



October 31, 2011

Donald M. Berwick  
Administrator  
Centers for Medicare & Medicaid Services  
United States Department of Health and Human Services  
Attention: CMS-9980-NC  
P.O. Box 8016  
Baltimore, MD 21244-8016

Dear Administrator Berwick:

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Request for Information Regarding State Flexibility to Establish a Basic Health Program Under the Affordable Care Act (CMS-9980-NC).

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state, and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We thank you for the opportunity to weigh in on the Basic Health Program (BHP) prior to the issuance of proposed regulations. We are committed to the success of the BHP because we believe it could be a powerful tool for improving access to affordable health care for some of the most vulnerable members of our society: those earning less than 138 percent of the federal poverty level (FPL) who don't qualify for Medicaid, and those earning between 138 and 200 percent FPL who don't have an affordable offer of Employer Sponsored Insurance (ESI.)

Ensuring affordable premiums and minimal cost-sharing for this population is central to achieving the coverage gains and improved access to health care envisioned by the Affordable Care Act (ACA), particularly since those earning less than 200 percent FPL represent well over half of the uninsured<sup>1</sup> and of the underinsured.<sup>2</sup>

The tax credits in the Exchange render premiums and cost-sharing substantially more affordable than they are today for this population. But at this income level, many families are struggling just

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<sup>1</sup> U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2011

<sup>2</sup> Cathy Schoen and others, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007", Health Affairs 27 (2008) 298-30

to make ends meet. Even with subsidies offered through the Exchange, too many low-income families will still find the costs of health insurance coverage and care to be out of their reach.

In states that don't take up the BHP option, the ACA requires this population to contribute 3-6.3 percent of their income towards premiums in the Exchange (\$731-\$2,307 for a family of three.) But experience from state Medicaid and CHIP programs suggests that even nominal premiums can cause substantial numbers of low-income families to leave public programs. For example, in 2003 Oregon used a Medicaid waiver to increase premiums for adults under the poverty level to \$6-\$20 per month, depending on their income. These seemingly trivial premium increases had a dramatic effect: enrolment in the Medicaid program dropped by nearly half or roughly 50,000 people.<sup>3</sup> And in 2002, Rhode Island began charging families earning over 150 percent FPL premiums ranging from \$43-\$58 per month, and nearly one in five families were disenrolled due to nonpayment over the next three months.<sup>4</sup> BHP offers the possibility of lowering the required premiums from \$1,218 annually for the average adult between 138 and 200 percent FPL in the Exchange to \$100 or less (CHIP-level premiums) – substantially increasing the likelihood that this population will take up health care coverage.<sup>5</sup>

Similarly, if the BHP population gets coverage through the Exchange, they can be required to spend substantial sums of their income on cost-sharing. For example, the average enrollee between 138 and 200 percent FPL would spend \$434 annually on out-of-pocket costs in the Exchange, in addition to their premiums.<sup>6</sup> But experience from state Medicaid and CHIP programs suggests that even moderate out-of-pocket costs can lead these families to significantly delay needed care, and to experience financial hardship.<sup>7</sup> By taking up the BHP option, states could offer coverage with substantially more affordable cost-sharing requirements, lowering the average annual out-of-pocket costs for those between 138 and 200 percent FPL from \$434 to \$96 annually.<sup>8</sup> For insured families at this income level, BHP could mean the difference between accessing needed health services and delaying or forgoing needed care altogether.

Additional experience underscores the importance of affordability to the overall success of the coverage provisions of the ACA. For example in Massachusetts, enrollees in Commonwealth Care face significantly lower premiums and cost-sharing than would enrollees in Qualified Health Plans (QHPs) under the ACA.<sup>9</sup> We strongly believe that this has contributed to both the high enrollment rate and the popular success of reform in Massachusetts. Experience with the Pre-existing condition health insurance plan (PCIP), where enrollment has been lower than many

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<sup>3</sup> Samantha Artiga and Molly O'Malley, Kaiser Family Foundation, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences"

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=53261>

<sup>4</sup> Artiga et al

<sup>5</sup> Stan Dorn, Matthew Buettgens and Caitlin Carroll, Urban Institute, "Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States," September 2011. <http://www.urban.org/publications/412412.html>.

