Washington State Health Care Authority

Report to the Legislature

Premium Assistance and the Federal Basic Health Program Option: Considerations for Washington State

Third Engrossed Substitute Senate Bill 5034
63rd Legislature, 2013 2nd Special Session

December 2014

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Appendices

Background

The Patient Protection and Affordable Care Act (ACA) presents opportunities for new partnerships between states and the Department of Health and Human Services (HHS) to make affordable, high quality health coverage available to low income individuals.

Section 1331 of the ACA creates state flexibility to establish a *federal* basic health program option (FBHPO) for low-income individuals with income up to 200 percent of the federal poverty level (FPL), who are not otherwise eligible for Medicaid. Effectively, the FBHPO replaces subsidized coverage that would otherwise be available in the Health Benefit Exchange (Exchange), and relies on federal funding that would otherwise be used for Exchange subsidies. The FBHPO is an insurance affordability program that sits between Medicaid and the Exchange and must be fully coordinated with these programs as changes in circumstances move individuals and their families across coverage options.

Individuals enrolled in a FBHPO no longer have access to coverage in the Exchange – enrollment in the Exchange applies only where incomes are greater than 200 percent of the FPL. Premiums and cost sharing for FBHPO enrollees may not exceed what would have been paid if they had been enrolled in the Exchange. States that choose to operate a FBHPO receive federal funding equal to 95 percent of the premium tax credit and 95 percent of the cost-sharing reductions that would have been available to eligible individuals enrolled in the Exchange.

The ACA also provides flexibility for states to use Medicaid/Children's Health Insurance Program (CHIP) funds as premium assistance to purchase subsidized coverage for Medicaid beneficiaries through Qualified Health Plans available in the Exchange. Under this scenario, premium assistance enrollees remain Medicaid beneficiaries and continue to be entitled to all Medicaid benefits and cost sharing protections.

2013 Legislative Study Request

Through enactment of Third Engrossed Substitute Senate Bill 5034 (3ESSB 5034), the 2013 Washington State Legislature directed the Health Care Authority (HCA) to conduct a study for possible implementation of these options in Washington State. The statutory reference is included as Appendix 1 of this report.

The Legislative intent was to address considerations for achieving key goals of coverage and care continuity, affordability, and whole-family coverage consistency as family circumstances change. Recognizing that federal rules were not yet available to support a comprehensive analysis of FBHPO and that other states were negotiating waivers to support premium assistance options, the study was required to consider:

Washington's Policy Goals

- *Maintain access to the same benefits and providers as family circumstances change*
- *Reduce affordability cliff as a result of a transition from Medicaid to the Exchange*
- *Enroll families in the same plan*
- *Minimize gaps in coverage*
- *Make cost-effective use of federal, state and private dollars*
- *Identify and optimize administrative simplification opportunities*
- *Comply with, or seek waiver from, specific ACA coverage and eligibility requirements*

(a) Application of individual premiums and cost-sharing that exceed the five percent of family income cap allowed under federal law;
(b) Recommendations to make the targeted premium assistance program cost neutral;
(c) Comparison of premiums and cost-sharing under the FBHPO and premium assistance options; and
(d) Options for implementing the FBHPO and premium assistance programs simultaneously.

Findings were ideally anticipated to cover detailed fiscal analyses, including estimated costs for system design and implementation, and information about impacted populations – beneficiaries and their families, health carriers operating in Washington State's public and commercial coverage markets, health care providers, and the State and Federal governments. Financing appropriated for the 2013 study of the FBHPO assumed federal financing participation consistent with traditional Medicaid fifty percent match rates for Washington State. However, federal law does not allow any federal financing for FBHPO administrative activities, including analysis, design, development and ongoing operation[1]. To maximize its value, the analysis directed by the 2013 Legislature in 3ESSB 5034 therefore built heavily on earlier work conducted in Washington State to engage the Centers for Medicaid and CHIP Services (CMS) in rule-making for the FBHPO and to understand the potential implications of churn to individuals whose changing family circumstances would move them – or select family members – between Medicaid and Exchange-based coverage. Details of this earlier work are referenced in Table 1 along with the federal documents that comprise staggered rule-making for the FBHPO and Washington's responses to proposed rules. Products shaded have been included in appendices to this report to consolidate the history of Washington State's consideration of the FBHPO in one document. Federal FBHPO documents can be downloaded from http://www.medicaid.gov/Basic-Health-Program/Basic-Health-Program.html.

Table 1: Chronology of Washington Analysis of the Federal Basic Health Program Option

Date	Analytic Products
Historical FBHPO Analysis	
March 2012	E2SHB 2319 directed the HCA to make recommendations on whether to proceed with implementation of a FBHPO in Washington state http://app.leg.wa.gov/billinfo/summary.aspx?bill=2319&year=2011
June 2012	Washington State "proof-of-concept" submitted to the Centers for Medicaid and CHIP Services (CMS) to inform and encourage early adoption of FBHPO rules **(see Appendix 3, attachment 1)**
October 2012	Analysis of impact and options for coverage and care continuity as individuals move across Insurance Affordability Programs (i.e., churn) **See:** http://www.hca.wa.gov/hcr/me/Pages/policies.aspx#churn

[1] FBHPO financing is to be used for premium and cost-sharing subsidies.

Date	Analytic Products
December 2012	Report to the Legislature in response to E2SHB 2319 **(see Appendix 3)** which explains the decision not to proceed with development of a FBHPO in Washington absent federal guidance and financing. This report includes federal and state statutory references; it reviews the history of engagement between Washington State executive and legislative leadership and CMS; it highlights elements for which federal technical assistance would be essential to finalize design and assess the merits of proceeding with implementation; and it includes concurrent efforts by local advocates to conduct an independent analysis of the viability of a FBHPO in Washington State. The latter analysis adapts the model previously used by the Urban Institute to estimate potential enrollment in Washington State based on implementation of the ACA Medicaid expansion.
3ESSB 5034 Analysis Concurrent with CMS Rule-Making	
June 2013	3ESSB 5034 directed the HCA to conduct a study to address considerations for a targeted premium assistance program and possible implementation of a FBHPO (**see Appendix 1.)**
September 2013	Federal notice of proposed rulemaking for FBHPO http://www.medicaid.gov/Basic-Health-Program/Basic-Health-Program.html
November 2013	Washington responses to notice of proposed FBHPO rulemaking (**see Appendix 2)**
December 2013	Federal notice of proposed 2015 FHBPO payment methodology http://www.medicaid.gov/Basic-Health-Program/Basic-Health-Program.html
January 2014	Washington responses to notice of 2015 FHBPO payment methodology rules (**see Appendix 2)**
March 2014	Final federal rules for 2015 start-up https://www.federalregister.gov/articles/2014/03/12/2014-05299/basic-health-program-state-administration-of-basic-health-programs-eligibility-and-enrollment-in Final 2015 payment notice describing the methodology CMS would use to calculate federal payments for 2015 (https://www.federalregister.gov/articles/2014/03/12/2014-05257/basic-health-program-federal-funding-methodology-for-program-year-2015) A summary fact sheet is available at: http://www.medicaid.gov/Basic-Health-Program/Downloads/BHP-Final-Rule-Fact-Sheet.pdf.
March-May 2014	Legislative debate on HB2594 – request for HCA to develop a Blueprint[2] for establishment of a FBHPO in Washington state (subsequently modified but did not pass out of the Senate) http://app.leg.wa.gov/billinfo/summary.aspx?bill=2594&year=2013

[2] The Blueprint is the form that states must use to make an official request for certification of a FBHPO as set forth in 42 CFR 600.110. The Blueprint is intended to collect the program design choices of the state and to provide a full description of the operations and management of the program and its compliance with the federal rules.

Date	Analytic Products
June 2014	Considerations published by CMS to define the certified methodology required for risk adjustment calculations to adjust payments based on differences in anticipated vs. actual health status of the FBHPO population http://www.medicaid.gov/Basic-Health-Program/Basic-Health-Program.html
October 2014	Federal notice of proposed 2016 FBHPO payment methodology rules and detailed data submission needed to determine federal payment amounts
November 2014	Federal template for FBHPO Blueprint which must be submitted to and approved by CMS before a state may operate a FBHPO. http://www.medicaid.gov/Basic-Health-Program/Basic-Health-Program.html
December 2014	3ESSB 5034 report summarizing consultant analysis and previous work

Context for 2013 3ESSB 5034 Consultant Analyses

As directed by 3ESSB 5034, HCA engaged a consultant team, Manatt Health Solutions (Manatt), to conduct further analyses beginning in the summer of 2013. The remainder of this report to the Legislature summarizes that analysis.

Work was conducted during a challenging period when coverage-related activities and resources in Washington State were focused on successful implementation of the 2014 Medicaid expansion and start-up of the new Exchange[3]. Manatt's engagement with CMS as consultant to the federal FBHPO technical assistance collaborative[4] brought a depth to the 3ESSB 5034 study that would not have been possible otherwise. As a result, HCA and Exchange staff were able to target engagement as necessary, without impeding progress on the Medicaid expansion or Exchange implementation.

Furthermore, Washington was able to leverage the Manatt consultant team's dual role to incorporate local expertise in discussions with CMS prior to the publication of federal rules for potential development of a FBHPO. Experience from the historically successful state Basic Health Program[5] prompted critical questions that had been raised in Washington's 2012 FBHPO "proof-of-concept" submission to CMS (see Appendix 3, attachment 1). Key concerns were generally consistent with other states' concerns over potential state fiscal risk in the short and long term, and drew on areas of uncertainty referenced in the independent Urban Institute analysis (see Appendix 3, attachment 2), in a California HealthCare Foundation analysis of a FBHPO in California (see www.chcf.org) as well as Washington's proof of concept' report. In addition to their pioneering work on the FBHPO, the Manatt team was engaged in other states' consideration of churn solutions, including the opportunity for states to use premium assistance to purchase coverage in the Exchange using Medicaid/CHIP funding. See Washington's earlier work on churn at http://www.hca.wa.gov/hcr/me/Pages/policies.aspx#churn.

[3] 3ESSB 5034 elaborated on policy direction for these efforts in addition to its request for further FBHPO study.

[4] Through a series of technical assistance collaboratives, CMS provided a forum for discussion with the 8 states initially interested in the FBHPO for the purpose of shaping federal guidance and supporting program implementation. www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Basic-Health-Program.html

[5] Although ultimately quite different in the operational fine points and the population covered, the Washington State Basic Health Program was the genesis of the ACA FBHPO.

The CMS Notice of Proposed Rulemaking (NPRM) for the FBHPO issued on September 25, 2013, "set forth a framework for Basic Health program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states and federal oversight." As a result of the extensive collaborative process, formal comments submitted by the HCA were somewhat limited. In general, they pertained to financial and administrative elements that would need acceptance by Washington State executive and legislative leadership before a FBHPO could be authorized for implementation. Specific implications for consumers were primarily addressed by local consumer representatives. The HCA informally previewed their comments along with additional thoughts from Exchange staff and highlighted common concerns. In addition, key questions were discussed with CMS staff during the collaborative process. Subsequent submissions to CMS on November 25, 2013 by HCA and Washington consumer representatives are included in Appendix 2.

Further guidance from CMS, issued on December 23, 2013, proposed the payment methodology for states intending to implement a FBHPO in 2015. HCA comments were limited based on the recognition that a 2015 implementation schedule could not be met without Legislative expenditure authority to proceed with implementation activities. Without extensive financing needed to conduct comprehensive econometric modeling and policy design, assurances that no state financing would be required to operate a FBHPO (in addition to financing to complete design and program implementation) were not possible. Responses to CMS on the proposed 2015 payment methodology, by the HCA and Washington consumer representatives, are included in Appendix 2. Rules for the proposed 2016 payment methodology were released in December 2014 and will be final in March 2015[6].

Overview of 2013 3ESSB 5034 Consultant Analyses

The scope of analysis by Manatt included:

- federal legal requirements, policy questions and decision points raised by proposed federal rules
- systems development and operational considerations
- financial implications for which substantial further econometric modeling would be required to answer the fundamental questions of viability and cost neutrality for Washington State.

Findings are included in Appendix 1, as a slide deck that summarizes critical points rather than as a written document. Although not ideal, we chose this path to accommodate progress on analysis of potential FBHPO application in Washington concurrent with delayed and staggered FBHPO rule-making and federal response to other states' premium assistance proposals. In December 2013 we conducted several webinars to broadly stakeholder the analysis-to-date prior to the 2014 Legislative session and CMS publication of final rules.

This approach avoided multiple rewrites and supported a strong baseline of current legal underpinnings as context should further work be directed on the FBHPO in the future. In addition, when CMS published final rules in March 2014, the slide deck was more easily modified to reflect potential

[6] This cycle of proposed/final payment methodology will continue annually for the FBHPO, with increasing precision as experience with Exchange enrollment and state coverage details stabilizes.

implications for Washington State. To simplify navigation of the Appendix 1 slide deck, Table 2 provides a topical cross walk.

Table 2: Topical Crosswalk of Analytic Slide Deck (Appendix 1)

Slide #	Topic
1-5	Legislative request and its complex overlay with the Washington State continuum of coverage options for children and adults
6	Data necessary to establish a market-based actual baseline from which econometric modeling of potential impacts could be estimated.
7-10	Review of national and local churn estimates that underpin Washington's policy goals for addressing the implications of churn, potentially through the options included in 3ESSB 5034.
11-13 14-29 30-31 32 33	**Federal Basic Health Plan Option** • Overview • Program requirements • Econometric modeling framework to assess(a) marketplace and delivery system impacts and (b) cost neutrality sustainability estimates of federal revenue and state costs • Underlying fiscal implications for consumers, providers, state, federal • Key implementation timing from point of legislative authority to proceed
34-36 37-51 52	**Premium Assistance** • Overview • Program criteria and other states' experience • Underlying fiscal implications for consumers, state, federal
53-56	**Alternatives to FBHPO and Premium Assistance** • Bridge Plan – QHPs offered by Medicaid Managed Care plans for consumers transitioning from Medicaid to Exchange • Underlying fiscal implications for consumers, state, federal • Medicaid expansion beyond 138% of the federal poverty level • Underlying fiscal implications for consumers, state, federal

Premium Assistance Considerations for Future Planning

Policy analysis related to premium assistance primarily summarized opportunities being considered in Arkansas, Iowa, and Pennsylvania, to use premium assistance to purchase coverage in the Exchange using Medicaid/CHIP funding. Recognizing that public policy debate and public-private coverage dynamics in each state are very different, our consultant team brought expertise to the Washington study from their engagement in these other state efforts. The slide deck identifies clear barriers to using this approach to resolve problems created when individual family circumstances change – discontinuity of coverage, discontinuity of care providers, affordability cliff and insurance-related operational

differences between Medicaid and Exchange coverage, and mixed coverage for different family members. The issues are generally referenced as decision points on slides #36-52. While coverage may be offered through the Exchange, Medicaid beneficiaries are entitled to a full Medicaid benefit.

Critical areas of work include further econometric modeling to demonstrate cost-effectiveness of a premium assistance approach, design of administrative processes to ensure a streamlined experience for consumers and health plans, and exploration of any necessary federal flexibility to mandate enrollment in the premium assistance program.

In addition, the recent decision of the Health Benefit Exchange board to disband premium aggregation services by 2016 raises a unique operational challenge. A similar premium aggregating function would be necessary for the collection and aggregation of premium dollars from different sources under any Medicaid premium assistance model. Such a service would either need to be reinstated or separately built to accommodate this new function.

FBHPO Considerations for Future Planning

Policy analysis of considerations for the FBHPO were based on CMS' *proposed* FBHPO rules, with revisions following release of final rules in March 2014 and the supplemental companion 2015 payment methodology. Without final CMS rules early in the process, and with limited data on Exchange enrollee experience and premium trend for the potential FBHPO income range, consultant analysis focused on identifying baseline data metrics, policy design considerations and econometric modeling needed to support any future consideration of a FBHPO in Washington state. Tables 3-5 summarize consultant and other input.

- Table 3 summarizes key policy design considerations;
- Table 4 covers minimum baseline data needed to assess the potential impact of the FBHPO; and
- Table 5 includes details of extensive econometric modeling that will be necessary to answer the fiscal questions posed by 3ESSB 5034. It references a recent late-November 2014 report from the Kaiser Family Foundation which offers one approach to "helping states develop estimates of average federal payments" for potentially eligible FBHPO consumers, "without determining, among eligible consumers, those who will likely enroll."[7] The detailed analysis of likely enrollees and federal payments will be critical to any future decision making on the financial advantages and disadvantages of a Washington FBHPO. As a starting point the Kaiser report uses Washington State as an "illustrative example" of the estimation methodology based on CMS rules for 2015.

