

BASIC HEALTH PROGRAM RFI

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 (BHP)? 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?**

Factors under consideration include:

- How the addition of the BHP will affect the viability of the exchange. What effect will the movement of a certain percentage of individuals from the exchange to the BHP will have on the residual exchange market?
- For the exchange to be viable it must be attractive to consumers, providers, issuers, and be administratively manageable. It is difficult to anticipate all the ramifications of the addition of a BHP when the health insurance exchange itself is a new entity.
- The cost to the state is an important factor. It would be helpful for CMS to develop a method for giving states reliable, advanced projections of BHP funding levels and a clear understanding of any future adjustment or reconciliation methodologies where possible.
- Service to consumers—how will a BHP benefit the consumer in comparison to a QHP offered through the exchange? Will the financial benefits of lower out of pocket costs and the reduced worry about reconciliation be offset by possible lower benefits or reduced choice in plans and providers? Many of these are unknown, because they involve predicting how various entities will react.
- The impact of the potential for inclusion of certain categories of lawfully residing immigrants who are federally ineligible for Medicaid in a BHP How will the BHP be impacted by the temporary reinsurance program, risk adjustment and risk corridors provisions (assuming that these provisions apply to BHP)? Also, if the BHP population is healthier than the exchange population, does it make sense to assess the BHP population?
- If the BHP population is less healthy than the exchange population, then tying the BHP premium to the second lowest silver plan in the exchange may be problematic as 95% of the premium tax credit would cover less than 95% of the premium.

- 2. What are key considerations for States in placing responsibility for a Basic Health Program within the State organizational structure?**

How funding for the establishment and administration of the program will be handled. Section 1331(d) of the ACA states that the funds for the program transferred to States from HHS must be placed in trust and used to reduce premiums and cost-sharing or to provide additional benefits to enrollees. Since some of the main reasons for considering providing a BHP to consumers are reduced cost-sharing, the provision of a more comprehensive benefits package, reduced churning, etc it would be helpful for HHS to clarify if or under

what circumstances a state that achieves one or more such goals may use some of the funds for administration of the program.

3. What are the challenges and costs associated with managing a Basic Health Program?

States interested in smooth, seamless coverage for its consumers would have yet another layer of coverage and two additional transitions that would need to be dealt with by the addition of a BHP.

The financial uncertainty is troublesome as we try to estimate the true cost of the BHP to the state while wondering whether additional state dollars would be available to offset costs not covered by the transfer from HHS. In evaluating these costs, it would be helpful for HHS to clarify how the process for subsidy reconciliation with states will work in light of the inconsistencies in section 1331(d)(3)(A)(ii) which states that payments to the States will be determined on a per enrollee basis but then goes on to say that the experience of other states will also be a factored in to the determination.

Factoring in the experience of other states could have detrimental results. We believe that, particularly in the early stages of the BHP, each state's experience should be viewed independently. New York has many unique characteristics as a community rated, high-cost state with broad demographic variations. For states like New York, payments based upon a one sized fits all approach or comparison to other states could result in inadequate payments.

We request more guidance as to how the calculation of payment discussed in Section 1331(d)(3)(A)(ii) will be adapted for a community rated state like New York. That section notes that age and health status will be taken into account in determining BHP payments, but the inclusion of those factors would be impermissible and inconsistent with New York's Exchange market. For example, in New York's Exchange the lowest cost silver plan will not be permitted to make premium adjustments based upon age and health. New York seeks clarification and urges consistency between the determination of payments for the BHP and the pricing of products in the Exchange.

However, the federal government must also ensure that community rated states get the full benefit of payments that would be available to support those with risk that would otherwise qualify them for participating in a risk adjustment or reinsurance mechanism, especially in view of the uncertainty of the risk profile of BHP enrollees and the substantial costs that can be introduced by a relatively small percentage of high cost enrollees. Appropriate decisions regarding payments must be considered in the context of whether the federal government will allow a single risk pool for the BHP and Exchange market and whether the BHP will be integrated with various risk adjustment and market stabilization mechanisms.

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?