<sup>6</sup> Dorn et al

<sup>7</sup> Artiga et al

<sup>8</sup> Dorn et al

<sup>9</sup> See Slide 12 from Stan Dorn and January Angeles, "The Basic Health Plan," November 17 2010.

[http://www.statecoverage.org/files/Basci\\_Health\\_Program111510.ppt](http://www.statecoverage.org/files/Basci_Health_Program111510.ppt)

anticipated, also underscores the importance of making sure that premiums and cost-sharing are affordable.

BHP holds incredible promise to lower health care costs for vulnerable families, thereby improving coverage rates and access to health care services for those most in need. But to realize this promise, the U.S. Department of Health and Human Services (HHS) must develop regulations that:

1. Ensure enrollees will have lower health care costs in BHP compared to what they would have been in the Exchange
2. Encourage continuity of care for enrollees as they move back and forth between Medicaid, BHP, and QHPs in the Exchange
3. Provide clarity for states on how federal financing will work, so states can reliably make the necessary projections to ensure viability of the program
4. Minimize any disruption to the Exchange from taking this population out of coverage in the Exchange and providing them with coverage through BHP instead
5. Empower states to use BHP to drive system change and explore improved models for care delivery and payment

Below, we respond to many of the questions laid out in the RFI, to give specific suggestions for how HHS can uphold the above principles.

## A. General Provisions

### **A1. 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?**

As we outlined above, we believe the most promising aspect of BHP is its potential to lower health care premiums and cost-sharing levels for its enrollees compared to what they would face in the Exchange. Lower premiums and cost-sharing will be most attractive in states where the administration is actively seeking to maximize the reach of coverage expansion. Certainly lower premiums and cost-sharing will make enrollment more attractive to the larger number of potential enrollees with incomes between 138 and 200 percent FPL.

The case for a BHP will be particularly compelling in the 19 states that have already expanded subsidized coverage to adults earning above 138 percent of the FPL<sup>10</sup>, and the 11 states that offer Medicaid or Medicaid-like coverage to some classes of lawfully present immigrant adults who do not qualify for federal matching funds because of their immigration status.<sup>11</sup> In many of those states, moving those populations into the Exchange in 2014 would represent a step backwards –

<sup>10</sup> Kaiser Family Foundation, State Health Facts, Income Eligibility Limits for Working Adults at Application as a Percent of the Federal Poverty Level (FPL) by Scope of Benefit Package, January 2011, <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>

<sup>11</sup> Marsha Rosenthal, Rutgers's Center for State Health Policy, "State Practices in Health Coverage for Immigrants: A Report for New Jersey", June 2009, <http://www.cshp.rutgers.edu/Downloads/8080.pdf>

coverage would become *less* affordable for these beneficiaries. BHP offers states the option of protecting these populations from an increased burden of health care costs.

Additionally, BHP can lower a family's health care costs if states can adjust BHP premiums to account for premiums the family is already paying in other public programs. Many families will be paying multiple premiums for their various members: one premium for each of their children in CHIP, plus another premium for parents in the Exchange. When these premiums are added together, a family can end up spending much more than the maximum percentage of income on premiums envisioned by the affordability schedule in the ACA. We recommend that HHS allow states to set *one* premium for families based on their income as a percentage of FPL, and reduce a family's BHP premiums by the amount they are already paying to enroll their children in other coverage.

Another advantage of BHP is that it offers the potential to keep family members in the same plan. If a state contracts with the same plans for Medicaid, CHIP and BHP, then parents and their children can remain on the same plan until the family's income reaches above 200 percent FPL – this may help minimize confusion for families and reduce churning.

BHP also protects families from facing an unexpected lump-sum payment at the end of the year if they enrolled in advanced tax credits through the Exchange and their income rose unexpectedly at some point in the year. This sudden financial obligation penalizes low-income families for having found a better job or gotten a raise, and imposes financial hardship on already-struggling families. Additionally, it reduces the number of people who will enroll in the advanced tax credits, since they will fear this type of unexpected cost – this means fewer people will get the coverage they need. But if a state takes up BHP, that protects the lowest income population – those earning less than 200 percent FPL – from these reconciliation penalties.