Following program policy and implementation design, states must submit a comprehensive Blueprint as an official request for certification of the program prior to approval for implementation[8]. Based on CMS

[7] http://kff.org/health-reform/report/estimating-federal-payments-and-eligibility-for-basic-health-programs-an-illustrative-example/

[8] Minnesota submitted a complete Blueprint in November 2014, available at: (http://www.medicaid.gov/basic-health-program/downloads/minnesota-bhp-blueprint-december.pdf). It was approved December 15, 2014 for a phased 2015 implementation. Minnesota used the infrastructure of its previous state-funded MinnesotaCare program as the basis for establishing its FBHPO.

rules, it is essentially the FBHPO "State Plan" and must include details, revised in the future as changes occur, to maintain the official, CMS-approved record of:

- Public input and Tribal consultation
- Trust Fund location, account information, trustees and administrative details
- Eligibility and enrollment standards and procedures, implementation transition planning and subsequent churn transition planning (to and from Medicaid and the Exchange based on changes in circumstances)
- Health plan contracting, carriers, delivery systems, product actuarial value, procurement processes and risk adjustment methods
- Premiums and cost sharing structures, systems, administration, compliance procedures and consequences of non-payment
- Operational assessment and contingency planning
- Standard health plan benefits and limitations
- Encounter data collection format and standards
- Applicant information verification plan.

Prior to final CMS rule-making for potential 2015 FBHPO start-up approval, costs and timing to complete policy analysis and design, implementation design, and the set-up of an infrastructure to support ongoing operations were considered during 2014 Legislative session debate on HB 2594. The fiscal note (**see** Appendix 4) assumes the need for staged legislative engagement to affirm policy guidance and expenditure authority to build a FBHPO for Washington State. Critical areas of work include policy design and development, systems impact design and development, the transition of individuals from coverage through the Exchange to a FBHPO, and non-benefit operating costs such as administrative and staffing expenditures, ongoing communications costs, and annual actuarial contracts. While HB 2594 did not pass, it does provide a comprehensive assessment of costs to Washington given that design, development, implementation and non-benefit operating costs for a FBHPO cannot be funded with federal monies.

Table 3: Policy Design Considerations for a Potential FBHPO

Section	Slide Reference	Sample Key Policy Design Considerations
Financing	12-21	• Implications of federal income adjustment factors – would 95% of reference premium tax credits and cost-sharing reductions cover premiums and cost-sharing lower than Exchange alternative? (*econometric modeling critical*) • Disbursement priorities and strategy for excess Trust funds • Source and strategy for obtaining funding in event of future Trust shortfall or distribution of Trust surplus • Operational financing sources – systems design, systems development, start-up and ongoing administration (*for preliminary estimates considered during 2014 Legislative session see Appendix 4 – HB 2594 fiscal note*) • Application of federal payment adjustment factors – retrospective adjustment for health status differences between FBHPO and Exchange enrollees; desirability of risk assessment/adjustment of premiums • Implications for cost of second lowest cost silver plan on which federal payment is based • Access to data for developing robust financing methodology
Eligibility	22	• Implications of eligibility for limited Medicaid benefits that do not meet minimum essential coverage
Covered Benefits	23	• Alignment of benefits with Medicaid (e.g., alternative benefit plan) or Exchange qualified health plans – potential for substituted benefits with consideration of federal prohibitions • Desirability/financial capacity for additional benefits beyond required "essential health benefits" • Options for dental and vision coverage
Premium Costs	24	• FBHPO premiums – opportunities to be higher/lower than the Exchange • Trust funding availability to further subsidize FBHPOP premiums – equitable application • Desirability and options for lenience in premium collection • Sponsorship opportunities
Cost-Sharing	25	• Options for FBHPO cost-sharing to be lower than the Exchange (*econometric modeling critical)* • Options to maintain actuarial value at least at minimum required levels • Trust funding availability to further subsidize FBHPO cost-sharing – equitable application • Impact of no cost-sharing for American Indians/Alaska Natives

Section	Slide Reference	Sample Key Policy Design Considerations
		• Implications of second lowest cost silver plan variations based on household size and region
Enrollment Period	26	• Alignment with Exchange open enrollment period or Medicaid continuous enrollment • Applicable disenrollment policy for non-payment of premium • Provider implications for cost-sharing collection • Adverse selection potential
Plan Enrollment, Procurement, and Contracting	27	• Timing of federal payment rules and procurement planning/premium evaluation • Open competitive procurement – process alignment with Exchange or Medicaid or separate • Criteria for selecting at least 2 carriers (aka "standard health plans") • Potential risk pooling/actuarial rate setting options • Provider network alignment – incentives and/or requirements across Medicaid, FBHPO and Exchange • Flexibility needed in rural areas • Performance expectations – network adequacy (availability and access), community linkages, and applicability of other Medicaid-based consumer protections • Potential for churn – expectations of Medicaid/Exchange participation and network overlap; ramifications introduced by individuals whose income changes result in movement into and out of FBHPO eligibility. For many of these individuals, "their final actual income for the calendar (taxable) year will differ from their projected income used to determine their eligibility, leaving considerable uncertainty about the amount of federal funding the state would receive for each person who enrolls in FBHPO"[9]. • Implication/opportunity for alternative payment methodologies that promote greater accountability for total cost of care at the provider level
Operational Considerations	28-29	• Governance structure – public agency, Health Benefit Exchange, other, and administrative alignment with Washington insurance/Medicaid regulations • FBHPO Fund – trustees for oversight, account balancing and forecast, relationship to State budget

[9] Curtis, R. and Neuschler, E. Institute for Health Policy Solutions, "Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program in California." 2 September, 2011.

Section	Slide Reference	Sample Key Policy Design Considerations
		• Use of HealthplanFinder and other Medicaid and/or Exchange systems – technical system assessment • Implementation design and development priorities, financing, resources, start-up, option to phase-in – degree of increased systems and administrative complexity for hybrid Medicaid-Exchange design • Administrative cost allocation • Application, update, and renewal implications as family circumstances change – alignment with Medicaid and/or the Exchange for notices, outreach, appeals, and due process requirements • Enrollee transition process for transfer from Exchange to FBHPO coverage at start-up (default plan assignment option) • Churn and whole-family coverage transition options – potential for "sticker shock" moving into Exchange or FBHPO; product choice limitations in FBHPO vs. the Exchange • Optional alignment/adoption of Medicaid-like retroactive eligibility • Blueprint options – preliminary/interim certification of design, full submission for certification of operational readiness • Public engagement plan – public comments opportunity, Tribal consultation following Exchange requirements, Medicaid alignment • Alignment with implementation of "Healthier Washington" strategies and expectation to participate in delivery system reforms

Table 4: Minimum Baseline Data for Estimating Impact of FBHPO

Data Needs	Current Washington State Analysis (Based on the October 2014 Exchange Coverage Enrollment Report unless otherwise noted)
Total Exchange enrollment – by month, quarter, year	Total enrollment in the Exchange was 139,700
Washington uninsured population and Exchange enrollment (by age, geographic area, coverage category, household size, income range, metallic tier, current available subsidies) • 0-100% of the FPL • 100-138% of the FPL • 138-150% of the FPL • 150-200% of the FPL	Official estimates for Washington's uninsured population (under age 65) are not yet available following implementation of the 2014 Medicaid expansion and Exchange start-up. 2014 analysis of coverage conducted by the Office of Financial Management indicate that uninsured rates for the total Washington population dropped from about 14% uninsured pre-2014 to 8% uninsured post-2014[10]. Approximately 41% of Exchange enrollees (through October 2014) have income under 200% of the FPL. This is consistent with figures reported in April 2014. • 0-100% of the FPL (~2%) • 100-138% of the FPL (~2%) • 138-150% of the FPL (~8%) • 151-200% of the FPL (~29%)
Churn: • Across 200% of the FPL (simulating churn between FBHPO and the Exchange) and • Across 138% of the FPL (simulating churn between FBHPO and Medicaid coverage)	Preliminary analysis of monthly churn between Medicaid and the Exchange between May and October 2014 indicate: • Less than 1% of all Exchange enrollees moved to Medicaid each month • Less than 0.1% of Medicaid enrollees moved to the Exchange each month

[10] Data sources included studies by Gallup, the Commonwealth Fund, and the Kaiser Family Foundation which weighted local estimates from the Washington county population estimation model.

Carriers certified for Medicaid managed care and Exchange Qualified Health Plans • By geographic region • Network distribution and overlap • Actuarial value of benefits covered	Greater choice in carriers and QHPs for 2015 • 10 carriers (8 in 2014) including 4 of the current 6 Medicaid managed care organizations • 82 QHPs (52 in 2014) – 23 are renewals and 59 are new products (http://wahbexchange.org/files/6814/0925/1849/WAHBE_Certification_Report_2015_Final.pdf)
Exchange Premiums – trend or projected trend • 2nd lowest cost silver; lowest cost bronze	A December 2014 report by the Commonwealth Fund indicates no average nationwide increase between 2014 and 2015 in Exchange premiums. In Washington State, average premiums for *all* QHPs decreased by 1%; premiums for silver plans decreased by 2%. http://www.commonwealthfund.org/publications/blog/2014/dec/zero-inflation-nationwide-for-marketplace-premiums
Health status of Exchange risk pool – up to 200% of the FPL and over 200% of the FPL • 12 months of utilization experience (at a minimum) needed to understand variations in health status and potential implications for risk pooling	Based on analysis in May 2014, close to 80% of November 2013 enrollees in the previous Washington State Basic Health program who transitioned their coverage through the HealthPlanFinder, enrolled in Medicaid for coverage in 2014. About 8% did not appear to have responded, however changes in circumstances that may have modified their identifying details are unknown. Those who enrolled in the Exchange represent less than 2% of prior Basic Health enrollees. Previous Basic Health utilization is therefore limited in its application to determination of underlying Exchange health risk baseline or potential FBHPO health risk.

Table 5: Econometric Modeling Needed

Based on baseline data experience of Exchange enrollees and flexibility available to align elements of the hybrid FBHPO policy framework with Medicaid or Exchange, consulting expertise continues to be necessary to model the impact of alternative FBHPO design options. Using Washington State as an "illustrative example," researchers at the Kaiser Family Foundation showed how revised methods of estimating potential numbers of FBHPO enrollees might be used in state modeling of average federal payments for FBHPO consumers. http://kff.org/health-reform/report/estimating-federal-payments-and-eligibility-for-basic-health-programs-an-illustrative-example/

Topic	**Example Econometric Modeling Necessary**
Financing	• Projected enrollee cost in comparison with alternative insurance options • Projected federal revenue stream (the Kaiser report suggests steps for modeling estimates based on 2015 CMS rules once policy design elements are clarified) • State costs – for operational start-up, ongoing administration, Trust shortfall/surplus • Disbursement scenarios under potential Trust surplus
Population Projections	• Kaiser Family Foundation estimated characteristics of 131,526 individuals ***potentially eligible*** *for* FBHPO enrollment By Age: 19-20 (5% - 6,677) 21-34 (41% - 53,526) 35-44 (17% - 22,020) 55-64 (20% - 26,174) By Income: <138% FPL (12% - 16,301) 139-150% FPL (16% - 20,672) 151-175% FPL (36% - 47,409) 176-200% FPL (36% - 47,144) • Characteristics and size of FBHPO population ***likely to enroll*** are critical for assessing FBHPO implications for Washington State • Impact on Washington's uninsured, employed, low-income populations
Health Status and Risk Adjustment	• Relative health status (and likely service utilization) of current and potential future FBHPO target population • Estimated impact on Exchange risk pool and associated premiums

Appendix 1: Legislative Study of Federal Basic Health Plan Option (FBHPO) and Targeted Premium Assistance

3ESSB 5034 – Budget Proviso Studies for Federal Basic Health Option and Premium Assistance

(a) $75,000 of the general fund--state appropriation for fiscal year 2014 and $75,000 of the general fund--federal appropriation are provided solely for preparing options with an expert consultant for possible implementation of a targeted premium assistance program and possible implementation of the federal basic health option. $75,000 of the amounts appropriated in this subsection is provided solely for the development of options related to the targeted premium assistance program. The authority shall develop options for a waiver request to the federal centers for Medicare and Medicaid services to implement a targeted premium assistance program for the expansion adults, identified in section 1902(a)(10)(A)(i)(VIII) of the social security act, with incomes above one hundred percent of the federal poverty level, and for children covered in the children's health insurance program with incomes above two hundred percent of the federal poverty level, with a goal of providing seamless coverage through the health benefit exchange and improving opportunities for families to be covered in the same health plans. The options must include the possibility of applying premiums for individuals and cost-sharing that may exceed the five percent of family income cap under federal law, and the options must include recommendations to make the targeted premium assistance program cost neutral. The authority shall submit a report on the options to the legislature and the governor by January 1, 2014. The authority is encouraged to be creative, use subject matter experts, and exhaust all possible options to achieve cost neutrality. The report shall also include a detailed plan and timeline. $75,000 of the amounts appropriated in this subsection is provided solely for the development of options related to the federal basic health option. The authority shall prepare options for implementing the federal basic health option as federal guidance becomes available. The authority shall submit a report on the options to the legislature and the governor by January 1, 2014, or ninety days following the release of federal guidance. The report must include a comparison of the premiums and cost-sharing under the federal basic health option with the premium assistance options described in this subsection, options for implementing the federal basic health option in combination with a premium assistance program, a detailed fiscal analysis for each coverage approach, including the estimated costs for system design and implementation, and information about impacted populations.

(b) Where possible, the authority shall leverage the same expert consultants to review each proposal and compare and contrast the approaches to ensure seamless coordination with the health benefit exchange.

(c) The authority shall collaborate with the joint select committee on health care oversight in the development of these options.

Consultant Analysis of Considerations for Washington State

The following section includes the complete slide deck presentation of consultant analysis for 3ESSB 5034.

Premium Assistance and the Federal Basic Health Program Option: Considerations for Washington State

REVISED March 2014

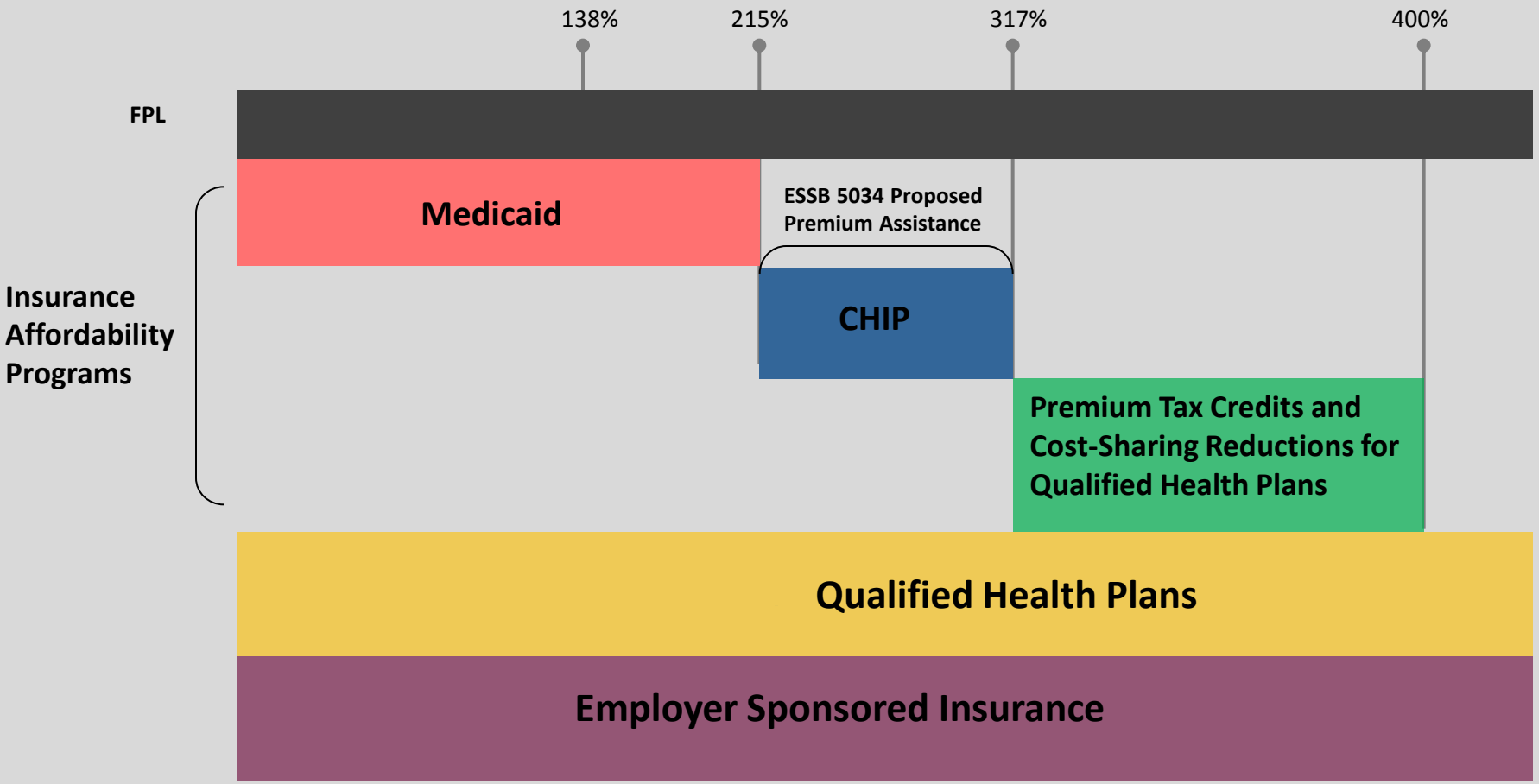
Project Overview

- Legislative Mandate & Washington Landscape
- Federal Basic Health Program Option
- Premium Assistance
- Alternatives to Premium Assistance and the Federal Basic Health Program Option
- Discussion