Limited time frames to set up required exchange components have states hesitant to take on additional programs initially. As some consultants have illustrated, knowledge of the QHP rates are a key variable in the BHP/exchange viability cost equation. If the BHP is set up later, that factor will be more of a known entity. On the other hand, adding an additional program later will result in moving consumers between programs with the subsequent disruption that involves.

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?

A study has been commissioned to study the effect of introducing a BHP into the New York State Health Benefits Exchange. In addition, the Community Service Society with support from New York State Health Foundation issued a report on the potential savings both to consumers and the State of implementing a BHP. Additional guidance regarding the BHP payment methodology is necessary to complete analysis of the impact of the program upon the State.

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?

Any federal requirements placed on the BHP, and specifics about calculation of the federal financial contributions should be outlined and in place as soon as possible so that states are not trying to work with too many moving pieces.

To determine income for Medicaid purposes, 5 FPL percentage points are deducted from MAGI. Will the BHP eligibility level start immediately above this MAGI level (often referred to in shorthand as 138%), except for those lawfully residing immigrants who are ineligible for Medicaid, where it will start at 0%?

In administering BHP how much flexibility do states have in determining income? Must they project annual income levels; may they use Medicaid methodologies for calculating “point in time” income, or may a state create/use another method?

Do states have the flexibility to require licensed insurers that serve BHP and the individual market to pool both sets of enrollees together and/or include BHP plans, whether or not they are state-licensed, within the risk adjustment and reinsurance mechanisms that apply to the individual market?

Is federal BHP funding based on premiums actually charged in the exchange? Or is it based on the potentially different premiums that would have been charged if BHP adults had been included in the exchange? If the latter, how are such premiums estimated?

Since BHP funding is linked to the second lowest cost silver plan, guidance on the essential health benefits is needed so that meaningful estimates of the plan benefits and premium can be generated. Until this is known a determination cannot be made as to whether offering a BHP will increase access to health care services for enrollees and be fiscally feasible for the state.

Section 1331(d) (3) (A) (ii) contains a reference to risk adjustment that creates confusion as to how the BHP is intended to interact with that program. The language reads as if it is an adjustment to the payment amounts for the BHP based on risk, rather than a mandate for inclusion in the stabilization mechanisms. How will the risk adjustment and reinsurance provisions that would otherwise apply in the absence of a BHP be applied within the BHP?

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

It would be helpful to outline the process for federal certification of BHPs and make it clear and streamlined. Any assistance on general exchange data verification and other requirements would also be helpful, as states are dealing with limited resources. The more time/effort/cost placed into setting up the mandatory elements of the exchange, within the appointed timeline, the less resources states have to develop optional programs.

Since many issues cross state and federal lines, sharing information and statistics developed by consultants and agencies could be helpful to the decision making process.

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?

Protecting this group of consumers from having to pay back money at the end of the year would probably encourage them to participate in the exchange. Should health plan standards be any different than the consumer protections offered in the QHP? The basic health plan may be seen as a bridge between Medicaid and private insurance. In examining consumer protections states should be permitted to rely on precedent set by their public programs and existing insurance markets. State flexibility in designing this would be helpful.

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?

State flexibility could be important here, so that a state can design a program that will be attractive to consumers, issuers and providers. While consumer protections in terms of benefit packages, limits on out of pocket costs and protection from year end reconciliation are undoubtedly important, it is also important for the consumers to have a healthy choice

of plans and for the basic health plan to be cost effective and sustainable. Each state, with their own distinct insurance market and consumer population would be in the best position to determine how best to accomplish this.

Some of the modeling that has been done for BHP assumes that enhanced benefits packages and minimal cost-sharing for consumers can be achieved by contracting at Medicaid managed care plan rates. A noted drawback to this approach is that providers may not be willing to contract at Medicaid rates which could result in provider networks that are not comprehensive enough to support the program. To counteract this tension, some of the models increase provider rates by investing anticipated savings based on the difference between the payment to States of the estimated 95% of the premium tax credit that the individual BHP enrollees would have been eligible for had they enrolled through the Exchange in the second-lowest silver plan along with the cost-sharing reduction they would have received based on percentage of FPL and the cost of the premium for BHP standard plans. However, this scenario is highly dependent on a BHP population which is much healthier than the remaining population and it is not clear whether or not this will be the case. It is also not clear if the relative health between the BHP population and the remaining exchange population will remain constant over time. At this point, there are too many unknowns to identify with any level of certainty costs that may be associated with an expanded benefit package or potential costs to the State based on fluctuations in BHP enrollee incomes to feel comfortable attributing potential savings to increase provider rates.