**A6. 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?**

After years of suffering from revenue shortfalls brought on by the current economic downturn, states' overriding concern right now is balancing their budgets. State policymakers may be attracted to BHP for all the reasons above, but policymakers will be wary of adopting any new program that could cost the state even moderate sums of money.

States therefore need guidance as soon as possible on BHP, particularly on the requirements for the benefit package they will be required to provide to enrollees and on the methodology for determining the payments to the states from the federal government. This guidance should be sufficiently clear so as to allow states to, with relative confidence, project the cost of running BHP and the payments they are likely to get from the Federal government, so they can be sure the BHP is viable.

There are a few areas where the language in the ACA leaves ambiguity that HHS should be sure to address in upcoming regulations. In particular, there is considerable evidence the section of

the law that specifies minimum actuarial values states must provide in BHP includes an unintended drafting error. Section 1331(a)(2)(ii) states that plans in BHP must provide at least platinum level coverage (90 percent actuarial value) for those earning 150 percent FPL or less, and at least gold level (80 percent actuarial value) for those between 150 and 200 percent FPL. By contrast, enrollees with incomes equal to or less than 150 percent FPL in the Exchange would receive a plan with 94 percent actuarial value, and those between 150 and 200 percent FPL would receive 87 percent.

However, we believe the drafters of the ACA intended to provide cost-sharing limits in BHP at least equal to what these individuals would have obtained in the Exchange. Under the Senate-passed version of the ACA, actuarial values in BHP were identical to those in the Exchange. The drafters likely forgot to update the actuarial value levels in the BHP section of the ACA after the cost-sharing subsidies in the Exchange were enhanced prior to final enactment.

The intention of drafters was to guarantee that enrollees would not be made worse off under BHP than they would be in the Exchange. For example, in the Senate Finance Committee markup when Sen. Cantwell first proposed the BHP amendment to the Senate Finance Committee chairman's mark, she explicitly states that "the intent of the legislation" is to ensure that the financial cost to individuals be no greater than it would be if the state had not pursued BHP:

**Sen. Bingaman:** "Mr. Chairman, first, let me congratulate Senator Cantwell for all the effort that has gone into this. I know she has spent a great deal of time looking into how this ought to be structured. My staff has provided some suggestions to your staff with regard to two things here. In order for a state to participate in this basic health plan, the idea was, the suggestion we made was that the Secretary of Health and Human Services would have to certify two things. First, that the financial cost to individuals and families is no greater than it would be if the state had not pursued the basic health plan option. And second, that the scope and the level of benefits are at the same level or better than they would otherwise be able to access. It is my understanding that those are -- that is a condition that does not cause you problems and you would be willing to agree to those provisions; is that accurate or not?"

**Sen. Cantwell:** "Yes, the Senator from New Mexico, those are clarifying points, exactly the intent of the legislation."<sup>12</sup>

Furthermore, the law requires the Secretary to transfer funds to states for BHP based on the amount the federal government would be spending on cost-sharing subsidies for those individuals through the Exchange. It would not make sense to pay states based on the cost-sharing subsidies available to those individuals in the Exchange, but then allow states to provide enrollees with less comprehensive benefit packages. And the Senate Democratic Policy Committee's section-by-section summary of the ACA, updated after the cost-sharing subsidies in the Exchange were enhanced in the law, explicitly states that the law "requires the Secretary to certify that participating individuals [in BHP] do not have to pay more in premiums and cost-

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<sup>12</sup> U.S. Senate, Committee on Finance, Transcript, Executive Committee Meeting to Consider Health Care Reform, October 1 2009, <http://finance.senate.gov/library/transcripts/download/?id=00243c7b-fd31-40c6-ad10-fa3d6c2285a5>

sharing than they would have paid under qualified health plans, and that the plans cover essential health benefits.”<sup>13</sup>

We strongly recommend that HHS draft regulations consistent with the intent of the drafters of the legislation, and clarify that BHP enrollees must be provided with coverage with cost-sharing levels that are no greater than the cost-sharing requirements they would face in the Exchange.