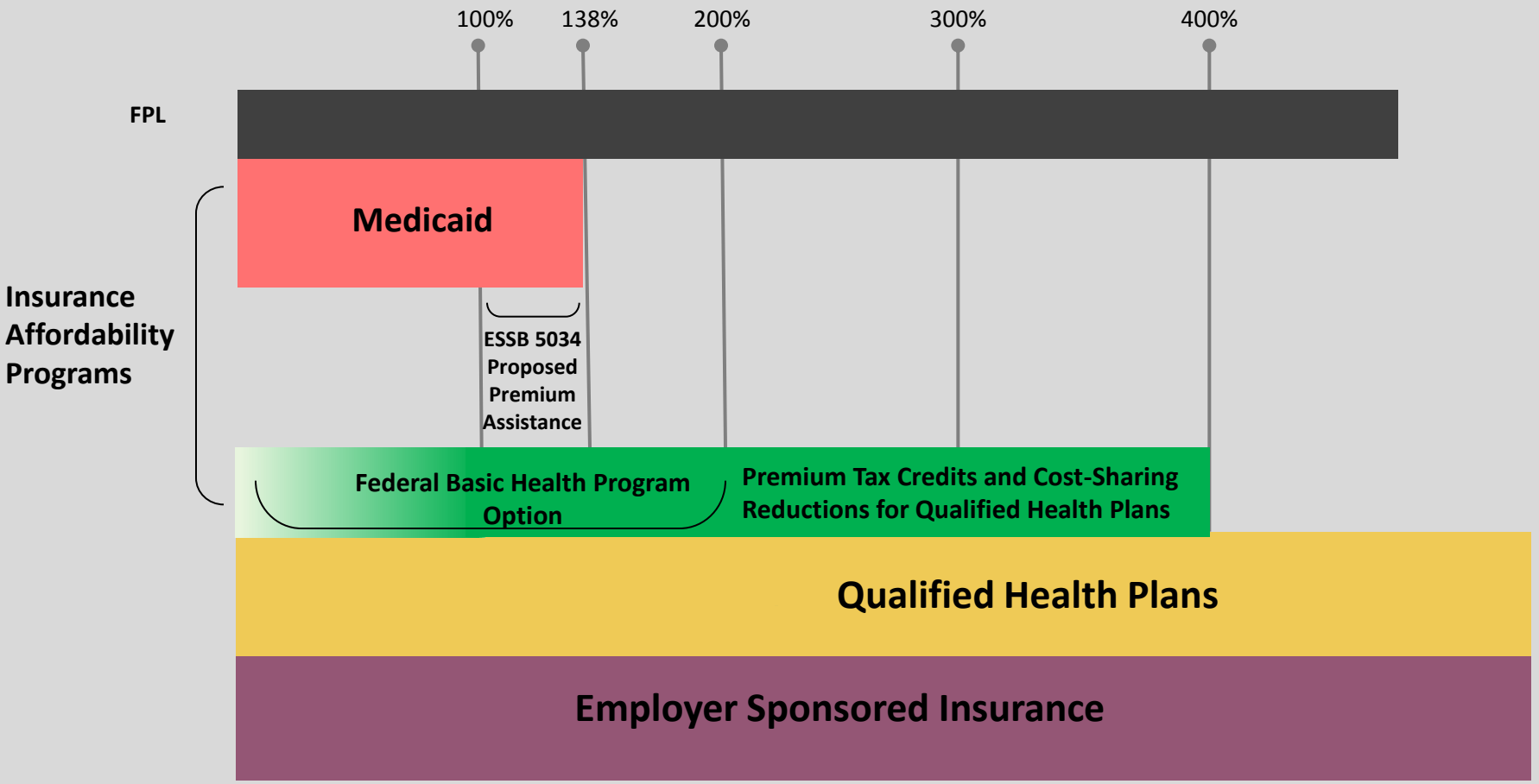
Legislative Mandate (ESSB 5034)

- **Options and Comparative Analysis**
  - Federal Basic Health Program Option
    - Adults with incomes between 138-200% of the FPL (or below 200% of the FPL if the applicant is ineligible for Medicaid because he/she has not been in the country for five years)
  - Medicaid premium assistance program in the individual market
    - Newly eligible Medicaid adults with incomes between 100-138% of the FPL
    - CHIP children with family incomes between 200-300% of the FPL (MAGI Conversion= 215-317% FPL)
  - Alternative mechanisms for achieving continuity of coverage
- **Scope of Analysis Based on Washington Coverage Landscape**
  - Federal legal requirements
  - Policy questions and decision points for Washington
  - Operational and systems considerations
  - Fiscal considerations

“Proposed” WA State Continuum of Coverage: Children



“Proposed” WA State Continuum of Coverage: Adults



Sizing the Baseline

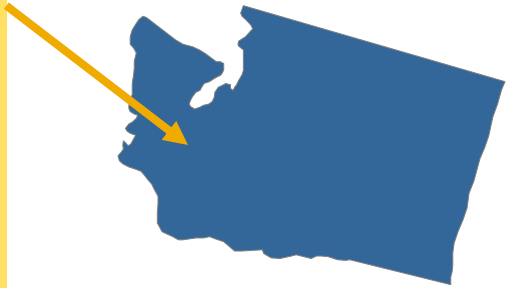
Data Points

Apple Health

- Projected Medicaid eligible individuals
- Projected Medicaid caseload
- Projected Medicaid enrollees with incomes 100-138% FPL
- Total children with family incomes 200-300% FPL

Marketplace (Health Benefit Exchange)

- Projected Marketplace enrollment: annual and quarterly
- Total Marketplace enrollment
- Projected Marketplace enrollees with income between 138-200% FPL (by age range, geographic area, coverage category, and household size, income range)
- Projected extent of churning between Apple Health and Marketplace coverage
- Plans certified as both Medicaid Managed Care (MMC) and Qualified Health Plans (QHPs) (current and projected)



National Churn Estimates

- Churn occurs when individuals experience a change in eligibility and, as a result, must **transition from one coverage vehicle to another**.

- The Urban Institute estimates that, nationally, **29.4 million individuals** under the age of 65 will change coverage vehicles from one year to the next:

  - **6.9 million** will move from Medicaid to subsidized Marketplace coverage or vice versa (e.g., an individual with income below 138% of the FPL gains employment and becomes eligible for tax credits);
  - **19.5 million** will move from Medicaid to ineligibility for all subsidized Marketplace coverage or vice versa (e.g., an individual with income below 138% of the FPL gains employment that offers affordable employer sponsored insurance and is ineligible for tax credits);
  - **3 million** people will move from subsidized Marketplace coverage to ineligibility for all programs or vice versa (e.g., an individual receiving tax credits with income between 138-400% FPL gains employment that puts his/her income above 400% of the FPL)

Source: Urban Institute, "Churning Under the ACA and State Policy Options for Mitigation," (June 2012); See also, Sommers, B, Graves, John, et al, "Medicaid and Marketplace Eligibility Will Occur Often in All States; Policy Options Can Ease Impact, " Health Affairs (April 2014)

Washington Churn Estimates

Income at Initial Determination v. Actual Annual Income for Enrollment Year

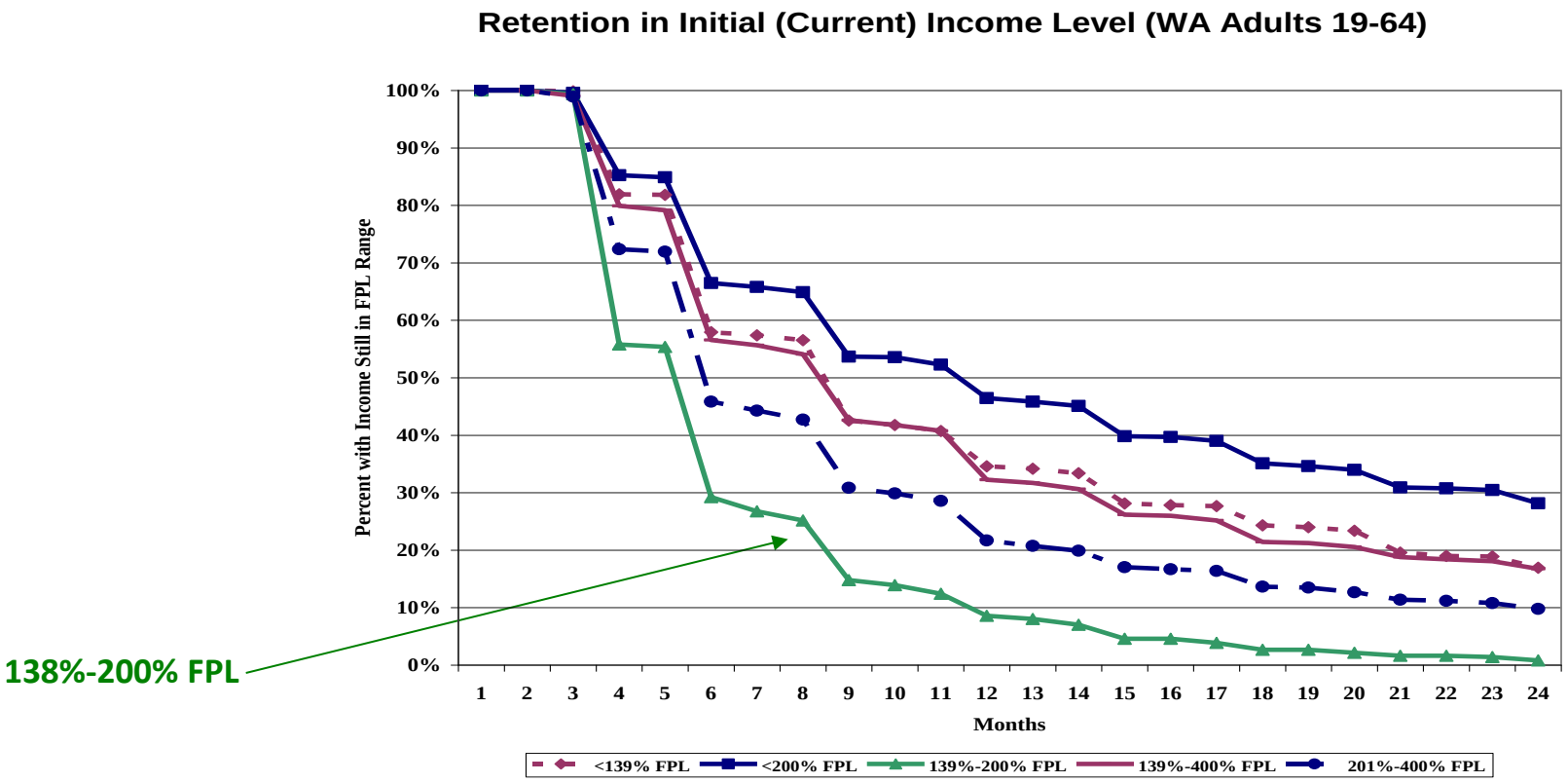
Row Percent	Final Federal Poverty Level (FPL) Range			
Initial FPL Range	**<139% FPL**	**139%-400% FPL**	**>400% FPL**	**TOTAL**
<139% FPL	68.9%	23.7%	7.4%	100.0%
139%-400% FPL	21.7%	65.5%	12.8%	100.0%
>400% FPL	13.5%	46.1%	40.3%	100.0%
TOTAL	47.0%	39.9%	13.1%	100.0%

Initial FPL Range	**<139% FPL**	**139%-200% FPL**	**201%-400% FPL**	**>400% FPL**	**TOTAL**
<200% FPL	63.0%	13.3%	16.3%	7.3%	100.0%
139%-200% FPL	33.0%	24.2%	35.8%	unreliable	100.0%
201%-400% FPL	15.8%	14.2%	54.2%	15.7%	100.0%
>400% FPL	13.5%	8.1%	38.0%	40.3%	100.0%

Source: Based on Washington State adults age 19-64 without employer-sponsored insurance (ESI) at initial determination; SIPP analysis by John A. Graves. http://www.hca.wa.gov/hcr/me/Pages/policies.aspx#churn

Washington Adults Likely to Experience Churn

Over several years, very few stay in the 138-200% FPL income range



Source: Washington Health Care Authority, "Washington State Medicaid Churn Mitigation Strategies," Presentation to the Oregon Medicaid Advisory Committee, February 26, 2014.

Washington's Policy Goals

- Maintain access to the same benefits and providers as family circumstances change
- Reduce affordability cliff as a result of a transition from Medicaid to a QHP
- Enroll families in the same plan
- Minimize gaps in coverage
- Make cost-effective use of federal, state and private dollars
- Identify and optimize administrative simplification opportunities
- Comply with or, seek waiver from, specific ACA coverage and eligibility requirements

Federal Basic Health Program Option (FBHPO)

Overview

- States may use federal funding to subsidize coverage for individuals with incomes 138-200% of the federal poverty level (FPL) who would otherwise be eligible to purchase coverage through the Marketplace. States can use the BHP to reduce premiums and cost sharing for eligible consumers. Depending on design, the BHP may also help consumers maintain continuity across plans and providers as their income fluctuates above and below Medicaid levels.
- **Competitive Contracting:** The state must use a competitive process to procure contracts for two or more standard health plans (with limited exceptions) offered by licensed HMOs, licensed health insurers, networks of providers, and/or non-licensed HMOs participating in Medicaid/CHIP.
- **Comparable, or Better, Costs and Benefits:** Enrollees must receive at least the same benefits and pay no more in premiums and cost sharing than they would in the Marketplace.
- **Financing Formula:** The federal government pays the state 95% of the value of the premium tax credits and cost sharing reductions it would have provided to eligible individuals enrolled in the applicable second lowest cost silver Marketplace plan.
- **Administration:** States must set up a Trust Fund to receive federal funding and identify trustees to authorize withdrawals.
- **Blueprint**: States are required to prepare an operational readiness Blueprint for CMS certification and approval to implement. States may also receive "Interim Certification" from CMS.

FBHPO Advantages and Disadvantages

Advantages

- Premiums and cost sharing are lower for enrollees than in QHPs
- May result in more individuals securing coverage and complying with the individual mandate
- Smoother transitions as incomes fluctuate at 138% FPL
- More affordable coverage vehicle for lawfully present immigrants who are not eligible for Medicaid because they have not been in the country for five years

Disadvantages

- Federal funding may not cover cost of plans; State has financial exposure
- Start-up and ongoing administrative costs not federally funded
- New transition point is created at 200% FPL
- Affordability cliff at 200% FPL (depending on subsidies of premium tax credits/cost sharing reductions)
- Exchange volume will decline; individuals with income below 200% FPL will be enrolled in the FBHPO and not a QHP
- In order to reduce consumer costs, providers could be paid at a lower rate than what they would be paid in a QHP
- Does not address whole family coverage issues

Scope of FBHPO Analysis

- **Program Requirements**
  - Financing
  - Eligibility
  - Benefits
  - Premium Costs
  - Cost Sharing
  - Enrollment Period
  - Disenrollment Procedures for Non-Payment of Premium
  - Plan Enrollment, Procurement and Contracting
  - Operational Considerations
  - Blueprint Submission and Stakeholder Input
  - Financial Feasibility
- **Implementation Timeline**

Financing

Legal Requirements and HHS Guidance

- A state receives 95% of the premium tax credit and cost sharing reductions that the federal government would have provided enrollees had they been enrolled in QHPs
- The FBHPO financing structure is based on the average amount of premium tax credits and cost sharing reductions per member/per month that would have been provided to persons in "rate cells" (similar to Medicaid Managed Care rate cells)
- Rate cells will be broken down by age range, geographic area, coverage category, household size and income range
- For each rate cell, the payment rate will be calculated as the sum of the following:
  - 95% of the premium tax credit that would have been provided to individuals in rate cell
  - 95% of the cost sharing reductions that would have been provided to individuals in rate cell

Source: ACA Section 1331(d)(2) and (3), 42 CFR 600.600-615, 700-705; Basic Health Program Federal Funding Methodology for Program Year 2015

Financing: Calculation of Premium Tax Credit

Determining the Premium Tax Credit Value by Rate Cell

STEP ONE: DETERMINE THE REFERENCE PREMIUM FOR EACH RATE CELL

"**Reference Premium**": Second Lowest Cost Silver Plan operating in the state's Marketplace broken down by:

- **Age Range**: 0-20; 21-34; 35-44; 45-54; 55-64
- **Geographic Area**
- **Coverage Category**: Self-only vs. Family
- **Household Size**: 1, 2, 3, 4, 5
- **Income Range by FPL**: 0-50%; 51-100%; 101-138%; 139-150%; 151-175%; 176-200%

STEP TWO: ADJUST REFERENCE PREMIUM

- **Income Reconciliation**: FBHPO enrollees are not subject to the same income reconciliation as Marketplace enrollees; factor will account for any differences between projected annual income at the time of application and income reported on federal income taxes at year end.
- **Population Health Factor:** To account for any differences in health status between FBHPO and QHP enrollees. While HHS will not make adjustments for differences in health status for program year 2015, states have the option to propose a state-specific adjustment factor to retrospectively determine the population health status differences between BHP and Exchange enrollees using 2015 data and adjust 2015 federal payments accordingly.
- **Premium Trend Factor for States Using 2014 Exchange Premiums:** HHS will use actual 2015 premium rates to determine 2015 federal payments to states. At state option, states may choose to calculate 2015 federal payments based on 2014 Exchange rates projected forward to 2015 using the annual growth rate in private health insurance expenditures.

