



October 31, 2011

The Honorable Donald M. Berwick  
Administrator, Centers for Medicare and Medicaid  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Attention: CMS-9980-NC: Request for Information Regarding State Flexibility to Establish a Basic Health Program Under the Affordable Care Act.**

Dear Administrator Berwick:

Medicaid Health Plans of America (MHPA) is pleased to offer responses to selected questions included in the Request for Information Regarding State Flexibility to Establish a Basic Health Program Under the Affordable Care Act (76 Federal Register 56767, September 14, 2011).

MHPA is the leading trade association solely focused on representing Medicaid health plans. Its members' 90 managed care plans serve more than 14 million Medicaid beneficiaries in 33 states and the District of Columbia. MHPA represents both non-profit and for-profit plans, ranging from large multi-state insurance corporations to small community-based plans.

MHPA believes the Basic Health Program option authorized under Section 1331 of the Affordable Care Act could help make coverage more affordable for eligible individuals, could allow family members eligible for different health programs to obtain coverage through plans operated by a single insurer, and could also ease the transition between enrollment in Medicaid/CHIP and coverage obtained through a qualified health plan operating in a State Exchange. Since MHPA members have broad experience meeting the health care needs of culturally diverse, low-income populations and contracting with providers who play an instrumental role in providing access to Medicaid and CHIP, they are well positioned to offer newly eligible single adults and legal immigrants coverage under the Basic Health Program.

However, MHPA also recognizes that States will want to carefully consider the policy and fiscal implications of this option and need additional information as quickly as possible to make informed decisions. For this reason, we appreciate the opportunity to offer the following responses to selected questions included in the Department's Request for Information.

## *A. General Provisions*

*4)... Are there opportunities to leverage existing systems and increase efficiency with the State structure?...*

**Response:** MHPA believes the Basic Health Program may have the potential to address some churning issues and make coverage more affordable for low-income individuals in some states. If States consider the Basic Health Program option, they may also want to consider leveraging their existing Medicaid and CHIP infrastructure. Utilization of existing Medicaid administrative capabilities, including IT systems, rate-setting mechanisms, and contracting processes would reduce operating costs for this program.

*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?*

**Response:** States may be reluctant to pursue this option until they have more certainty about the methodology that will be used to calculate per-enrollee payments to states and a detailed understanding of the reconciliation process HHS will use to adjust these payments.

For this reason, MHPA urges the Department of Health and Human Services (HHS) to consider issuing informal guidance on the State payment methodology and the reconciliation process prior to publication of proposed rules. Such guidance should also clarify whether payments will be made on a Federal fiscal year or State fiscal year basis under §1331(d)(1) of the Affordable Care Act and whether States will be able to utilize risk adjustment to address any adverse selection, also an important consideration for health plans considering participation in the Basic Health Program.

Since States currently face serious fiscal constraints, it would also be helpful for HHS to clarify the federal funding sources that States may use for the operation and oversight of a Basic Health Program. A lack of sufficient administrative funding could be a serious barrier to implementation.

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

*1. What additional standards, if any, should standard health plans participating in a State's Basic Health Program meet?...*

**Response:** Medicaid health plans have experience serving these low-income populations, and are well-suited for this population having had experience contracting with safety-net providers. If a State exercises this option, the Basic Health Program should be open to all health plans, not just nonprofit plans, and all Medicaid plans

operating in the State should be deemed eligible to qualify as standard health plans. Also, with respect to application of the annual insurer fee in the Affordable Care Act, all plans should be treated equitably whether coverage is provided on or off an Exchange or through the Basic Health Program.

*2. What plan design issues should be considered?...What are the advantages of an expanded benefit package for standard health plans compared to qualified health plans?*

**Response:** MHPA believes that States should be given maximum flexibility to design their Basic Health Programs, especially in the early years of implementation. States know their local markets better and should be able to design programs that best fit their needs.

The Basic Health Program option could be used to provide additional benefits to low-income enrollees beyond those required as part of the Essential Health Benefits package through a cost-effective managed care delivery system. Under the Affordable Care Act, however, mandating the coverage of additional benefits by qualified health plans would require a State to fully finance their cost for individuals eligible for premium and cost-sharing subsidies and drive up premiums for unsubsidized individuals, making coverage less attractive for the healthiest members of this pool.

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

**Response:** Ideally, standard health plans would pay providers above Medicaid fee-for-service rates to minimize cost-shifting to the private market and to encourage more of them to participate in programs serving low-income populations, thereby improving access to care. However, health plans must be paid actuarially sound rates by States to sustain these higher payments and avoid unintended consequences on their markets.

When considering the Basic Health Plan option, States should carefully weigh the proper balance between the scope of the benefits package, the amount of premium and cost-sharing subsidies, and the adequacy of provider payments to ensure continued access to care through the Basic Health Program, while avoiding cost-shifting by providers that will make coverage less affordable and also reduce access for the unsubsidized population.

*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?*

**Response:** For individuals that frequently churn between program eligibility thresholds, a Basic Health Program based on a State's Medicaid managed care system could ease the financial burden that may accompany shifts between Medicaid and the Exchange, while increasing the likelihood that existing doctor-patient relationships could be maintained, thus promoting continuity of care.

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

**Response:** A Basic Health Program standard health plan offered by a health issuer also providing Medicaid and CHIP coverage could make coverage for a low-income family more seamless and affordable. All family members choosing to receive health care services through the same issuer could receive similar plan cards and benefit from coordinated customer services. Plan materials could include an explanation of the similarities and differences in coverage and family members could obtain detailed information on benefits, cost-sharing and providers from a single source.

6. *Are standard benefit 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?*

**Response:** Issuers offering standard health plans may already offer Medicaid and CHIP plans, and should be able to participate in Exchanges so long as they comply with the same state and federal standards applied to all other plans, but should not be required by CMS or States to offer a full spectrum of plans. Plans targeting low-income populations eligible for public programs, such as Medicaid and CHIP, are subject to different requirements and rules than commercial plans, have different networks of providers, and may not have the back-office capabilities to offer commercial products. Individuals eligible for coverage under the Basic Health Program option will be more similar to Medicaid and CHIP beneficiaries than populations covered under commercial insurance. CMS and States could encourage standard health plans to also operate Medicaid, CHIP, and Exchange plans by identifying for individuals side-by-side plans that are available when their eligibility status changes. However, requiring Medicaid plans that seek to offer Basic Health Program standard health plans to also offer one or more Exchange plans might discourage their participation in the Basic Health Program.

#### *F. Eligibility*

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

**Response:** Many individuals in the target population may not currently be enrolled in health plans and may be unfamiliar with insurance terminology. Online and written materials should be presented in a simple, straightforward format. Outreach will be needed to help encourage participation in the Basic Health Program, explain coverage options and beneficiary costs, and to answer questions from prospective enrollees. Entities conducting such outreach should have the experience and training needed to engage culturally diverse, low-income populations and to carry out both education and enrollment activities. Enrollment activities should be coordinated with the Exchange, Medicaid, CHIP, and other state health programs.

On behalf of MHPA and our member plans, I want to thank you for giving us the opportunity to provide feedback on the Basic Health Program option authorized under the Affordable Care Act. We look forward to continuing to work with HHS on the development of implementing regulations.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas L. Johnson". The signature is written in a cursive style with a large initial "T".

Thomas L. Johnson  
President & CEO