Another area of ambiguity concerns the payment transfers to states. Section 1331(d)(3)(i) specifies that the Secretary should transfer to the state an amount “equal to 95 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals [...]” The law therefore could be interpreted to mean that states get 95 percent of premium tax credit and either 95 percent or 100 percent of the cost-sharing subsidy.

We recommend that HHS interpret this provision to mean 100 percent of the cost-sharing subsidy – this will give states more cushion to ensure that the program breaks even financially, while still ensuring that the federal government saves money through a state’s election of BHP (since they only spend 95 percent of what they would have spent on premium tax credits).

## **B. Standard Health Plan Standards and Standard Health Plan Offerors**

### **B1. 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?**

Federal standards should ensure that BHP plans have adequate provider networks to meet consumers’ needs and ensure high quality care. Specifically, federal standards should require standard health plans to:

- **Meet provider network standards:** Standard health plans’ provider networks must be adequate to provide timely adequate access to all services covered under BHP. HHS should establish a minimum acceptable standard for waiting times to obtain an appointment, require plans to maintain a minimum ratio of providers to enrollees for both primary and specialty care, and enforce requirements that ensure appropriate geographic distribution of providers. We also recommend that BHP be required to include “essential community providers” in their networks.
- **Monitor and report on performance measures:** Section 2717 of the Public Health Services Act, as added by the ACA, requires insurers in the individual and group markets to report on activities designed to improve quality of care. BHP should be held to the same standard, and HHS guidance should clarify that these strategies should include strategies to reduce disparities of care. Plans should also be required to monitor and report on a standard set of performance measures – including measures of quality of care, access to care, and health care disparities – which should be set through guidance by

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<sup>13</sup> Senate Democratic Policy Committee, “Section-by-Section Analysis with Changes Made by Title X and Reconciliation”, accessed October 27, 2011, <http://dpc.senate.gov/healthreformbill/healthbill96.pdf>



HHS. These measures should include the core set of health care quality measures for Medicaid-eligible adults established under section 2701 of the ACA. The access measures should ensure that covered services are available within reasonable time frames, enrollees receive continuous care, there is adequate capacity to meet enrollees' primary care and specialty care needs, and that enrollees have access to language services. HHS should have the authority to review such documentation.

**B2. 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?**

Before seeing the benefits included in Essential Health Benefits (EHB) package, it is difficult to predict whether states will or should try to provide more comprehensive benefits in BHP than EHB. If EHB allows strict limits on prescription drugs or other restrictions on essential care, low-income consumers would benefit from having coverage with a more comprehensive set of benefits in BHP. Nothing in the federal standards should prevent states from offering a more expansive benefit package.

In setting the parameters for potential plan designs for states, HHS should keep in mind that cost is the most common barrier to coverage and care for this population right now. BHP plan designs should prioritize lowering premiums and cost-sharing for enrollees while still maintaining high quality-of-care and access standards.

With that in mind, HHS should clarify that high-deductible health plan (HDHP) with a Health Savings Account will not get Secretarial approval for BHP. These types of plans are designed to require beneficiaries to face high upfront costs for accessing health care. This is clearly inappropriate for the low-income families BHP is intended to serve; they would likely respond to high upfront cost-sharing by delaying or forgoing needed care, which could result in increased complications and costly hospital admissions. The HDHP plan design is also clearly incompatible with the intention of the BHP to provide more affordable coverage to this population.

Finally, as discussed under A6, the statute allows states to provide coverage with higher cost-sharing requirements under BHP than the population would get if they were enrolled in coverage through the Exchange. However, we believe this was a legislative oversight; drafters likely forgot to increase the actuarial values in the BHP section when they improved the cost-sharing subsidies in the Exchange. As evidenced by transcripts of Senate Finance Committee debate on BHP, the structure of payments to states for BHP, and summaries of the law by the Senate Democratic Policy Committee, the intention of the drafters was to ensure that enrollees not be made worse off by a state's decision to opt into BHP (see A6 for more detailed evidence of Congressional intent). Therefore, we urge HHS to clarify in future guidance that BHP enrollees must be provided coverage with at least the actuarial values they would have received in the Exchange.