STEP THREE: MULTIPLY THE "ADJUSTED REFERENCE PREMIUM" AMOUNT BY 95%

Source: ACA Section 1331(d)(2) and (3); 42 CFR 600.600-615, 700-705; Basic Health Program Federal Funding Methodology for Program Year 2015.

Financing: Calculation of Cost Sharing Reduction

Determining the Cost Sharing Reduction by Rate Cell

STEP ONE: DETERMINE CSR SUBSIDY FOR EACH RATE CELL USING ADJUSTED REFERENCE PREMIUM

"**Reference Premium**": Second Lowest Cost Silver Plan operating in the state's Marketplace broken down by:

- **Age Range**: 0-20; 21-34; 35-44; 45-54; 55-64
- **Geographic Area**
- **Coverage Category**: Self-only vs. Family
- **Household Size**: 1, 2, 3, 4, 5
- **Income Range by FPL**: 0-50%; 51-100%; 101-138%; 139-150%; 151-175%; 176-200%

STEP TWO: FURTHER ADJUST REFERENCE PREMIUM

- **Apply all Premium Tax Credit Adjustments (see previous slide) plus**
- **Tobacco Rating:** In states that allow tobacco use as a rating factor.
- **Administrative Costs**: Average proportion of total premium covering allowed health benefits. Adjustment accounts for amount of premium covering taxes, fees and other administrative expenses.
- **Change in Actuarial Value (AV)**: Accounts for increase in CSRs that are statutorily required for QHP enrollees with household incomes below 200% FPL. (100-150% FPL AV increases from 70-94%; 150-200% FPL AV increases from 70-87%)
- **Induced Utilization**: Accounts for increases in health care utilization that are associated with higher amounts of CSRs.

STEP THREE: MULTIPLY CSR AMOUNT BY 95%

Source: ACA Section 1331(d)(2) and (3); 42 CFR 600.600-615, 700-705; Basic Health Program Federal Funding Methodology for Program Year 2015.

Financing: Final Calculation for Payment Rate to States

Final Calculations:

- To determine payment rate to the state for each rate cell, the premium tax credit calculation and the CSR calculation are added together and multiplied by the number of enrollees expected to be in each rate cell
- Total payment to states for all FBHPO enrollees equals the sum of payments for each rate cell

Example Payment Calculations for Rate Cells X, Y, and Z:

Rate Cell X = ((95% PTC + 95% CSR) x # Projected Enrollees)
\+ **Rate Cell Y** = ((95% PTC + 95% CSR) x # Projected Enrollees)
\+ **Rate Cell Z** = ((95% PTC + 95% CSR) x # Projected Enrollees)
= **Total Payment to State**

Source: ACA Section 1331(d)(2) and (3); 42 CFR 600.600-615, 700-705; Basic Health Program Federal Funding Methodology for Program Year 2015.

Financing (cont')

ACA Requirements and HHS Guidance

State Data Submission by November 1, 2014 for January 1, 2015 Payment Rates

- 2015 data on second lowest cost silver plan and lowest cost bronze plan (for American Indian/Alaska Natives) in the Marketplace and basic plan information (plan name, issuer and plan ID) by geographic area and monthly premiums
- Enrollment projections
- CMS will issue further guidance on state data submission requirements

Annual Payment Rates and Publication Timing

- HHS will establish state-specific annual payment rates for each rate cell
- For states that do not submit data by November 1, 2014, CMS will publish a separate payment notice with a state's federal payment amount
- States must submit data no later than 30 days after submitting their FBHPO Blueprint
- In subsequent years, HHS will issue a proposed payment methodology each October and a final payment methodology each February for the following program year

Source: ACA Section 1331(d)(2) and (3); 42 CFR 600.600-615, 700-705; Basic Health Program Federal Funding Methodology for Program Year 2015.

Financing (cont')

ACA Requirements and HHS Guidance

Quarterly Payments

- Payment amount to state will be the product of the final payment rates and the state's quarterly enrollment projections
- Payments to be deposited in a Trust Fund

Prospective Payment Adjustments

- Payments to states will be adjusted 60 days after the end of each fiscal year quarter using actual enrollment figures
- HHS will adjust the payment amount by either depositing the difference in the state's Trust Fund (if the state had more enrollees than projected) or by reducing the upcoming quarter's prospective payment by the difference (if the state had fewer enrollees than projected)

Trust Fund

- May only be spent on reducing enrollees' premiums and cost sharing, or providing additional benefits to enrollees
- No federal Trust Fund money may be used for start-up and administrative costs.
- Unspent Trust Fund money may be carried over to the next year.

Source: ACA Section 1331(d)(2) and (3); 42 CFR 600.600-615, 700-705.

Financing: Washington Decision Points

- Will 95% of the PTCs and CSRs for FBHPO enrollees in each rate cell be sufficient to enable the State to purchase coverage with premiums and cost sharing that is less than what these consumers would have paid in the Marketplace?
  - In the event there are "extra" Trust funds, what will be the State's priority disbursements?
  - How will the State cover any Trust shortfall?

- What non-federal funds will the State use to underwrite the costs for design, development, start up and ongoing administration?

- Will the State take up the option to retrospectively adjust for health status differences between BHP and Exchange enrollees?

- To what extent will FBHPO enrollment by individuals who would otherwise be Marketplace eligible impact Marketplace costs and the cost of the second lowest cost silver plan?

- If Washington were to move forward with implementing the FBHPO how will State obtain needed rate cell data for financing methodology?

Eligibility Requirements

Legal Requirements

- Enrollees must meet the following eligibility requirements:
  - State resident;
  - <65 years old;
  - U.S. citizen or lawfully present non-citizen;
  - Household income (Modified Adjusted Gross Income) between 138% and 200% FPL (or below 200% FPL and ineligible for Medicaid due to immigration status);
  - Not eligible for Medicaid or other minimum essential coverage ("MEC"); Medicaid eligibility for a limited benefit package, such as family planning, is not considered MEC; and
  - Not incarcerated (post disposition)

- State may not impose other conditions of eligibility, including restrictions related to geographic location, enrollment caps, or waiting periods.

Source: ACA Section 1331(e), 42 CFR 600.305

Covered Benefits

Legal Requirements

- Plans must cover at least the 10 Essential Health Benefits offered in the Marketplace.
- State must select a base benchmark plan (and may select more than one benchmark plan).
- State may permit substitution of benefits, except for prescription drug benefits, if actuarially equivalent and supplementation of benefits if not covered under an EHB category.
- Plans must cover state mandated benefits.
- Marketplace non-discrimination rules apply.
- Plans must comply with Marketplace prohibitions on federal funding for abortion services.

Washington Landscape

- **Washington EHB Marketplace (and Medicaid Alternative Benefit Plan) Benchmark Plan**: Regence Innova (plan from largest small group)
- **Pediatric Dental**: State CHIP Plan
- **Pediatric Vision**: Federal Employees Dental and Vision Insurance Plan (FEDVIP)

19 & 20 year olds

Washington Decision Points

- Will FBHPO benefits be aligned with QHPs or Medicaid?
- Will FBHPO include additional benefits beyond Essential Health Benefits?

Source: ACA Section 1331(b); 42 CFR 600.405.

Premium Costs

Legal Requirements

- Enrollees monthly premiums must be no more than the monthly premiums they would have paid if they had enrolled in the second lowest cost silver plan in the Marketplace.
- The Blueprint will include the group(s) subject to premiums; collection method and procedure for payment; and consequences of nonpayment.
- State may vary premiums based on household income so long as it does not favor enrollees with higher income over enrollees with lower income.

Washington Decision Points

- Based on available funding, the State may decide to reduce the individual's premium obligation below what they would have paid in the Marketplace.

Premium Credits by Income Under Health Reform

Income (2013)		Expected Family Contribution	
Percentage of poverty line	Annual dollar amount (2013 $)	Premium contribution as percentage of income	Monthly premium contribution
Individual			
0 – 100%*	$0-11,490	2%	$19 – $25
100 – 133%	$11,490 - $15,282	2%	$19 – $25
133 – 150%	$15,282 - $17,235	3 – 4%	$38 – $57
150 – 200%	$17,235 - $22,980	4 – 6.3%	$57 - $121
Family of four			
0 – 100%*	$0-23,550	2%	$39 - $52
100 – 133%	$23,550 - $31,322	2%	$39 - $52
133 – 150%	$31,322 - $35,325	3 – 4 %	$78 - $118
150 – 200%	$35,325 - $47,100	4 – 6.3%	$118 - $247

*For immigrants not eligible for Medicaid
Note: This is for 2013 FPL and do not reflect the 5% MAGI disregard.

Source: ACA Section 1331(a)(2)(A); 42 CFR 600.605, 600.520; HHS ASPE Issue Brief –Health Insurance Marketplace Premiums for 2014. September 25, 2013. SLCSP is a weighted average. The Premium Obligation chart does not reflect MAGI conversion

Cost Sharing

Legal Requirements

- Enrollee's cost sharing obligations may not be more than what the individual would have paid if they had enrolled in a second lowest cost silver plan (based on their age, geography, household size, coverage category and income).
- Cost sharing may vary based on household income only in a manner that does not favor enrollees with higher income over enrollees with lower income.
- Plans for individuals below 150% FPL must have actuarial value of at least 94%; i.e. plan must cover at least 94% of medical costs after premium is paid
- Plans for individuals 150-200% FPL must have actuarial value of at least 87%.
- No cost sharing permitted for preventive services.
- American Indian/Alaska Natives (AI/AN) exempt from cost-sharing.

Washington Decision Points

- Based on available funding, Washington may decide to further reduce individual's cost-sharing obligation.
- Washington may further reduce cost-sharing for a subset population based on income.
- How many American Indian/Alaska Natives will enroll in FBHPO coverage? Will no cost sharing for American Indians/Alaska Natives have implications on program costs?

Source: ACA Section 1331(a)(2)(A); 42 CFR 600.160, 600.510, 600.520.

Enrollment and Disenrollment Policies

Legal Requirements

- States have the option to align with Marketplace or Medicaid enrollment periods.
  - Marketplace: Limited to open enrollment and special enrollment periods
  - Medicaid: Continuous enrollment
- American Indian/Alaska Natives may enroll in, or change enrollment, one time per month.
- Disenrollment procedures depend on whether a state aligns procedures with Marketplace or Medicaid enrollment period rules.

Washington Decision Points

- What policy will the State adopt with respect to enrollment periods?
  - If Washington applies the Marketplace's open enrollment period, adverse selection could be reduced; however, there may be confusion for current Medicaid enrollees who are accustomed to continuous enrollment.
  - If Washington applies Medicaid's continuous enrollment period, there may be less confusion for current Medicaid enrollees; however, there may be an increased risk of adverse selection.
- Enrollment period rules will determine applicable disenrollment procedures.

Source: 42 CFR 600.160, 320(d), 525.

Plan Procurement & Contracting

Legal Requirements

- State must conduct the contracting process in a manner that provides full and open competition consistent with Medicaid or QHP standards. Exception permissible for 2015.
- State may contract with existing Medicaid plans and Marketplace plans for FBHPO, but State must offer 2 or more standard health plans. If State can not meet this requirement, State may apply to receive an exception.
- State must negotiate premiums, cost sharing, and benefits and inclusion of innovative features.
- At a minimum, the FBHPO contract negotiation criteria must include:
  - Premiums and cost sharing;
  - Benefits;
  - Care coordination, incentives for preventive services and other innovative features;
  - Network adequacy;
  - Quality improvement and performance measures;
  - Coordination between IAPs; and
  - Privacy and security of information.

Washington Landscape

- Washington has 5 participating Medicaid managed care plans, 3 of which are also QHPs in the Marketplace.

Washington Decision Points

- What provider network alignment incentives or requirements would help to maintain continuity of coverage and care for consumers transitioning between Medicaid and FBHPO; and between a QHP and FBHPO?
- What criteria will Washington use to select FBHPO plans? Which issuers will Washington contract with?
  - Medicaid/CHIP managed care plans
  - QHPs
  - Both
  - Other
- Would FBHPO be jointly procured with Medicaid? Would such a procurement process influence network adequacy and premiums?

Source: ACA Section 1331(c); 42 CFR 600.410

Operational Considerations

Legal Requirements

Administrative Infrastructure:

- States required to establish FBHPO trust fund and identify trustees responsible for oversight of the fund.
- FBHPO must use Medicaid or Exchange appeal process.

Systems Infrastructure:

- States will need to modify eligibility and enrollment systems to accommodate FBHPO eligibility determination and enrollment.

Enrollment Transition:

- Once FBHPO is established, states must transition current QHP enrollees with incomes below 200% FPL to FBHPO.
- State may propose phased-in enrollment plan for 2015 implementation.

Washington Decision Points

Administration:

- What agency will administer FBHPO and who will be the Fund trustees?
- What legislative action, if any, will be needed to support the FBHPO's design, development implementation & operation?

Systems:

- Which systems (Marketplace or Medicaid) will best support FBHPO functions and how will costs be allocated to FBHPO administration?
- What is the scope, cost and priority of system changes – eligibility, enrollment, premium collection, payment, etc?

Transitions:

- How will the State transition QHP enrollees to FBHPO to minimize disruptions in coverage and care? How will this impact families with mixed Medicaid/CHIP coverage?
- What will be the communication strategy for notifying transitioning individuals?

Source: 42 CFR 600.115, 335, 700

Blueprint Submission and Stakeholder Engagement

Legal Requirements and HHS Guidance

- **FBHPO Blueprint Submission**
  - States must submit a FBHPO Blueprint to CMS demonstrating FBHPO program design meets CMS requirements and operational readiness for CMS certification. E.g.,
    - FBHPO trust fund trustees, their qualifications and responsibilities, and procedure for their appointment
    - Eligibility, enrollment, disenrollment and verification procedures
    - Benefits, premiums, cost-sharing
    - Contracting process and requirements, assurance of health plan availability and plan for coordination with other Insurance Affordability Programs
    - Fiscal policies, accountability procedures, and program integrity plan
    - Operational assessment plan
    - For 2015 implementation only, an enrollment transition plan
  - States must also submit a funding plan to accompany the Blueprint describing enrollment and cost projects for first 12 months of operation and funding sources, if any, beyond Trust Fund.
- **Stakeholder Input**
  - State must provide opportunity for public comment prior to submitting Blueprint.
  - State must conduct tribal consultation that follows Exchange consultation requirements.
- **Certification Process**
  - The date of certification is the date the Secretary of HHS signs the full Blueprint.
  - States may submit the Blueprint in two parts: 1) limited submission for interim certification; and 2) full submission for full certification.

Source: 42 CFR 600.110-120.

