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CMS Urged to Give States Guidance on Basic Health Program

Information Needed as States Develop Plans for Health Exchanges

As states develop plans for creating their Health Benefit Exchanges, they're hitting a roadblock created by insufficient information about an attractive and promising option for serving low-income people. The health care reform law allows states to create a special Basic Health program (BHP) to serve residents just above the income threshold for Medicaid eligibility.

But for states to make informed decisions about whether to create this new program, or serve these individuals and families through the new Exchanges, they need more information from federal agencies about the rules and funding that will be available to operate the program. In a letter to the Centers for Medicare and Medicaid Services (CMS), the Association for Community Affiliated Plans (ACAP) urged the agency to provide guidance to states within six months.

"Currently, states face a barrier to thoroughly evaluating and making decisions regarding the BHP because they do not have a reliable understanding of the financial implications," wrote Margaret A. Murray, the CEO of ACAP, which represents 56 Safety Net Health Plans. The option, she said, "cannot be separated from decisions a state must make about the structure and function of their Exchange."

A BHP would cover individuals and families between the new Medicaid threshold of 133 and 200 percent of the federal poverty level. Otherwise, those within that window would be eligible for subsidized coverage from qualified health plans through the state Health Benefit Exchange.

Murray said a BHP could be designed to offer more affordable options for enrollees than Exchange coverage, provide more comprehensive benefits, reduce churning between programs as enrollees' incomes change, and keep families together within the same health plan. In the letter, she outlined the types of information states need in order to decide whether to establish a BHP and made recommendations for how a BHP could work.

Discussions about the BHP option are occurring in at least 10 states, including California, Colorado, Connecticut, Illinois, Maine, New York, Oregon, Pennsylvania, and Rhode Island. A BHP in Washington State was the model for the federal legislation.

Murray said that states are attracted to BHPs by “the desire to align coverage for low-income persons, thus smoothing transitions between programs when household income changes and providing consistent health plan choices when members of a given family qualify for different public programs and potentially offering coverage options with lower cost-sharing.”

In the letter to Cindy Mann, the Director of CMS’s Center for Medicaid, CHIP and Survey & Certification, Murray said states need to know now the amount of federal funding they might receive. BHP funding is set at 95 percent of what a beneficiary’s subsidy would be under commercial Exchange coverage, but Exchange benefits have yet to be specified. States therefore need CMS to provide “an estimated subsidy level or identify a reasonable method states can use to make such estimates.” Murray also said that while subsidies are being clarified, CMS should reduce the risk to states by providing a “hold harmless” provision to protect states in case federal estimates for BHP are inaccurate.

Within the “considerable flexibility” states are given to design Medicaid, a BHP, and their Exchange, ACAP outlined a series of recommendations for meeting the needs of low-income people.

- Permit flexibility in risk pools to let states determine whether the BHP market should be merged with the Exchange and/or Medicaid.
- Let states use their current Medicaid or CHIP policies to facilitate, for example, the amendment of existing Medicaid or CHIP contracts. Using existing infrastructures, “BHP becomes a ‘turnkey’ start-up that could minimize administrative costs” and streamline the interplay between public coverage options.
- Extend ACA’s requirement that Exchanges contract with essential community providers to apply to the BHP too.
- Ensure that rates paid to BHP health plans are actuarially sound.
- State explicitly that nonprofit Safety Net Health Plan revenue from a BHP is not counted as commercial and thus subject to ACA’s health insurer fee.

- Allow states to implement BHPs on a regional basis and for specific types of individuals, such as pregnant women.
- Permit states with federally operated Exchanges to establish the BHP.
- Allow states to align quality standards across their Medicaid, BHP, and Exchange programs.

“States should take a serious look at the BHP as a way to retain low-income individuals’ access to safety net providers and plans that have developed a unique expertise in meeting the needs of low-income communities,” Murray said. Besides the advantages for BHP enrollees, states could see fewer uninsured residents and a reduced administrative burden on Medicaid agencies from less churning on and off public programs.

Murray wrote that one of the chief benefits of the BHP is that “it can improve enrollment, retention and access to care for low-income adults” in relations with the Medicaid program. But to reduce churning between public and private coverage, BHP should use the same income-reporting requirement as the Exchanges and Medicaid. States should be allowed to establish one-year continuous eligibility period for both BHP and Medicaid. And to reduce coverage gaps during transition periods, BHP enrollees who become ineligible for BHP coverage should continue to receive benefits until they are enrolled in Medicaid or the Exchanges.

“ACAP member plans are actively engaged in preparation to participate in these new marketplaces,” Murray wrote, referring to the BHP, Medicaid, and the Exchanges. “Safety Net Health Plans are prepared to work with state policymakers to design the BHP in ways that best align the three programs and meet the needs of low-income residents.”

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NOTE: **ACAP** (www.communityplans.net) represents 56 nonprofit safety net health plans in 26 states that serve eight million people through Medicaid, Medicare, and the Children’s Health Insurance Program. A copy of ACAP’s May 5 letter to CMS is available upon request and at:

<http://communityplans.net/PolicySupport/CommentsandRegulations/tabid/351/Default.aspx>