### **B3. What is the expected impact of standard health plans on provider payments and consumer access?**

If states contract with Medicaid Managed Care Organizations they will likely be reimbursing at lower rates than the private plans these consumers would otherwise have been enrolled in through the Exchanges. However, several analyses have concluded that with the funds available through BHP, states could provide packages with CHIP-level premiums and cost-sharing and still have substantial funds left to boost provider payments above Medicaid levels.<sup>14</sup>

We would note that since the majority of potential BHP enrollees are currently uninsured<sup>15</sup>, providers are receiving minimal reimbursement for their care now. Furthermore, reimbursing for this population at full commercial rates (generally cost-plus) is not an efficient use of scarce subsidy dollars. Also, although provider payments would likely be lower under a BHP than in QHPs, lower cost-sharing will also mean less bad debt.

Additionally, states may receive a lump-sum payment at the end of the year if their original payment from the federal government turned out to be too small. States could use this money to further boost provider payments, by offering an end-of-year per-enrollee bonus to providers in the BHP program.

If states are able to pay providers higher rates in BHP than in Medicaid, they could actually use BHP to expand the Medicaid provider network by requiring providers who accept BHP to also accept Medicaid payments. That way providers attracted to BHP because of its higher payment rates would also open their doors to Medicaid beneficiaries.

## **C. Contracting Process**

### **C1. What innovative features should States consider when negotiating through the contracting process with standard health plans to participate in Basic Health Program?**

Section 1331(g) makes it clear that standard health plans under a basic health program “may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.” While many states will simply elect to contract with their standard Medicaid Managed Care Organizations (MCOs), HHS should provide further clarity on the range of other options.

For example, states should be allowed to contract with Accountable Care Organizations, networks of providers like Community Care of North Carolina – North Carolina’s primary care case management system – and other innovative delivery models to offer a BHP. This will

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<sup>14</sup> See, for example, Dorn et al; Elisabeth R. Benjamin and Arianne Slagl, “Covering more New Yorkers while easing the state's budget burden”, June 2011, [http://www.healthcarereform.ny.gov/research\\_and\\_resources/docs/bridging\\_the\\_gap\\_exploring\\_basic\\_health\\_insurance\\_option.pdf](http://www.healthcarereform.ny.gov/research_and_resources/docs/bridging_the_gap_exploring_basic_health_insurance_option.pdf)

<sup>15</sup> Kaiser Family Foundation, “A Profile of Health Insurance Exchange Enrollees”, March 2011, <http://www.kff.org/healthreform/upload/8147.pdf>



empower states to use BHP to enhance Medicaid's market leverage in driving system change and improving current models for care delivery and payment.

Regulations, however, should define standards that networks of providers must meet to ensure they are adequate to deliver BHP services to its enrollees, and to meet the quality-of-care and access standards that apply to MCOs and standard health insurers in the program.

Regulations should also encourage states to adopt payment innovations in BHP that will promote quality and efficiency. BHP could act as platform for states to leverage the payment strategies states are already using in their Medicaid programs. For example, the ACA prohibits federal payments to states for the costs associated with treating certain health care acquired conditions. Some states are going even further: tying Medicaid payments to hospitals' rates of a more comprehensive list of potentially preventable conditions and readmissions.<sup>16</sup> This type of innovative payment reform should be encouraged in BHP, so that the incentives created by state health care programs are aligned to the maximum extent possible.

#### **D. Coordination with Other State Programs**

##### **D1. What is the expected impact of a Basic Health Program on the Exchange's purchasing power and viability? How might States organize a Basic Health Program with respect to purchasing structure?**

The questions about purchasing power and viability are distinct. Viability will be determined by whether the Exchange is adequately financed and whether it avoids adverse selection. States adopting a BHP can take a number of steps to enhance the viability of the Exchange – by using a broad-based financing mechanism (e.g. assessment on all plans not just participating plans) or by running the BHP through the Exchange so the BHP bears a share of the administrative costs. The ACA contains provisions to avoid adverse selection in the Exchange and states can take additional steps by prohibiting the sale of plans outside the Exchange that would tend to be disproportionately attractive to healthier enrollees.