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

Standardization of plans across various programs in the exchange could encourage participation by providers and consumers. Families have an increased chance of being enrolled in plans from the same issuer.

The expected impact of standard health plans is highly dependent on the ability to strike a balance between the actual level of benefits, the cost of those benefits, and provider reimbursement amounts. For example, richer benefits with lower cost sharing will increase the likelihood that providers will participate at reduced rates. Conversely, inadequate benefits with high cost sharing that does not meet the needs of consumers will serve as a disincentive to provider participation, as providers would be concerned about bad debt and an inability to provide their patients with needed services. Also, if provider rates are set too low, providers will need to make-up the shortfall by billing higher amounts for services rendered to non-BHP participants. This “bubbling out” of costs will impact consumer access in the non-BHP Exchange market.

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?

It has been suggested that a requirement to offer products across the spectrum of programs could ease transitions and reduce disruptions for consumers. It is unclear what effect this would have on the issuers willingness to contract.

2. What considerations exist in determining whether to utilize the regional compact authority in Section 1331(c)(3)(B) of the Affordable Care Act? Are States interested in pursuing this approach?

Given the differences in State's health insurance markets, health care costs and the short establishment/implementation timeline, it does not seem feasible to coordinate program management with other states. However, New York is a state with a large population, able to achieve broad risk sharing and economies of scale. States with smaller populations may need to consider program coordination with other states to ensure a viable program.

D. COORDINATION WITH OTHER STATE PROGRAMS

1. 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 modeling we have seen reduces the size of the Exchange market which has the potential of raising premiums in the Exchange. An Exchange servicing a smaller population will have less bargaining power to negotiate provider rates and achieve economies of scale. A smaller Exchange that relies upon user fees to fund administration will need to charge higher fees per member. Additionally, a viable Exchange must offer sufficient health plan access and choice in provider networks. The smaller the population of the Exchange, the less incentive there will be for health plans to participate. The health plans that do participate will also have a decreased ability to successfully negotiate with providers for participation at rates that reflect a large volume of enrollees. A lack of sufficient health plan competition and provider choice could impact the viability of the Exchange over time. If the BHP was operated with issuers currently offering Medicaid managed care and CHIP plans it might improve the purchasing power of existing public 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?

Modeling we have seen so far indicates that individuals enrolling in the BHP may be healthier than the general Exchange population. Offering a BHP could increase the risk profile of the individual market in the Exchange and result in increased premiums. One way to diminish the effect on the Exchange market might be to combine the risk pool or risk adjust with BHP, but it is unclear how viable this is. It is possible that the low income population eligible for the BHP will include a disproportionate share of younger people, with relatively healthy risk profiles. This will leave relatively less healthy people in the Exchange, impacting the cost of coverage. If this is the case, a state must be concerned that the existence of the BHP will impact access to coverage in the Exchange market. Conversely, if the risk profile of the population eligible for the BHP is worse than the standard Exchange population, a state must be concerned that the funding determined based upon the pricing of the silver Exchange plan will be adequate. These issues must be adequately addressed to ensure the long term sustainability of both the BHP and the Exchange.

- 3. What are some of the major factors that States are likely to consider in determining how to structure their Basic Health Program? Are States likely to structure the Basic Health Program as one component of its other public programs? Are States likely to consider a CHIP-like approach or other options? What are the pros and cons of these various options?**

One of the reasons cited for the success of CHP programs in covering uninsured children is that states had a lot of flexibility to tailor their program to meet the needs of their particular population, insurance market, and state administration. State flexibility could be helpful here to increase chances of success.

How a BHP is treated for tax purposes is relevant. Non-profit health plans would be more likely to participate in a Basic Health Plan if it were not classified like private coverage in determining whether insurers are subject to taxation.

- 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?**

Eligibility standards should be as consistent as possible to prevent any potential enrollee from falling through the gaps. It can also be helpful to align plans across programs for continuity of provider coverage. If providers are paid less than in QHP's, any access to health care benefit gained by decreased cost may be diminished by smaller provider networks. Aligning plans will help the consumer but it may discourage plans from participating in the exchange altogether.