Econometric Modeling to Assess Potential Impact

- Project demographics of FBHPO target population by specific factors for the following:
  - Current Marketplace enrollees with income below 200% FPL
  - Potential enrollees who are currently uninsured

- Estimate fiscal implications of alternative FBHPO design (e.g., aligned with Medicaid vs. aligned with QHPs)
  - Enrollee cost (in comparison with alternative insurance options)
  - Federal revenue
  - State costs

- Calculate relative health status of QHP enrollees above and below 200% FPL

- Assess market and delivery system implications such as:
  - Future financial stability of the Exchange
  - Frequency of churn across health insurance programs and impact on continuity of coverage and care
  - Options for families with coverage split across Medicaid/Apple Health/QHPs
  - Provider reimbursement levels, participation and network adequacy

Source: 42 CFR 600.115

Assessing Financial Feasibility

Estimating Revenue and Costs of FBHPO

- **Estimating Federal Revenue**
  - Submit data to CMS for payment notice and rates – including enrollment projections; 2nd lowest cost silver plan premiums and lowest cost bronze plan premiums (by county and age points requested)
  - Estimate the value of the second lowest cost silver plan in each rate cell, adjusted per CMS regulations
  - Estimate the value of the cost sharing reduction (CSR) in each rate cell, adjusted per CMS regulations
  - Take 95% of each of the premium and CSR estimates for each rate cell

- **Estimating State Costs**
  - Obtain actuarial estimate of FBHPO premiums and cost sharing
  - Determine non-federally funded start up costs (design, development, implementation) and ongoing administrative costs

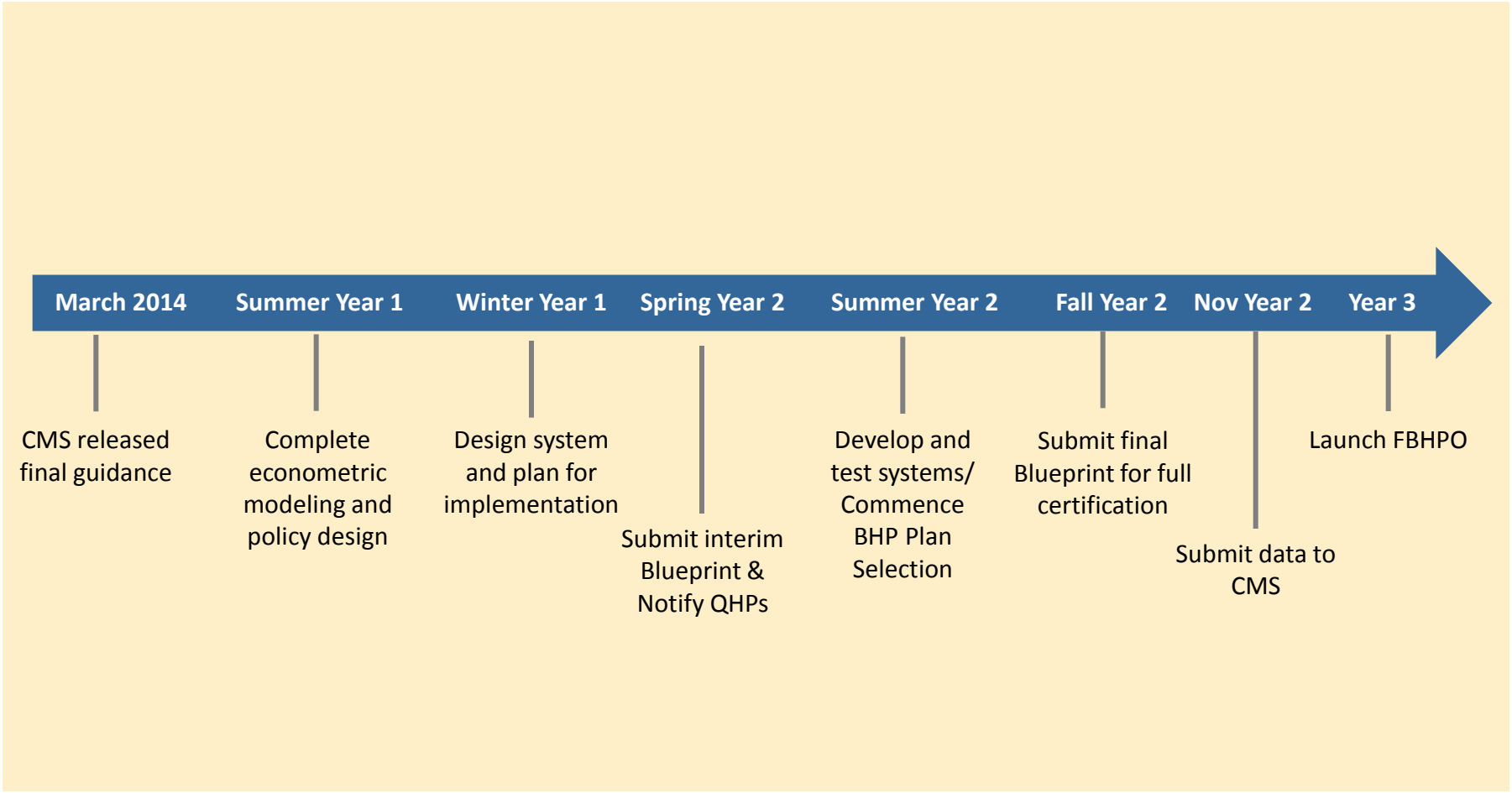
Source: Proposed 42 CFR 60.115

QHP vs. Federal Basic Health Option: Fiscal Implications

POPULATION	ELIGIBILITY LEVEL	COVERED SERVICES	OPTIONS	Implications			
				Provider Reimburse-ment	Consumer Premiums/ Cost Sharing Change	Available Federal Funding	State Fiscal Exposure
Eligible for Qualified Health Plan (QHP) through the Exchange	138-200% FPL	Essential Health Benefits	Maintain Enrollment in QHP	→	→	→	→
			Federal Basic Health Option	↓	↓	↓ →	↑ →

↑ INCREASE ↓ DECREASE → NO CHANGE

Implementation Timeline*



* Assumes legislature authorizes FBHPO

Premium Assistance

Premium Assistance Overview

- Premium Assistance allows states to use Medicaid dollars to purchase employer sponsored insurance or coverage in the individual market.
- Historically, premium assistance in Medicaid/CHIP was only permitted for employer-sponsored coverage.
  - States could make premium assistance mandatory for Medicaid-eligible individuals with access to employer-sponsored insurance (ESI). CHIP employer-sponsored premium assistance has to be voluntary.
  - Medicaid/CHIP required to wrap missing benefits and cost sharing to Medicaid/CHIP standards.
- Regulations released in January 2013 allow states to use premium assistance to purchase QHP coverage in the Marketplace using Medicaid/CHIP funding.
- Premium assistance through the Marketplace must be voluntary unless the state secures an 1115 waiver.

Sources: SSA 1906A Medicaid and the Affordable Care Act: Premium Assistance. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf; 42 CFR 435.1015

Premium Assistance Advantages and Disadvantages

Advantages

- Enables continuity of coverage and care as individual's (and family) income fluctuates
- May increase State's market leverage
- Beneficiaries continue to have all Medicaid protections

Disadvantages

- Administratively complex for State to operationalize
- May not be cost effective
- May require an 1115 Waiver if State's goal is to make this mandatory

Scope of Premium Assistance Analysis

- **Program Criteria**
  - **Cost Effectiveness**
  - **Eligibility**
  - **Benefits**
  - **Cost Sharing**
  - **Plan Selection and Enrollment Process**
  - **Federal Approval**
- **Implementation Timeline**

Cost Effectiveness

Legal Requirements and HHS Guidance

- HHS has advised that, "Cost effective generally means that Medicaid's premium payment to private plans plus the cost of additional services and cost sharing assistance that would be required would be comparable to what it would otherwise pay for the same services."
- In evaluating the cost effectiveness of premium assistance in the individual market, states are permitted to consider the following factors:
  - cost savings associated with reduced churning between Medicaid and the Marketplace;
  - the economic benefits of increased competition in the Marketplace;
  - Improved access; and
  - Improved patient outcomes.
- If state seeks waiver to authorize mandatory premium assistance state must demonstrate budget neutrality.

Washington Decision Points

How will the State demonstrate cost effectiveness of premium assistance considering the following:

- Cost of QHP premium versus cost of Medicaid Managed Care premium
- Costs of premium and cost-sharing wraps
- Administrative costs
- Benefits of reduced churn
- Provider access (against comparable population)
- Clinical quality measures (against comparable population)

Source: Medicaid and the Affordable Care Act: Premium Assistance. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

Template to Analyze State Costs of Premium Assistance for Targeted Adults in Medicaid and Children in CHIP

Year	2014	2015	2016	2017	2018	2019	2020	2014-2020 (cumulative)
Medicaid New Adults FMAP	100% FMAP	100% FMAP	100% FMAP	95% FMAP	94% FMAP	93% FMAP	90% FMAP	
CHIP FMAP	65% FMAP	65% FMAP	88%* FMAP	88%* FMAP	88%* FMAP	88%* FMAP	88% FMAP	
Total Number of Eligible Individuals: Adults (100-138% FPL) Children (215-317% FPL)								
Cost Per Member Per Year of Purchasing QHP								
Cost Per Member Per Year of Purchasing Wrap Services								
Administrative Costs								
Total Costs								

*Assuming Congressional CHIP reauthorization

Eligibility

Legal Requirements and HHS Guidance

- **Eligibility Requirements:**
  - No program requirements beyond standard Medicaid/CHIP eligibility rules.
  - CMS has suggested a preference for demonstrations that target individuals with incomes between 100-138% FPL.
- **Target Population:**
  - HHS will only consider proposals that are limited to individuals whose benefits are closely aligned with benefits available in the Marketplace, e.g., expansion adults receiving the alternative benefit plan (ABP).

Sources: Medicaid and the Affordable Care Act: Premium Assistance. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance-Adf

Other State Experiences

Arkansas

In 2014, will enroll:

- Childless adults with incomes between 0-138% FPL
- Parents with incomes between 18-138% FPL

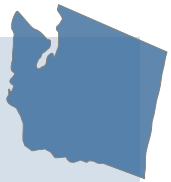
In 2015, may seek approval to enroll:

- Parents with incomes from 0-17% FPL

Iowa

- Will enroll adults between 101-138% FPL.

Eligibility: Washington Decision Points



Washington Target Population

- ESSB 5034 targets two population groups for premium assistance:
  - Adults with incomes between 100-138% FPL
  - Children enrolled in CHIP with family incomes 215-317% FPL

Decision Points

- How will medically frailty exemptions be determined?
  - Need to develop process for determining medical frailty
- How will the State handle undocumented children?
  - Undocumented children may not be processed through the Exchange; Washington will need to determine alternative plan enrollment process
- How will Washington transition current Medicaid adults and CHIP children into the premium assistance program?
  - Washington will need to develop operational transition plan to avoid coverage gaps

Medicaid/CHIP Benefits and Network Requirements

Legal Requirements and HHS Guidance

- **Alignment of Benefits**
  - Premium assistance enrollees remain Medicaid/CHIP beneficiaries entitled to all Medicaid/CHIP benefits. For new adults, this is the Alternative Benefit Plan (ABP).
- **Benefits Wrap Required**
  - State must wrap missing Medicaid/CHIP required benefits or seek waiver.
- **Medicaid/CHIP Provider Access Requirements Apply**
  - FQHCS/RHCs
  - Urban Indian Health Program Providers
  - Family Planning providers
- **Alignment of Pharmacy**
  - States must align Medicaid and QHP prior authorization requirements.
  - States must also align Medicaid and QHP formularies. Medicaid beneficiaries are entitled to barbiturates, and benzodiazepines, which might not be covered in the QHP.

Sources: Medicaid and the Affordable Care Act: Premium Assistance. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf; ACA Sec. 1302

Other State Approaches

Arkansas

•Will provide all Medicaid benefits not covered by a QHP by giving enrollees a Medicaid Client Identification Number (CIN) with which providers can bill fee-for-service Medicaid for wrap benefits.

Iowa

•Will provide all Medicaid benefits not covered by QHP except for Non Emergency Medical Transportation (NEMT) for which it secured a one-year waiver.

Benefits: Washington Decision Points

- Will Washington seek to waive requirement to provide benefits not offered by QHPs (NEMT and EPSDT for 19 and 20 year olds?)
- How will Washington wrap Medicaid benefits not provided in QHPs (e.g., adult dental, NEMT)?
  - Fee-for-service; or
  - QHP Rider
- How will Washington address Medicaid access requirements with respect to FQHCs, I/T/U providers and family planning providers?
  - Assure they are in the QHP; or
  - Provide fee-for-service wrap.

Cost Sharing and Premiums

Legal Requirements and HHS Guidance

Medicaid

- **Cost Sharing**
  - Cost sharing must comply with Medicaid cost sharing requirements unless state receives a waiver.
  - Aggregate cost sharing imposed on family with income < 150% FPL may not exceed 5% of family income on a monthly or quarterly basis.
  - States are required to track an individual's cost sharing contributions in order to determine when the 5% aggregate maximum is reached, if reasonable risk that beneficiaries could reach the aggregate cap.
  - HHS will only consider proposals that wrap/reduce QHP cost sharing.
- **Premiums**
  - Enrollees with incomes below 150% FPL may not be charged premiums unless state receives a waiver.

CHIP

- **Cost Sharing**
  - No copayments are permitted for well-baby and well-child care services.
  - Services provided to an American Indian/Alaskan Native by an Indian health care provider or through referral under contract health services are exempt from cost sharing.
- **Premiums**
  - No upper limit on premiums for families with incomes > 150% FPL but federal Maintenance of Effort (MOE) requirements preclude states from increasing CHIP monthly premiums until 2019.

Sources: SSA 1916A; 42 CFR 447.64; SSA 1916; 42 CFR 457.520; 42 CFR 457.560; Medicaid and the Affordable Care Act: Premium Assistance. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

Cost Sharing/Premiums: Washington Decision Points

Washington Current Practice

- ESSB 5034 directs Washington to consider, "the possibility of applying premiums for individuals and cost-sharing that may exceed the five percent of family income cap under federal law."
- Washington currently does not impose cost sharing or premiums for adults enrolled in Medicaid.
- For CHIP, Washington currently charges monthly premiums of:
  - $20 per child in families with incomes between 215%-265% FPL
  - $30 per child in families with incomes between 265%-317% FPL

Decision Points and Considerations

Cost Sharing

- What cost sharing requirements will Washington impose?
- How will cost-sharing be operationalized for non-exempt individuals?
  - Through a wrap; or
  - Buying down cost-sharing reductions
- Will Washington seek to waive 5% cost-sharing cap? Any other cost-sharing provisions?
- If Washington does employ cost-sharing, the State must notify populations exempt from cost sharing.

Premiums

- What premium will Washington impose?
- Will Washington seek to waive premium requirements for Medicaid beneficiaries?

Systems development costs: what systems changes would be needed to support new functionality

Plan Selection, Enrollment Periods and Effective Dates

Legal Requirements and HHS Guidance

Plan Selection

- Enrollees must have a choice of at least two QHPs.

Enrollment Periods

- Enrollment must be permitted at any time; it cannot be limited to open enrollment period.
- Upon an eligibility determination, an individual must be able to receive fee-for-service Medicaid coverage until enrollment into a QHP.

Retroactive Coverage Prior to Eligibility Determination

- Enrollees are eligible for three months retroactive coverage.

Sources: Medicaid and the Affordable Care Act: Premium Assistance. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf; SSA 1902(a)(34)

Other Issues; Other State Approaches

Plan Selection

- **Arkansas** enrollees will be able to choose among all high-value silver plans with a 94% actuarial value (AV) in their service area (i.e., the plan must on average, cover 94% of medical costs).
- **Iowa** will give enrollees a choice of "participating" 100% AV plans in their geographic region.

Auto Assignment

- **Arkansas** will auto assign individuals who do not select a plan within 30 days post-enrollment. The auto assignment methodology is based on target minimum QHP issuer market share.
- **Iowa** will auto assign enrollees to QHPs on an alternating basis in the first year of its demonstration.

Enrollment Periods

- **Arkansas** plans to allow individuals to enroll at any time.
- **Iowa** will allow individuals to enroll at any time.

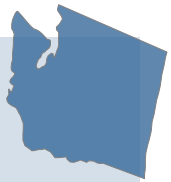
Retroactive Coverage

- **Arkansas** will provide three months retroactive coverage.
- **Iowa** requested a waiver to be exempt from providing retroactive coverage; waiver denied.

Coverage Prior to QHP Enrollment

- **Arkansas** and **Iowa** will provide fee-for-service Medicaid coverage from the time an individual receives an eligibility determination until enrollment into a QHP.

Enrollment: Washington Decision Points



- Will Washington offer premium assistance with respect to all QHPs or a subset? What criteria would Washington use to select a subset?
- How would Washington operationalize QHP selection and enrollment for premium assistance beneficiaries? What systems changes would be required and when could they be accommodated?
- To fulfill its oversight responsibility, Medicaid will need to enter into a memoranda of understanding with the Washington State Office of the Insurance Commissioner and QHPs.

Federal Approval

Legal Requirements and HHS Guidance

- States may pursue premium assistance through a SPA or an 1115 waiver.
  - A SPA is used to implement a voluntary premium assistance program.
  - An 1115 waiver must be used to implement a *mandatory* premium assistance program.
- Premium Assistance Demonstrations end on December 31, 2016:
  - "HHS will only consider proposals that…end no later than December 31, 2016."
  - In 2017, states will be permitted to apply for State Innovation Waivers.

Washington Decision Points

- Would premium assistance be voluntary or mandatory?
- If mandatory, for how long would the State wish to continue the demonstration?

Source: Medicaid and the Affordable Care Act: Premium Assistance. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

Traditional Medicaid vs. Premium Assistance: Implications

POPULATION-	ELIGIBILITY LEVEL	COVERED SERVICES	OPTIONS	Implications			
				Benefit Change	Consumer Cost Sharing Change	Federal Financial Participation	State Financing
Medicaid/ CHIP Eligible	Adults: 100-138% FPL Children: 200-300% FPL	Medicaid/ CHIP Required Benefits	Maintain Enrollment in Medicaid/ CHIP	→	→	→	→
			Premium Assistance	→	↓	→	→

↑ INCREASE ↓ DECREASE → NO CHANGE

Alternatives to QHP Premium Assistance and Federal Basic Health Option

Coverage Alternatives for Low and Moderate Income Consumers

Goal

- Address cost-sharing cliff between Medicaid and Qualified Health Plans
- Ensure continuity of coverage and care as income fluctuates

Bridge Plan

- Bridge Plans are QHPs offered by Medicaid Managed Care (MMC) plans
- Enrollment is limited to consumers transitioning from Medicaid to Marketplace coverage or family members of consumers enrolled in or transitioning from MMC coverage to Exchange coverage
- Bridge Plan originally developed by Tennessee
- California is awaiting approval from CMS to offer Bridge Plans to an estimated 670,000 individuals with incomes below 200% of the FPL

Expansion of Medicaid beyond 138% of the FPL

- State may expand Medicaid eligibility levels above 138% FPL, under the optional adult category.
- State will receive regular, not enhanced, FMAP for individuals above 138% FPL.