Although it is generally assumed that a BHP would reduce the Exchange's purchasing power, it is important to note at the outset that a BHP would be likely to enhance the purchasing leverage of a state Medicaid program, particularly because the benefits of managing the BHP efficiently will flow directly to enrollees and also can accrue to providers in the BHP (and Medicaid) network. The exercise of leverage by the Exchange will serve primarily to reduce the cost of federal tax credits with less benefit flowing directly to state residents or providers. Also it is not clear to what extent states plan to aggressively use the leverage they have. Even if they are willing, concentrated insurance markets' requirements that similar plans be priced comparably in and out of Exchanges and the unwillingness of carriers to "negotiate against themselves" may attenuate Exchange leverage even where no BHP is present.

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<sup>16</sup> Community Catalyst, "Smart Payment Reforms Can Reduce Costs and Improve Quality: A Short Primer", March 2011, [http://www.communitycatalyst.org/doc\\_store/publications/Medicaid\\_Payment\\_Reform\\_Savings.pdf](http://www.communitycatalyst.org/doc_store/publications/Medicaid_Payment_Reform_Savings.pdf)

Additionally, analysis shows that BHP would decrease the number of total enrollees in the Exchange by 16 percent on average.<sup>17</sup> While this is probably not enough to significantly impact Exchange leverage in larger states, each state must conduct its own analysis to determine the impact on its Exchange of pulling out the BHP population.

If BHP does lead to a small increase in premiums in the Exchange, BHP will still likely improve coverage rates (assuming it offers lower premiums and lower cost-sharing than BHP enrollees would have faced in the Exchange). This is because those below 200 percent FPL are especially price-sensitive due to their tight budgets; a moderate decrease in premiums from BHP will likely lead to a much higher take-up rate. Independent analysis projects that if all states were to take up BHP and offer coverage with CHIP premiums and cost-sharing levels, coverage rates would increase by nearly 600,000.<sup>18</sup>

On the other hand, if BHP causes a minor increase in premiums in the Exchange, this would be unlikely to cause a major drop in coverage. This is because most people in the Exchange are receiving premium tax credits, so they contribute a fixed percentage of their income towards premiums. In other words, the price these families pay for coverage is unrelated to the premiums in the Exchange. Only those who don't qualify for tax credits – primarily people earning above 400 percent FPL – face the full premium. While maintaining low costs for this population is an important priority, this higher-income group is less likely to drop out of coverage altogether as a result of a small premium increase.

Furthermore, the ACA provides other tools to states to help hold down the price of insurance in general, most particularly rate review and minimum loss ratio provisions. States that offer a BHP can also compensate for reduced leverage over plans by requiring carriers with a certain number of enrollees outside the Exchange to also offer QHPs.

**D2. 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?**

As noted above the impact on overall coverage is likely to be positive because a BHP will be able to offer lower premiums and cost-sharing to enrollees and avoid the tax-based reconciliation process which may deter enrollment.

It is difficult to predict the impact of BHP on the risk profile in the Exchange. The BHP population may have higher health care costs than the Exchange population as a whole, because lower-income individuals have a higher burden of chronic illness. In this case, pulling them out of the Exchange would improve the risk profile of the Exchange, and potentially lower premiums in the Exchange. On the other hand, other analysts suggest that the BHP population may be younger than the Exchange population as a whole, and therefore have lower health care costs. In that case, pulling them out of the Exchange and into BHP could potentially increase premiums in the Exchange.

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<sup>17</sup> Dorn et al

<sup>18</sup> Dorn et al

Since the premium and cost-sharing levels in the Exchange are still relatively high for this low-income population (as addressed in the introduction to these comments above), the Exchange may be affected by adverse selection at this income level – only those sick enough or high-risk enough will be willing to pay those premiums. In that case, BHP may pull a higher-risk population out of the Exchange while also attracting healthier, lower-risk enrollees who otherwise would have remained uninsured.

