation (hence changing premium obligations) and who some insurers may view as more challenging or otherwise less desirable than middle-class customers. Such insurers may

be more interested in participating in an exchange if it lacks the lowest-income members allowed by the Affordable Care Act.