QHP Coverage vs. Bridge Plan: Implications

POPULATION	ELIGIBILITY LEVEL	COVERED SERVICES	2014 OPTIONS	Implications				
				2014 Benefit Change	Consumer Cost Sharing Change	Federal Financial Participation	State Financing	Change in Provider Network
QHP Eligible Individuals Transitioning from Medicaid Managed Care	138-400% FPL	Essential Health Benefits	QHP	↓	↑	→	→	Yes
			Bridge Plan	↓	↑	→	→	No

↑ INCREASE ↓ DECREASE → NO CHANGE

QHP Coverage vs. Medicaid Expansion > 138% FPL: Implications

POPULATION	ELIGIBILITY LEVEL	COVERED SERVICES	2014 OPTIONS	Implications: 2014 Benefit Change	Implications: Consumer Premium/ Cost Sharing Change	Implications: State Financing
QHP Eligible Individuals Transitioning from Medicaid	>138% FPL	QHP: Essential Health Benefits	Enrollment in a QHP	↓	↑	→
		Medicaid Expansion: Medicaid Required Benefits	Expand Medicaid > 138% FPL	→	↓	↑

↑ INCREASE ↓ DECREASE → NO CHANGE

Thank You!

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Appendix 2

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

November 25, 2013

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2380-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Sir/Madam:

SUBJECT: Comments on September 25, 2013 Notice of Proposed Rulemaking: *Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity.*

The Washington State Health Care Authority (HCA) respectfully submits the following comments to the Centers for Medicare and Medicaid Services (CMS), in response to the proposed regulations related to the Basic Health Program, published in the Federal Register on September 25, 2013.

We thank CMS for its efforts to develop the proposed rules with substantial input from states interested in considering the potential of making affordable coverage available through the federal Basic Health Program (BHP). The BHP Learning Collaborative was a constructive forum for healthy discussion between states and CMS to inform development of the rules. The webinars were well done and follow-up questions answered timely and thoughtfully. We appreciate the extensive consideration of questions raised in Washington State's original submission of a BHP implementation concept (dated June 18, 2012). And we also appreciate the expressed intent to provide templates for data submission and for future submission of BHP Blueprint details needed for CMS to certify a BHP before it can begin operating. As a result of these interactions, our comments on the proposed BHP rules are somewhat limited.

We refer you to the comprehensive set of comments submitted by Washington State's advocacy organizations that have thoroughly assessed the proposed rules with an eye toward specific implications for consumers. In some cases we have incorporated excerpts from their comments where they reflect common concerns.

In general, our comments pertain to financial and administrative elements that will need acceptance by our Legislature if a BHP is to be developed in Washington State. We were directed by the 2013 Legislature to conduct a study of options for providing coverage to populations potentially eligible for the federal BHP. Preliminary analysis is due from our contractors early in December, and a presentation to the Legislature is being planned for January 2014 to inform 2014 legislative deliberations. Comments are therefore listed in order of the sections in the proposed rules without consideration of any priorities.

BHP Blueprint (§600.110)

The BHP Blueprint is a comprehensive written document that provides essential details and assurances on a state's BHP program prior to certification that allows operational start-up and flow of federal financing. We provided comments during the BHP Learning Collaboratives to support a multi-step Blueprint certification. We suggest that CMS incorporate the option for an "interim certification" step in which a state's initial BHP Blueprint would lay out policy design parameters for preliminary approval by CMS. This would support states in obtaining legislative expenditure authority to develop a BHP with assurance that the program to be developed would meet CMS policy expectations. Given that no federal financing is available to develop or implement a BHP; "interim certification" would mitigate the risk of substantial state investment in a program that requires further investment to meet CMS certification requirements.

Enhanced Availability of Standard Health Plans (§600.420)

As explained during the BHP Learning Collaboratives, the proposed §600.420 rule requires a choice of at least two benefit packages in addition to a choice of different carriers. While we understand that multiple carriers would be expected to offer BHP coverage, we suggest that the option of also requiring a choice of benefit packages be at the State's discretion. Requiring multiple benefit packages will add significantly to administrative costs that are likely to be passed on to enrollees because BHP Trust funds must not be used to cover administrative costs. This adds a financial barrier for states that might wish to consider alignment of BHP benefits with those of the Medicaid program.

BHP Payment methodology (§600.605)

As described in the comprehensive comments provided by Washington State's consumer advocates, the proposed rule fails to recognize a fundamental distinction between the premium tax credits and the cost-sharing reduction amounts provided to states, resulting in an unfortunate conclusion that states may only receive 95 percent of cost-sharing reductions.

The intent of §1331(d)(3)(i) of the Affordable Care Act (ACA) is to provide states with 95 percent of the tax credits that would otherwise be provided to enrollees, with the expectation that states can efficiently manage these funds, negotiating standard plan premium rates that save at least 5 percent over commercial market plans. Once purchased, however, these standard plans must charge enrollees cost-sharing no higher than the Exchange. Proposed 42 CFR §600.520(c). That is, the state must provide for cost-sharing reductions *to the enrollee* (sometimes referred to as "actuarial boost") at least equivalent to what they would receive in an Exchange silver plan. States have no discretion to negotiate or bargain with enrollees to lower these subsidies; they must provide them in full.

Under the proposed rule, states receive only 95 percent of these funds from the Federal Government and are thus left financing the other 5 percent from the BHP Trust fund. But the only other money in the BHP Trust fund is from the 95 percent premium tax credits. Thus states must use some of this tax credit money to compensate for the reduced cost-sharing dollars. As a result, the tax credits available to a state to purchase standard health plans would be *less than* 95 percent of the tax credits, jeopardizing the fiscal viability of a BHP. To avoid this unfortunate result we suggest that the statute be interpreted and rules revised to provide states with 100 percent financing of cost-sharing subsidies.

Further Payment Methodology Clarification Needed
While the payment methodology specifies the use of factors much like those for adjusted community rating, the rules do not explicitly direct that a standard health plan must use adjusted community rating or any other particular form of rating. We request that this be clarified. Further comments related to the payment methodology will be considered in our review of proposed details in the forthcoming Payment Notice.

Quarterly Payments (§600.615) and Retrospective Adjustments (§600.610)
As described in the comprehensive comments provided by Washington State's consumer advocates, our understanding of the proposed rule is that CMS will *not* require the state to make retrospective adjustments to their quarterly payments to account for BHP enrollees' income changes throughout the quarter. Rather, the proposed rule will account for enrollee income changes – and the corresponding repayment amount that would be owed by the individual for their advanced premium tax credits if they were enrolled in the Marketplace – in the prospective payment formula. We would appreciate clarifying language that confirms our interpretation. As we have indicated in our previous BHP concept proposal and subsequent discussions, it will be very difficult to obtain legislative expenditure authority for a BHP in Washington State if we cannot be reasonably assured of protection against unpredictable financial risk.

Secretarial determination of BHP payment amount (§600.610)
We understand that publication of rules for the payment methodology and factors (the Payment Notice) is anticipated in December 2013. During the last BHP Learning Collaborative, data needs were discussed and states were alerted to an upcoming state-specific data request that would feed the Payment Notice details. We have since determined that our Exchange submitted this data to the Center for Consumer Information and Insurance Oversight (CCIIO) as a function of Washington State's Exchange readiness review and subsequent engagement. We suggest that a procedure be established to obtain the data from CCIIO, thereby ensuring that the BHP and the Exchange are using common data, with a process that enables states to confirm that this is the case. Such data sharing between CCIIO and CMS would ensure that we streamline administrative effort and avoid duplication and potential unintended errors for both the state and federal governments.

We add a further comment for consideration as the payment methodology rules are developed. The BHP Learning Collaborative discussion on data generated contemplation of the complexity of the Exchange rating process. The "second lowest cost silver plan premium" is tied explicitly to family composition and circumstances rather than being unique to a county, which was the

implication of the BHP Learning Collaborative discussion. While there is indeed considerable consistency in a county (especially for single adults filing taxes as single adults), there are also people living next door to each other in the same county who will have different "second lowest cost silver plans" because of different family composition/tax household details. We offer this comment to acknowledge potential implications for the payment rules and data collection request.

BHP Trust Fund (§600.705(d))
Preliminary conversations in the BHP Learning Collaborative suggested that CMS was looking at fiscal options for supporting states in developing and operating a BHP, given that BHP Trust Funds may not be used for administrative costs. We would appreciate regulations and/or guidance that provide alternatives for states to pay the administrative costs of BHP.

Additional Clarification Needed
Section 1331(b) of the Affordable Care Act provides that a standard health plan is a benefits plan which, if offered by a health insurance issuer, has a medical loss ratio (MLR) of at least 85 percent. We request clarification of two related points. What is intended if a plan does not achieve an 85 percent MLR? And, is the intent that the BHP use the same calculation of MLR previously established by CMS for individual and small group plans in the Exchange? This is a major hurdle for states.

Again, thank you for the opportunity to provide comments on the BHP proposed rule, and for engaging states regularly as you continue your important work implementing the Affordable Care Act. We look forward to continuing our collaboration.

Should you have any questions or concerns, please contact Nathan Johnson, Division Director, by telephone at 360-725-1880 or via email at nathan.johnson@hca.wa.gov.

Sincerely,

Dorothy F Teeter

Dorothy F. Teeter, MHA
Director

cc: Bob Crittenden, Senior Policy Advisor, Governor's Legislative Affairs and Policy Office
MaryAnne Lindeblad, Medicaid Director, HCA
Nathan Johnson, Division Director, HCP, HCA
Jenny Hamilton, Senior Policy Analyst, HCP, HCA
Carol Peverly, Associate Regional Administrator, CMS

NoHLA

Northwest Health Law Advocates

November 25, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2380-P
Baltimore, MD 21244-8016

RE: Washington State Advocates' Comments on September 25, 2013 Notice of Proposed Rulemaking: *Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity*

Dear Sir/Madam:

The undersigned Washington State organizations, members of the Healthy Washington Coalition, respectfully submit the following comments to the Centers for Medicare and Medicaid Services, Department of Human Services in response to the proposed regulations related to the Basic Health Program, published in the Federal Register on September 25, 2013. The Healthy Washington Coalition is dedicated to ensuring that Washington State has quality, affordable health care coverage for all of its residents.

We strongly support CMS's recent efforts to implement the Basic Health Program (BHP). BHP has the potential to greatly benefit low-income consumers and help ensure the success of the Affordable Care Act (ACA). Enabled by meaningful administrative rules, the Basic Health Program could reduce premiums and out-of-pocket costs for financially strapped households, improve enrollment rates, reduce barriers to needed care and support continuity of care. In short, the Basic Health Program has the potential to help the Affordable Care Act meet its key goals of making affordable coverage available to everyone and maintaining stable, continuing care for those enrolled.

We appreciate the chance to offer comments on these proposed regulations. We support many of the provisions in the proposed regulations, and offer suggestions for changes that would help this program meet its potential. Specifically, our recommendations are aimed to ensure consumer protection and input, promote adequate and stable financing states need to be able to take up this option, facilitate continuity of care and encourage delivery system innovations that improve care quality.

Our comments are listed in order of the sections in the proposed rules; the order of the issues raised in our comments does not reflect the priority we place on them.

4759 15th Ave NE, Suite 305 ♦ Seattle, WA 98105-4404
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We commend the provisions in the proposed rule that would:

Provide for enrollment assistance and information requirements (§600.150)
We support the Department's proposed standard that states must require participating standard health plans to make publicly available, and maintain, the names and locations of currently participating providers. This requirement will help enrollees select a plan that best meets their needs, and identify any providers that may overlap with prior or future Exchange coverage. To the extent the Exchange and a state's Basic Health Program have overlapping provider networks, it is important that enrollees be able to identify a standard health plan's provider network and potentially select a plan option based on the ability to maintain continuity of care should they "churn" between the Exchange and BHP. To strengthen this standard, we urge the Department to require states to update the names and locations of providers at least quarterly to ensure that enrollees have up-to-date information.

Adopt Nondiscrimination standards (§600.165)
We support the proposed rule's nondiscrimination standards, which make clear that the State and standard health plans cannot discriminate based on race, color, national origin, sex, age, disability, sexual orientation, or gender identity, among other bases. These protections are essential to ensuring that individuals receive equal access to health care and to nondiscriminatory health coverage through BHP. These standards are also consistent with the nondiscrimination rules that apply to other health programs, and therefore meet the proposed rule's stated goal of aligning BHP rules with existing rules governing coverage through the Exchange, Medicaid, or CHIP.

Specifically, the proposed rule provides that the state and standard health plans "must comply with all applicable civil rights statutes and requirements. The proposed rule also provides that the state "must comply with the nondiscrimination provision at 45 CFR 155.120(c)(2) (which bars discrimination in the Exchanges). In addition, the proposed rule states that standard health plans cannot discriminate in benefit design on the terms described under 45 CFR 156.125 (which bars discrimination in Essential Health Benefits). Collectively, these protections are essential to fulfilling the ACA's goals of ensuring individuals have equal access to health benefits, including through BHP.

Allow BHP to adopt Medicaid's continuous open enrollment policy (§600.320(d)). The BHP population will likely experience frequent income fluctuations and be vulnerable to times of financial hardship that may lead them to lose coverage due to nonpayment of premiums. Given this context, continuous open enrollment will no doubt reduce churn and minimize the length of gaps in coverage that do occur. This option is particularly important in states that have already expanded coverage which includes continuous open enrollment to this population, because these states may want to use BHP to ensure that current enrollees do not lose protections they have had for years.

Require Basic Health Programs to use the Medicaid appeals process (§600.335(b)).
From the enrollee perspective, it will be very important to ensure that once in BHP, an

individual will be able to access needed providers and address any eligibility concerns through a robust appeals process, since they are unlikely to be able to afford any other option for coverage or care. By using existing Medicaid rules in these areas, HHS will afford enrollees the high standard of consumer protections in Medicaid that were specifically designed for a low-income population, like the population eligible for BHP. In addition, HHS should specify that states must also include in their contracts with health plans a requirement to use Medicaid grievance and appeal procedures.

Provide flexibility for states in setting up their BHP programs in 2015 (§600.405). We appreciate that the proposed rule provides states an exemption from these contracting requirements for the first year, so this contracting process will not be a barrier to states' getting a BHP up and running by 2015. However, we have concerns about the competitive contracting processes required for standard health plans in BHP beyond 2015, as they would render a BHP impossible in most if not all states that currently use a PCCM system or might consider adopting PCCM (see more on that below).

Allow states to contract with non-licensed HMOs that participate in Medicaid or CHIP (§600.415). Contracting with Medicaid plans for BHP coverage will allow states to stretch each health care dollar further, since Medicaid plans typically are significantly more efficient than private market plans. This will lower out-of-pocket costs for consumers, improving coverage rates and access to care. It will also promote continuity of care as beneficiaries' income fluctuates between Medicaid and BHP by allowing people to maintain the same providers and benefits as they move back and forth.

Ensure BHP enrollees receive a plan with an actuarial value (AV) at least as high as they would get in the Marketplace, accounting for their cost-sharing reductions (§600.520). This is an essential protection that ensures BHP meets a "do no harm" standard implicit in the Basic Health statute by ensuring that those eligible for BHP are no worse off than they would have been had they enrolled in the Exchange.

Provide states with reasonable financial certainty through quarterly payments (§600.615) and retrospective adjustments only in the cases of a mathematical error in applying the payment formula or when aggregate enrollment for the quarter differs from the predicted amount. (§600.610) Our understanding of the proposed rule is that CMS will *not* require the state to make retrospective adjustments to their quarterly payments to account for BHP enrollees' income changes throughout the quarter. Rather, the proposed rule will account for enrollee income changes – and the corresponding repayment amount that would be owed by the individual for their advanced premium tax credits if they were enrolled in the Marketplace – in the prospective payment formula. It protects states against unpredictable financial risk which would serve as a significant barrier to states taking up BHP. We strongly support this decision, and we would appreciate clarifying language that confirms that states will not be required to make retrospective adjustments to their quarterly payments to account for BHP enrollees' income changes.

While we appreciate the NPRM's proposal to institute a method of prospective payments to states that substantially reduces the risk that they would have to repay funds to the federal government, we remain concerned that in two areas the proposed rules fail to maximize the opportunity to support the financial viability of a BHP in the States: (1) the NPRM misconstrues the plain meaning of the statute which authorizes 100 percent federal financing to support the consumer's cost-sharing reductions; and (2) it fails to provide guidance on permissible ways for states to finance administrative costs of a BHP, given that trust funds may not be used for these costs. Any financial barriers to a state may cause it not to pursue a BHP and result in the most vulnerable low-income consumers opting for low-value Bronze plans or gaps in coverage because they are unable to maintain consistent premium payments for silver or higher level plans. These two issues are further discussed below.

We urge you to amend the following provisions in the proposed regulations to:

Develop specific transparency and public input requirements for states submitting a BHP blueprint (§600.115(c) Development and Submission of BHP Blueprint).

We suggest that you expand the public notice opportunity suggested at 42 CFR § 600.115(c) to include more detailed steps for public notice and comment as the Basic Health Program Blueprint is developed. Given that BHP is a brand new program that will cover large numbers of low- income adults, ensuring that there is adequate time for public notice and comment is of particular importance.