**D4. 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?**

If states contract with Medicaid plans to provide BHP, they can help improve continuity of care for low-income enrollees whose income frequently fluctuates above and below 138 percent FPL. Rather than churning between Medicaid and Exchange plans – which often have very different benefit structures and provider networks – these low-income enrollees would essentially stay on the same plan with the same provider networks.

However, if states contract with plans that are neither part of their Medicaid program nor offered in the Exchange as a QHP, the introduction of BHP could create *more* churning and disruptions in care, as there would be a break at both 138 percent FPL and at 200 percent FPL. To avoid this scenario, states should be required to have some overlap between Medicaid, CHIP, QHP and BHP. At a minimum, we recommend that HHS require that states offer at least one plan or provider network in BHP that is also offered in Medicaid, so that BHP fulfills the promise of improving continuity of care for those at the lowest end of the income spectrum who may experience more frequent income fluctuations<sup>19</sup> and who are often least able to manage care interruptions.

Although the ACA took significant steps towards aligning income-counting rules in Medicaid and the Exchange, there are still some important ways in which they differ. For example, in the Exchange family size and household income will be defined by the tax unit. Medicaid, however, will make some exceptions to this rule. For example, pregnant women can still count as a family of two in Medicaid, whereas in the Exchange a pregnant woman would count as a household of one. Additionally, Medicaid still uses point-in-time income to determine eligibility, whereas Exchange uses annual income. Since we anticipate that most states will build on their Medicaid and CHIP programs for BHP, we recommend that in cases where income-counting rules differ in Medicaid and in the Exchange, the BHP adopt Medicaid rules.

Finally, we recommend that HHS require states to develop a “safe harbor” to avoid short-term gaps in coverage during transitions. Under this safe harbor, when individuals’ income drops below or above BHP levels, they should be allowed to maintain BHP coverage until they are enrolled in Medicaid or Exchange.

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<sup>19</sup> Dorn et al

**D5. How could establishing a Basic Health Program affect the ability of an entire family to be covered by the same plan?**

As discussed under A1, BHP offers the potential to keep family members in the same plan. If a state contracts with the same plans for Medicaid, CHIP and BHP, then parents and their children can remain on the same plan until the family's income reaches above 200 percent FPL. HHS should encourage this when possible.

**E. Amount of Payment**

**E1. 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?**

As discussed under A6, the statute allows states to provide coverage with higher cost-sharing requirements under BHP than the population would get if they were enrolled in coverage through the Exchange. However, we believe this was a legislative oversight; drafters likely forgot to increase the actuarial values in the BHP section when they improved the cost-sharing subsidies in the Exchange. As evidenced by transcripts of Senate Finance Committee debate on BHP, the structure of payments to states for BHP, and summaries of the law by the Senate Democratic Policy Committee, the intention of the drafters was to ensure that enrollees not be made worse off by a state's decision to take up BHP (see A6 for more detailed evidence of Congressional intent). Therefore, we recommend that HHS clarify in future guidance that BHP enrollees must be provided with coverage with at least the actuarial values they would have received in the Exchange.

**E2. What are the likely administrative costs for a Basic Health Program? What factors, especially in terms of resources, are likely to affect a State's ability to establish a Basic Health Program? How are States likely to fund the costs associated with establishing and administering a Basic Health Program?**

We strongly recommend allowing states to spend BHP dollars on the administrative costs associated with running the program. Otherwise we believe very few states will take up the option, since state budgets are already stretched thin and the administrative cost of setting up and running the BHP would be prohibitively high.

To ensure that BHP dollars are spent efficiently and are maximally directed at lowering health care costs, HHS should establish a cap on administrative spending. Administrative costs account for about 5 percent of state Medicaid spending<sup>20</sup>, so 5 percent is likely an appropriate cap for

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<sup>20</sup> Center on Budget and Policy Priorities, "Policy Basics: Introduction to Medicaid", December 2008 <http://www.cbpp.org/cms/index.cfm?fa=view&id=2223>

BHP administrative costs. Should HHS decide on a higher cap, it should be no higher than the cap in CHIP, which limits administrative spending to 10 percent of total CHIP expenditures.