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

Contracting with plans that participate in Medicaid managed care and CHIP may increase the likelihood that family members would be in the same plan.

- 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?**

Aligning requirements as much as possible would be helpful here, whether they are eligibility, documentation or verification requirements. Removing barriers and adding enticements for plans that participate in the full spectrum of coverage options may be helpful.

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?**

Rigorous spending restrictions could be detrimental for state exchanges. The ability to use federal funds for some state administrative costs, especially as there may be many unforeseen, could be essential to creating a viable BHP.

2. 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?

It is clear under the statute that enrollees are not allowed to be enrolled in the Exchange if they are eligible for BHP. Section 1331(e)(2). However, there is no guidance on whether the BHP can be operated by the State's Exchange. It would be helpful for HHS to clarify whether the BHP can be operated by an Exchange and if yes, whether establishment funds can be utilized in the establishment of the BHP and whether ongoing administrative costs could be funded out of the general operating funds for the Exchange.

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?

Determination of the value of premium tax credits and cost sharing reductions should be conducted at the individual state level in order to reflect the unique nature of the market that exists in each state. For example, taking other states' experiences into account to arrive at some "average" can be unfair for states such as New York where the costs have traditionally been higher than average. The state could be penalized for being a high cost state by having to cover more of the costs of the BHP out of state dollars. This statutory provision appears to provide a tool for the federal government in the event a given state's poor practices result in inappropriate costs. It should not be used in the absence of such a problem.

The statute doesn't specify how comparison to other states should be done in year one or going forward. States that are ready to implement a BHP in 2014 should be a given guidance in advance in order to be able to begin the program.

4. 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?

If an individual transitions from the BHP to a QHP during the year how will the federal BHP payments be impacted? How often will an enrollee's income be reviewed (monthly, quarterly, and annually) and how will such transitions impact payments? How will the federal government determine BHP payment levels in community rated states that do not allow discrimination in pricing based upon age, sex, health status or occupation?

It is important that the federal government takes a practical approach to funding the BHP. For example, states must know in advance what they can expect to receive on a per person basis for enrollees participating in the BHP and this amount must be guaranteed for a fixed period of time. Without this advance knowledge and predictability, it would be difficult for the states to contain their own risk by entering into capitation arrangements with standard health plans. Predictability in payments could offset concerns relating to what appears to be a built-in disincentive to aggressive negotiation of low premiums for the Exchange's second lowest cost silver plan. States must be given the tools to effectively meet their promise to the BHP population to provide a comprehensive and stable insurance option, while also meeting their obligation to Exchange purchasers to ensure accessibility to affordable health insurance coverage. Competitive pricing of Exchange products must be achieved alongside of a sustainable BHP.

5. The statute specifies that the funding calculation is on a per-enrollee basis. How should the Federal government acquire the detailed information necessary to perform this calculation?

Exchanges should report income used in the initial determination of eligibility and any income changes reported by BHP enrollees during the course of the year to the Federal government to reduce the impact on potential recoveries from States.

6. What are the best State-specific data sources to use in estimating the availability of affordable employer sponsored insurance?

7. 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?

Whatever standards and procedures determine whether a federal BHP payment was in "error" and therefore requires a compensating adjustment in a later year must balance several factors. These include: state interest in fiscal predictability; undesirability of penalizing states for factors outside their control; and the federal interest in BHP payments that accurately reflect the subsidy amounts BHP consumers would have received in the exchange.

F. ELIGIBILITY

1. What education and outreach will be necessary to facilitate a helpful consumer experience? Would this be any different than what will be done for the exchange and public health programs generally?

It may be confusing to consumers to do a separate campaign about BHP. Rather than focusing on the different public and commercial insurance options, it might be more helpful to consumers for marketing efforts to focus on the affordable (emphasizing that many people will be eligible for insurance with no or very low premiums and cost-sharing) and comprehensive health benefits that can be obtained by applying and enrolling in health coverage through the Exchange.

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?**

Whatever system is designed should be one that is easy for the state to use and provide answers quickly.

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

Ease of use for the states—clear rules and quick turnarounds.