We suggest that the BHP blueprint follow the simple but effective steps that are now a routine part of the application requirements for Medicaid § 1115 waivers and extensions of existing Medicaid § 1115 waivers. These steps would allow the public to comment both as the state develops a BHP blueprint, and as HHS is considering approval of the Blueprint and ensure that the public has an opportunity to discuss and understand key elements of the BHP as states take steps toward building the program. The Medicaid rules also include specific timeframes help to ensure that there is time for meaningful public input.

Key elements of the Medicaid 1115 Waiver Approval that we suggest the BHP Blueprint follow are provided below. The complete rules are available at 42 CFR §431 or at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8292.pdf

Transparency and specific timeframes for input as the state develops the BHP blueprint:

- 30-day notice and public comment period at the state level
- The state's draft BHP blueprint must contain a sufficient level of detail to ensure meaningful input from the public.
- The state must keep a current webpage to share the draft BHP blueprint and related materials allow interested parties to sign up for an email notification to be kept in the loop on the application.

- The state must hold at least 2 public hearings on separate dates and locations that offer the public a chance to learn about the draft BHP blueprint and comment on it.
- The state's proposed BHP blueprint for HHS must include similar specifics to those provided in the initial waiver proposal, document the public process conducted by the state and include a report on how the state considered issues raised by the public.

Additional transparency and specific timeframes for input as the state shares its proposed BHP Blueprint with HHS:

- Within 15 days of state's submission of proposed BHP blueprint to HHS, HHS must send the state a notice of receipt which initiates a 30-day comment period.
- HHS will publish the notice of receipt, the proposed BHP blueprint and other relevant materials on its website along with an email address through which the public can send comments that will be made publicly available.
- To ensure the public has adequate time to provide input in this stage, no federal decision on a blueprint would be made until 45 days after the notice of receipt.

There are a number of other elements in the proposed BHP regulation related to transparency that we agree with and urge you to keep in the final rule:

- 42 CFR § 600.115(c)(1) – The state must also seek public comment on significant revisions that alter the core elements of the blueprint required under 42 CFR § 600.145(e).
- 42 CFR § 600.115(c)(2) – Federally-recognized tribes have to be included in process, and by creating public comment and notice periods, others will also have a chance to participate in the process.
- 42 CFR § 600.110(c) – Requirement that HHS make BHP blueprints available online.
- 42 CFR § 600.410(d) – Tracking and monitoring of grievance and appeals.

Define the type of "significant change(s)" that would require a state to revise its BHP blueprint to capture a broad range of changes (§600.125(a)).

What might be considered a small change in some programs could be much more significant in BHP, since, without BHP, consumers would be able to access coverage through the Exchange. Anything that could potentially alter the calculus of whether consumers would be better off in BHP versus in the Exchange should be subject to public input.[1]

[1] For guidance on how to define the type of program changes that would trigger resubmission of a blueprint, CMS could look to the types of changes that would trigger a State Plan Amendment in Medicaid. Medicaid law currently requires State Plan Amendments for any "material changes in State law, organization, or policy, or in the State's operation of the Medicaid program." (42 C.F.R. § 430.12(c)(1)(ii))

Specifically, we encourage you to define "significant program change" in such a way that would ensure public input before a state makes a change in its BHP program that would affect:

- premiums or out-of-pocket costs
- the benefit package
- choice of plans or providers
- the appeals, enrollment or renewal process
- the contracting process.

Give states the option to provide Basic Health to low-income adults when an offer of employer-sponsored insurance is unaffordable and give states flexibility in how they fund coverage of this group (600.305(a)(3)(ii)).

Now known as "the family glitch," a drafting error in the Affordable Care Act leaves hundreds of thousands of children and spouses, who could have received premiums for coverage in the marketplace, without an affordable coverage option. While we know you can't fix the drafting error in the BHP regulations, we suggest that you give states flexibility in how they fund coverage of this group in the Basic Health Program. States can currently cover children otherwise caught in the family glitch through CHIP, which is funded with a combination of federal and state funds. We suggest that states be given the option to cover spouses otherwise caught in the family glitch through BHP, and that they be given the greatest flexibility allowable in how they choose to fund it.

- **Eligibility**: The NPRM requires a BHP to cover low and moderate-income adults even when a worker has an offer of employer coverage that is affordable for the worker but unaffordable for his/her spouse (NPRM at 600.305(a)(3)(ii)). The NPRM refers to the IRS requirement to maintain *minimum essential coverage* and allows individuals whose coverage exceeds 8 percent of household income to be eligible for BHP (IRC 5000A (e)(1)(A)).
- **Payment**: However, under the NPRM, a BHP would only receive federal funds for people who would have qualified for a premium tax credit in the exchange (NPRM at 600.605). Under current IRS rules, spouses would not be eligible for *premium tax credits in the marketplace* if the worker's offer of coverage alone requires a contribution of less than 9.5 percent of household income (1.36B-2(c)(3)(v)(C).

As currently drafted in the NPRM, the BHP requires this group of low-income and moderate adults to be eligible for BHP, but does not allow federal funds to finance their coverage. We suggest that you revise the rules to give states the option – but not require them – to cover this group, since the payment methodology does not adequately compensate states for this coverage. We also suggest you explicitly give states flexibility to fund people caught in the family glitch and potentially allow them to use BHP trust fund carry over to cover this group.

Allow states to provide 12-month continuous eligibility (§600.340).

The proposed rules require BHP enrollees to report changes in circumstances, at least to the extent that they would be required to report such changes if enrolled in coverage through the Exchange, and requires the state to redetermine their eligibility at that time.

But income of the low-income individuals served by BHP is uniquely variable. They tend to receive an hourly wage rather than a salary. This makes their income immediately impacted by seasonal, market or other workplace changes. Further, wage workers are more likely to experience to periodic layoffs and re-hire. Indeed, we know that half of people below 200% FPL are predicted to experience a shift in eligibility from Medicaid to BHP or Marketplace coverage, or the reverse.[2] Under this policy, we can expect a significant portion of BHP enrollees to experience reportable income changes that would trigger eligibility redetermination and necessitate their transfer to a new health coverage program.

Twelve-month eligibility would help ensure the levels of coverage stability common among higher income groups and reduce the administrative burdens for public agencies and insurers of serving this population. It would also be consistent with existing state options to institute 12-month continuous eligibility in Medicaid and CHIP. For families with parents on BHP and children in CHIP, this would allow the whole family to have the same eligibility terms.

For these reasons we urge HHS to give states the option to institute 12-month continuous eligibility in BHP.

Explicitly allow states flexibility to include additional benefits at state option (§600.405).

In the NPRM, the Basic Health Program is required to include, at a minimum, the essential health benefits and to use as a reference plan one of the commercial insurance benchmark plan options (NPRM at 42 CFR 600.405). In addition, the preamble of the NPRM suggests that a state can choose to add additional benefits to its standard health plan, but this language is not included in the actual regulation text. The NPRM preamble says that adopting the determination of the exchange about which mandated benefits are inside the reference plan premium structure, is "not the same as a state choosing to add additional benefits only to its standard health plan(s), and "Payment for these benefits would come from either state funds or trust fund surplus." "("Basic Heath Program; Proposed Rule," 78 Federal Register 186, (September 25, 2013), pp. 59129). However, these elements of the preamble are not reflected in the proposed regulation text.

[2] Sommers, Benjamin, and Sara Rosenbaum. "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges." *Health Affairs* 30.2 (2011): 228-236. http://content.healthaffairs.org/content/30/2/228.full.html

We suggest that you add explicit language to the regulation text that allows states to add additional benefits at state option beyond the commercial insurance benchmark plan. While some states may want to use the commercial market EHB benchmark plan already selected in their state, other states may choose to include additional benefits beyond the reference plan. The state's choice of benefit design may depend on a number of factors including how the state assesses the population's needs, and how they plan to administer the program, and how they plan to organize service delivery. As you know, some states may run the BHP from their state marketplace, and some may do it from the Medicaid or Human Service agency. Some states would choose to build off of benefits and delivery system commercial market, and others would build on the Medicaid delivery system in order to make it work best and need flexibility to add benefits.

We suggest that after 600.405(b) you should add (c) to specify additional benefits that standard health plans must include, as follows:

"(c) *Additional benefits at state option*. The state may specify additional benefits that standard health plans must include."

Require that a state adopt Medicaid or Exchange standards for network adequacy and essential community providers (§600.410(d)).

Network adequacy has been identified as a critical issue in the new health insurance marketplaces, and it has long been a concern in Medicaid managed care plans.[3] If networks do not have sufficient available providers, enrollees' geographic access, ability to see appropriate providers, and waiting times are compromised. DHHS, recognizing the seriousness of this issue in the federal marketplace, and to implement the federal regulation requiring sufficiency in number and type of providers, including "essential community providers," issued guidance that requires QHPs to meeting minimum network adequacy standards.[4] In addition, detailed network adequacy standards apply to Medicaid managed care plans, intended to assure access to care for vulnerable individuals.[5]

BHP enrollees' access to health care services under the BHP is only minimally discussed in the proposed rules. We appreciate that proposed §600.415(b)(1) will require states to include network adequacy standards in their contracts with Standard Health Plans, but urge CMS to include additional specifics. Proposed §600.410(d) requires states to negotiate plan contracts based on a number of factors. The primary ones are premiums, benefits, costs and "innovative features." Network adequacy considerations are relegated

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[3] *See, e.g.*, National Committee for Quality Assurance (NCQA), "Network Adequacy & Exchanges: How delivery system reform and technology may change how we evaluate health plan provider networks" (2013), http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf.

[4] 45 C.F.R. §§ 156.230 (network adequacy), 156.235 (ECPs); *see also* CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE & MEDICAID SERVS., AFFORDABLE EXCHANGES GUIDANCE 6-10 (2013), *available at* http://www.cms.gov/CCIIO/*Resources*/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf, .

[5] 42 C.F.R. §§ 438-206-438.208.

to an "other considerations" category in this list of factors; one of these considerations is "local availability of, and access, to health care providers."

BHP enrollees, who are the lower-income segment of the Exchange population, should not have less protection than QHP enrollees. They will have more limited plan choice than QHP enrollees, and should have network adequacy protections at least as strong. States should also be allowed to align BHP network adequacy standards with Medicaid standards. This will be an important option for states doing joint procurement of Medicaid and BHP. We recommend that §600.410(d) be revised to require that states align BHP network adequacy standards with either their QHP standards or their Medicaid managed care standards. However, states should not be prohibited from requiring a more robust network adequacy standard than either of these baselines.

Evaluate negotiation criteria, including innovative features proposed by a state (§600.410(d))

We support the overall goal of providing high-quality care for BHP enrollees and recognize that case management and care coordination can improve access to critical services, especially for lower-income populations with multiple chronic conditions. Incentives such as gift cards that encourage participation in health screenings or other rewards for successful completion of an educational series, for example, can help to keep families engaged in their health care. However, incentives for BHP enrollees should not be tied to premiums or have adverse financial outcomes. Often, low-income women – especially single parents – are balancing multiple responsibilities that severely restrict their time, that make it difficult or impossible to comply with requirements to engage in, for example, an exercise or weight loss program. Furthermore, HHS must ensure that "incentives" do not reduce the overall actuarial value of a plan. Given the lack of specificity of innovative plan features and incentives, HHS should— as part of the certification process—carefully evaluate the proposed negotiation criteria in the state's BHP Blueprint, as required by § 600.410(d).

Provide flexibility for states that administer Medicaid through PCCM to participate in BHP (§§ 600.410 and 600.415).

As mentioned above, we have concerns about the competitive contracting processes required for standard health plans in BHP, as they would make it impossible to set up a BHP in most, if not all, states that use a Primary Care Case Management (PCCM) system to deliver Medicaid services (see detailed explanation in comments submitted by Community Catalyst).

Provide flexibility regarding contracting parties and competitive contracting (§600.415 and .410).

We support the concerns of states that purchase Medicaid services through a PCCM model and seek to align BHP with this system. Under PCCM, states contract individually

with medical practices to coordinate care for their Medicaid patients; they don't contract with an entire network of providers under one large contract. But the only choices for an "offeror" which a state may contract with, under proposed §400.415, are insurers, licensed and unlicensed HMOs, and a "network of health care providers." This should be remedied by allowing any PCCM state that also contracts with a statewide administrative services organization (ASO) for administrative functions related to the PCCM program to qualify as an "offeror." Contracting with this kind of entity, if it recruits or assists the PCCM practices, should be an additional option under §600.415, even if the state, and not the ASO, contracts directly with the individual PCCM practices. We support the additional detailed comments on this issue submitted by Community Catalyst.

We also support the comments that competitive bidding requirements in §600.410 are too strict relative to the way that PCCM states contract with individual practices. This requirement should be revised to allow grandfathering of ASO entities already under contract with the state, if those related contracts were competitively bid.

Further, we suggest broadly defining what constitutes competitive contracting to encourage development of innovative models of care delivery. Specifically, initially permitting less than two responsible bidders serving a local health care market could be helpful to states pursuing far-reaching delivery system reform. Under community-based coordinated care-global budget models and other kinds of ambitious efforts, it may take time for many competitors to emerge. CMS could challenge such states to adopt strategies to prevent the risks to consumers typical of a marketplace that lacks vigorous competition and to take steps to foster competition in future Basic Health contracting.

Explicitly provide flexibility for states to have either a single benefit package or a single offeror of coverage (§600.420).

We are concerned that the proposed §600.420 is ambiguous. The rule may be interpreted to require BHP states to offer a choice of "standard health plans" without clearly stating that this may be a choice between either benefit packages or between plans offered by different carriers. The proposed rule could be interpreted to require only the former, but we believe the statute is inclusive and permits the latter. In the interest of state flexibility to create choice that is most beneficial to BHP consumers, both options should be available to states.

Limiting state options regarding choice could be detrimental to consumers for a number of reasons. Requiring multiple benefit packages could add significantly to administrative costs. Federal BHP funds are not available for administrative costs, so these costs are likely to be passed on to these low-income, price-sensitive consumers. In addition, if states are required to offer multiple benefit packages, it would defeat a state's ability to align with Medicaid and would create needless complexity and confusion – for example by requiring a lesser-benefit package to be offered when a very comprehensive one is provided by a state for a zero premium.

States should also be able to offer a choice of benefit packages when there are not two managed care organizations available. This is the only way to ensure that a state can participate in BHP if it has low managed care organization penetration and only one plan is available to contract, or if there are two plans and one drops out.

> Section 1331 may be interpreted to allow state flexibility in offering consumer choice of either benefit package or offeror.

Section 1331(c)(3)(A) provides:

> (3) ENHANCED AVAILABILITY.—
> (A) MULTIPLE PLANS.—A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

The language of the statute does not specify that the intended meaning of "standard plans" in this section is limited to multiple benefit packages – it could mean either packages or offerors of plans. And neither is it an absolute requirement as the "maximum extent feasible" clause and the word "seek" make clear.

The definition of "Standard Health Plan" in §1331(b)[6] is not a model of clarity. The first clause of the definition is "a health benefits plan that the State contracts with under this section," suggesting that "plan" refers to the contracting entity – the offeror. The remainder of the definition has clauses that could be used to support either interpretation.

Similarly, "Qualified Health Plan" is sometimes referred to as a contracting entity, as in §1311(h)(1) ("a qualified health plan may contract with (A) a hospital…; or (B) a health care provider…"), but at other times as a benefit package. This is significant since §1331 draws many parallels between SHPs and QHPs.

In addition, this section of the ACA was closely modeled on an existing state-based program, the Washington Basic Health program. Section 1331 was offered as an amendment by Washington's Senator Maria Cantwell. In Washington's BHP, a single benefit package is offered through multiple issuers.

For these reasons, it is reasonable to interpret the "choice" requirement of 1331 as meaning a choice of either benefit packages or of plans.

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[6] (b) STANDARD HEALTH PLAN.—In this section, the term ''standard heath plan'' means a health benefits plan that the State contracts with under this section—
(1) under which the only individuals eligible to enroll are eligible individuals;
(2) that provides at least the essential health benefits described in section 1302(b); and
(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

Further, §1331(c)(3)(A) recognizes that a state may have challenges achieving consumer choice, and therefore includes the "maximum extent feasible" qualifier. The purpose is to offer consumers as much choice as possible.

In some states or regions of states, a state may only be able to contract with one offeror, but could offer a choice of benefit packages. In others, the state may contract with multiple offerors and determine that the trust funds could be better spent on a single benefit package. For example, a state may be able to contract with multiple offerors to offer a zero-premium, comprehensive benefit package with minimal or no cost-sharing that is aligned with the Medicaid package. It would be unfeasible in this situation to justify coming up with another, lesser benefit package with higher cost-sharing, just to meet the choice requirement. Moreover, this could disadvantage all BHP enrollees by adding administrative costs. Such a state should have the option of offering a choice of companies/entities rather than a choice of package.

However, another state may best serve consumers by creating an efficient BHP that maximizes continuity of care. In the case of PCCM in conjunction with an ASO specifically, the state does not contract with risk-bearing entities so there are not multiple offerors of plans to enrollees. Rather, it contracts on a non-risk basis with individual practices throughout the state to coordinate care for enrollees, while administering the program through a single statewide system that includes a contract with a single ASO to conduct some administrative functions. Requiring multiple plans in this situation would be confusing and inefficient. As such, it is not feasible for a state to offer multiple "plans" under its PCCM program extended to BHP enrollees.