**E4. Other than those listed in the statute, what factors should be considered when establishing the methodology for determining the amount of Basic Health Program funding to States? How should the Federal government implement this calculation?**

Section 1331(d) requires that the Secretary transfer to the state an amount equal to 95 percent of the premium tax credits and the cost-sharing reductions that would have been provided to eligible individuals if they were allowed to enroll in qualified health plans through an Exchange. But premium tax credits are based on the cost of the second-lowest-cost silver plan in the Exchange, so this financing mechanism for BHP creates a perverse incentive for the state to keep premiums *high* in its Exchange: the more effective a state's Exchange is at holding down premium costs, the smaller the state's BHP payment amount.

We recommend that HHS develop an alternative methodology for calculating the per-enrollee BHP payment amounts that divorces the state's payment levels from its premiums in the Exchange, while still accounting for differences in underlying health care costs across states. One potential solution would be to base per-enrollee payment amounts on the costs of that state's second-lowest-cost silver plan for 2014. Then, for each year thereafter, index that amount by the average growth of premium tax credit payments *nationally*. This would still account for geographic differences in health care costs while aligning incentives states face to keep health care costs down in the Exchange: after 2014, the better a state is at keeping down health care costs relative to other states, the further their BHP dollars will go.

**E7. What methods should be considered to measure and monitor compliance with the 95 percent cap on funding? How should CMS implement the provisions in Section 1331(d)(3)(B) of the Affordable Care Act regarding corrections to overpayments made in any year?**

States are wary of exposing themselves to significant financial liability. So the prospect of having to pay back large amounts of their BHP transfer at the end of the year could deter states from taking up this option. To encourage states to take up BHP, HHS should put boundaries on the funds that states would be required to repay if their original payment from the federal government turns out to be higher than it should have been. Some of those boundaries can be found in the ACA's language around reconciliation for individuals in the Exchange.

Although there is no limit on how much individuals can recoup at the end of the year if they collected smaller tax credits throughout the year than they were owed in the Exchange, Congress placed caps in the ACA on how much low- and moderate-income families could be required to repay. Section 36B(f)(2)(B)(i) of the Internal Revenue Code of 1986 caps these "reconciliation" amounts at \$600 for families (or \$300 for individuals) with incomes less than 200 percent FPL, \$1,500 for families (or \$750 for individuals) with incomes at least 200 percent but less than 300 percent FPL, \$2,500 for families (or \$1,250 for individuals) with incomes between 300 and 400 percent FPL.

We recommend that the Secretary apply these reconciliation “caps” to the amounts paid to the state as well. Under this scenario, there is no cap on how much the state can recoup from the federal government if it was not paid enough, but would only have to pay back a maximum of 95 percent of the above caps if its enrollees increased throughout the year. This type of cap would temper the fiscal uncertainty inherent in BHP. It is also consistent with the intention of the ACA that the state receive 95 percent of whatever the federal government would have spent on that individual in the Exchange – the federal government should not collect more from the state than they would have collected from the individual had the individual been enrolled in the Exchange.

Reconciliation may also be necessary if the second-lowest-cost silver premium is higher or lower than the Secretary projected when calculating the original transfer amount, introducing a second avenue for financial risk and liability for the state. We recommend placing an upper- and lower-percentage-based band around the amounts the state would have to repay or would have to remit to the federal government because of miscalculation. To account for the fact that the federal government has more leeway to absorb shocks to its budget than states do, the band for receipt should be higher than the band for remittance.

## **G. Secretarial Oversight**

### **G1. 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?**

Public input to the design of BHP is essential if the program is to effectively meet the needs of this vulnerable population. Accordingly, we recommend that HHS adopt a process for transparency and public input in both the development of the application at the state level and the approval of the application by HHS that mirrors the process laid out in the September 17, 2010 proposed regulations for Medicaid Section 1115 Waivers. These regulations require states and HHS to make all relevant information about the BHP application available on a public websites, and to open the process to public input at the state level before applying for Secretarial certification, and at the federal level before rendering a final decision on Secretarial approval.

Sincerely,



Robert Restuccia  
Executive Director  
Community Catalyst