Some states are fixing their fragmented health care systems by extensively coordinating care through local community-based coordinating organizations operating within global Medicaid budgets. Not all enrollees in such states have multiple coordinated care plan options, in some cases because the local health system and participant pool are not large enough to support multiple plans. Allowing them to continue these delivery system innovations within BHP would be appropriate when it is beneficial to low-income enrollees, especially considering the "maximum extent feasible" clause, and in light of the ACA's interest in pursuing these kinds of approaches. Perhaps high standards for network adequacy and other consumer safeguards could be used to meet the consumer interests that would otherwise be met through multiple plan options.

Circumstances will vary from state to state as to what type of "choice" is most meaningful to consumers. The statutory language contains the flexibility to allow states to make this determination in light of what is most desirable given the local healthcare and financing landscape.

The proposed rule should be clarified to allow state flexibility.

45 C.F.R §600.420 requires states to "include in its BHP Blueprint an assurance that at least two standard health plans are offered under BHP, and if applicable, a description of

how it will further ensure enrollee choice of standard health plans." The preamble language in the proposed rule at page 59131 indicates, on the one hand, the agency's intent to ensure choice of benefit packages, and on the other hand, its intent to protect consumers "in the event that a single standard health plan becomes unavailable," because "BHP, unlike Medicaid, does not have a fee-for-service program available" in that event. This clearly refers to choice-of-plan as a choice of offerors.

While we do not support an inflexible requirement of benefit package choice or offeror choice, we believe CMS has the authority and responsibility to review Blueprints to ensure that they comply with the statutory intent of offering meaningful choice to consumers to the maximum extent feasible. This authority should serve as a check on a state that might be overly restrictive in its offerings to consumers.

In light of the statutory language and goal of BHP state flexibility, the proposed rule should be clarified as follows:

(a) *Choice of standard health plans.* The State must include in its BHP Blueprint an assurance that at least two standard health plans, or at least one standard health plan offered by two or more offerors, are offered under BHP, and if applicable, a description of how it will further ensure enrollee choice of standard health plans. When certifying a Blueprint under §600.120, the Secretary shall waive this requirement based upon a finding that it is not feasible for a state to offer a choice of plans or offerors. Such a finding shall be reviewed annually.

Clarify that cost-sharing subsidies are to be administered in a manner that is invisible to the consumer. (§600.520(c)(3)).

We appreciate your responsiveness to consumer concerns regarding cost-sharing administration, by requiring in §600.520(c)(3) that states ensure that consumers are not held responsible for monitoring cost-sharing reductions. We would appreciate further clarification that consumers should not be required to pre-pay the full amount of cost-sharing, including the subsidy amount, and then seek reimbursement of the subsidy. Since we know all BHP enrollees will qualify for these reductions, there should be no reason not to administer the cost-sharing in a seamless manner.

Ensure that states do not terminate coverage of BHP enrollees who fail to pay an insignificant part of their premium payment (§600.525).

We support the proposal to align disenrollment procedures and consequences for nonpayment of premiums with the state's disenrollment policies for either the Exchange or Medicaid. However, we urge HHS to ensure that states do not terminate coverage of enrollees who fail to pay only an insignificant or "de minimis" part of their insurance premiums. Doing so would be overly punitive in the case of an enrollee who has paid most of the premium amount due.

Include in the federal BHP payment 100 percent of the cost-sharing reduction for which the eligible individual would have qualified in the Marketplace (§600.605).

The proposed rule fails to recognize a fundamental distinction between the premium tax credits and the cost-sharing reduction amounts provided to states, resulting in an erroneous conclusion that states may only receive 95% of cost-sharing reductions.

The intent of §1331(d)(3)(i) of the ACA is to provide states with 95% of the tax credits that would otherwise be provided to enrollees, with the expectation that states can efficiently manage these funds, negotiating standard plan premium rates that save at least 5% over commercial market plans. Once purchased, however, these standard plans must charge enrollees cost-sharing no higher than the Exchange would. Proposed 42 CFR §600.520(c). That is, the state must provide for cost-sharing reductions *to the enrollee* (sometimes referred to as "actuarial boost") at least equivalent to what they would receive in an Exchange silver plan. States have no discretion (nor should they) to negotiate or bargain with enrollees to lower these subsidies; they must provide 100% of them to enrollees.

Under the proposed rule, however, states receive only 95% of these funds from the federal government and are thus left financing the other 5% from the BHP trust fund[7]. But the only other money in the BHP Trust Fund is from the 95% premium tax credits. The inescapable conclusion is that states must use some of this tax credit money to make up for insufficient cost-sharing dollars. So the tax credits available to a state purchase standard health plans would be *less than* 95% of the tax credits, possibly making a Basic Health program prohibitive.

Example: The silver benchmark QHP premium in a state's exchange is $500. An enrollee's subsidy is $400, and their average cost-sharing reduction is $80. Under the proposed rule, a BHP state would receive a premium tax credit of $380 and a cost-sharing reduction payment of $76. The state must ensure that the person receives an $80 cost-sharing reduction, so $4 is allocated from the $380 tax credit for this purpose. $376 remains to subsidize a silver-equivalent plan, which is *94%* of the premium tax credit.

Based on the above analysis, it seems clear that in order to avoid effectively reducing premium tax credits <u>below</u> 95%--and potentially passing these reductions on to very low-wage consumers--states need to receive 100 percent of the cost-sharing reductions that BHP enrollees would have been eligible for in the Exchange.

In order to avoid the unfortunate result of "raiding" tax credit funds to provide cost-sharing subsidies, the statute must be interpreted to provide states with 100% financing of cost-sharing subsidies. This interpretation is consistent with the literal reading of the statute. Section 1331(d)(3)(i) specifies that the Secretary should transfer to the state an amount:

[7] We estimate this amount to be in the range of $3-6 per member per month.

> 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 […].

A plain reading of this statutory language indicates that Congress intended to offer 95% financing for the premium tax credits and 100% financing for the cost-sharing reductions. Congress placed the comma after the word "1986" to indicate that the 95% only applies to the tax premium credits and does not apply to the cost-sharing reductions. If Congress had intended the 95% to apply to the cost-sharing reductions, there would be no need for a comma and the commencement of a separate clause concerning the cost-sharing reductions. Accordingly, the proposed rule should be revised to ensure that a state that opts for a BHP, and the vulnerable consumers that would be served by such a program, receives adequate financing. This approach still allows the federal government to save money through a state's election of BHP (since they only spend 95 percent of what they would have spent on premium tax credits).

Provide states with explicit options for paying the administrative costs of BHP, including using some of the user-fee assessments built into Exchange carrier rates (§600.705(d)).

We understand that BHP funds may not be used for administrative costs, but we would appreciate regulations and/or guidance that provides states with options for paying the administrative costs of BHP. We understand from earlier communications that CMS intends to allow states to impose user fees and assessments, including those that are built into carrier rates in the Exchange, to cover administrative costs picked up by the BHP instead of the Exchange. These are logical funding sources for BHP administrative costs, since a BHP enrollee population will be carved out of the Exchange. Helping states identify funds for the administrative costs of BHP is essential to BHP's success, since the administrative costs could otherwise create a barrier to states taking up BHP.

We reserve judgment on the decision to remove BHP from the regular ACA risk adjustment approach (i.e., creating a separate risk pool for BHP) until we have the opportunity to evaluate how risk adjustment applies to BHP payments to states, as will be proposed in the forthcoming Payment Notice.

Thank you for the opportunity to provide comments on this proposed rule, and for keeping consumers a priority as you continue your important work implementing the Affordable Care Act. If you have any questions regarding our comments, please contact Janet Varon at 206-325-6464, janet@nohla.org.

Sincerely,

Northwest Health Law Advocates
Children's Alliance
League of Women Voters of Washington
Legal Voice
Neighborhood House
Puget Sound Advocates for Retirement Action
SEIU Healthcare 1199NW
Washington Community Action Network
Washington Dental Service Foundation
Washington State Coalition Against Domestic Violence
Washington State Labor Council, AFL-CIO

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

January 22, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2380-PN
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on December 23, 2013 Notice of Proposed Methodology: *Basic Health Program: Proposed Federal Funding methodology for Program Year 2015*

Dear Sir/Madam:

The Washington State Health Care Authority respectfully submits very limited comments to the Centers for Medicare and Medicaid Services, (CMS) in response to the proposed federal Basic Health Program (FBHP) payment methodology published in the Federal Register on December 23, 2013. Our limited response is based on the recognition that the rules focus on a 2015 implementation option, which is not possible in Washington State. We require Legislative authority to proceed with full systems design and econometric modeling and subsequent expenditure authority to implement a federal BHP. At this time we anticipate that Washington will be better positioned to provide a more comprehensive response when the payment methodology for a 2016 implementation of the FBHP is published in October 2014. By that date we would expect to have any further direction from the Legislature. In addition we will have the benefit of a stabilized insurance affordable program continuum that would allow essential econometric modeling of the potential impact of a BHP on Washington's commercial marketplace, the State and potential FBHP enrollees.

Again we thank CMS for its attention to developing the proposed payment rules with substantial input from states interested in the potential of making coverage more affordable through the FBHP option. We encourage continued attention to maximizing state flexibility to design a program that best addresses local marketplace dynamics, financing, authorizing timelines and data availability. This is critical to Washington stakeholders and the Legislative process through which expenditure authority to proceed would be made available.

In addition, we refer you to the comprehensive set of comments submitted by Washington State's advocacy organizations. Their review of the proposed 2015 payment methodology highlights further important opportunities to (a) minimize the state and federal administrative burden and uncertainty in determining the FBHP payment to states, (b) ensure that Exchange-based adjustments for American Indian and Alaska Natives apply to the FBHP program, and (c) increase the accuracy of the risk

assessment and risk adjustment steps that drive payment to states. We believe these aspects will be important considerations for the payment methodology rules beyond 2015.

Again, thank you for the opportunity to provide comments on the FBHP proposed payment rules, and for engaging states regularly as you continue your important work to implement the Affordable Care Act. We look forward to continuing our collaboration.

Sincerely,

Dorothy F. Teeter, MHA
Director

cc: Bob Crittenden, Senior Policy Advisor, Governor's Legislative Affairs and Policy Office
MaryAnne Lindeblad, Medicaid Director, HCA
Nathan Johnson, Division Director, HCP, HCA
Jenny Hamilton, Senior Policy Analyst, HCP, HCA
Carol Peverly, Associate Regional Administrator, CMS

NoHLA

Northwest Health Law Advocates

January 22, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2380-PN
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on December 23, 2013 Notice of Proposed Methodology: *Basic Health Program: Proposed Federal Funding Methodology for Program Year 2015*

Dear Sir/Madam:

Northwest Health Law Advocates (NoHLA) and the Economic Opportunity Institute (EOI) respectfully submit the following comments in response to the proposed methodology related to the Basic Health Program, published in the Federal Register on December 23, 2013. NoHLA is a Washington State consumer advocacy organization whose mission is to achieve a seamless health care system, in which all individuals receive affordable, quality care, and are assured of basic rights and protections. EOI is a public policy research and advocacy center that works to ensure access to affordable health care for Washington's working families.

We commend CMS for its efforts to implement the Basic Health Program (BHP). The BHP has the potential to benefit low-income consumers and help ensure the success of the Affordable Care Act (ACA).

Because this new funding mechanism is based on the unique experience of this population in a market that is specific to each state, the development of the BHP funding methodology must take into consideration various market-wide reforms under the ACA and their current and future impact on state health insurance markets.

Even before the ACA, the experience of individuals in the health insurance market varied widely by state in terms of health benefits, consumer protections, coverage options, and affordability. While consistency across markets was one of the laudable goals of the ACA, it is clear that there are still significant differences among state health insurance markets. Moreover, state health insurance markets are currently experiencing a great deal of flux after implementing such large market reforms. It will take several years for state markets to stabilize. This transition period is reflected in CMS' standards and administration of reinsurance, risk corridors, and risk adjustment programs, which aim to mitigate the impact of potential adverse selection and stabilize premiums in the individual market as states implement insurance reforms.

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We appreciate that CMS listened to states and proposed a streamlined funding methodology which aims to provide simplicity and predictability and attempts to ease the administrative burden for states choosing to implement the BHP. For several variables needed, the proposed payment methodology applies national data to all states. This simplified approach will be more feasible for some states who do not have their own data or who would find it burdensome to collect and report on their own data

However, Basic Health Programs run by states also need to have rates that accurately reflect their anticipated costs, so that they can fairly determine the scope and affordability of enrollees' coverage and the level of payments to plans. There is an underlying uncertainty in estimating a payment rate without complete information about the population being served. While insurance carriers might be expected to bear the risk of such uncertainty, Basic Health is different because states are not in the business of taking insurance risk. On the contrary: states must operate within fixed appropriations, so certainty that the funding will cover the costs is critically important. Moreover, HHS has an inherent interest in encouraging states to adopt the Basic Health program, since it is a way to innovate and experiment with cost-saving in public delivery systems.

For these reasons, the payment methodology should provide flexibility to states who wish to achieve more accuracy by providing their own data. This includes providing CMS with actual state-specific data on their market and BHP population to better reflect actual market trends and years of experience with the health care costs of this population. The methodology should also reflect state-specific policies related to enrollment and eligibility review. This option would allow for a federal payment that more accurately reflects the statutory intent for BHP payments to be tied to the cost of a *state's* population had that population actually enrolled in a qualified health plan through the *state's* Exchange.

Thus, many of our comments below regarding the methodology for determining BHP payments reflect the need for CMS to provide states with more flexibility so the BHP can be a success for those states choosing to pursue this new option. For some states, the streamlined funding methodology proposed in the notice will be preferable. However, CMS should allow states that have actual state data for this population to use it, so the payment methodology can produce the most accurate results. Specifically, our recommendations are aimed at promoting fair, adequate and stable financing that states will need in order to establish, implement, and maintain the BHP for their populations.

The comments below are listed in order of the sections in the proposed rules; the order of the issues raised in our comments does not reflect the priority we place on them.

We commend the following provisions in the proposed payment methodology:

(Section II.D. Discussion of Specific Variables Used in Payment Equations Reference Premium and Simplifying Assumptions)

CMS proposes to use as the reference premium the second lowest cost silver plan available to any enrollee for a given age, geographic area, and coverage category. The methodology also assumes that all people enrolled in the BHP would have elected to enroll in a second-lowest-cost silver level plan if they had instead enrolled in a QHP through the Exchanges. Additionally, the funding methodology proposes to use the lowest cost bronze plan as the basis for the reference premium for enrollees who are American Indian or Alaska Natives. We support these simplifying assumptions. These assumptions help to minimize both the state and federal administrative burden in determining the BHP funding.

(Section II.E. Adjustments for American Indians and Alaska Natives)
CMS proposes a number of adjustments for American Indians related to the cost sharing reductions (CSR) portion of BHP funding. We support these modifications to the methodology.

Consistent with other comments in this letter, we urge CMS to modify the BHP payment methodology to provide an option for states to have BHP payments retrospectively reconciled for the actual premiums for the lowest-cost bronze plans in the market for calculating CSRs for American Indian and Alaska Native people.

We urge you to make modifications to the following provisions of the BHP funding methodology to:

Provide flexibility for states to have BHP payments reconciled retrospectively for the reference premium using actual, state-specific data (Section I. Background)

Under the proposed methodology the final BHP payment notice would be published in the Federal Register in February each year and apply to the following program year. The Background section also provides: "*Once the final methodology has been published, no modifications to the methodology will occur during the program year. As described in the BHP proposed rule, we will only make modifications to the BHP funding methodology on a prospective basis*." The Payment Notice also identifies a number of data sources and methodologies to prospectively estimate various factors used in the BHP funding methodology (e.g., reference premium and premium trend factor).

In the proposed methodology, the only modification to the payment methodology would be based on actual enrollments, which that state is required to provide. However, as described below, estimating the reference premium for 2015 based on rates in 2014 will be highly speculative and in some cases significantly inaccurate. At least for the first year

(2015) when projections will be especially challenging, the methodology should be changed to allow for CMS to estimate payments for Quarters 1 and perhaps 2, then allow a state to submit actual data on the reference premium and have the payments reconciled. Below, we also request that the payment methodology allow states the option to retrospectively reconcile their payments for the actual population health adjustment. This will allow the payment to reflect a state's actual health insurance market experience for a year.

Allow flexibility for states to use actual state data for Reference Premium and Premium Trend Factor (Discussion of Specific Variable used in Payment Equations Sections II.D.1. and 2. Reference Premium and Premium Trend Factor)

Use Actual Reference Premiums, Rather Than Projected Reference Premiums
The proposed BHP funding methodology uses 2014 premiums for the adjusted monthly premium for the second-lowest-cost silver plan. Because the 2014 premiums are for the year prior to the 2015 BHP program year, CMS proposes to apply a premium trend factor to account for the change in health care cost per enrollee. CMS proposes to use the annual growth rate in private health insurance expenditures per enrollee from the National Health Expenditure projections. We have serious concerns that in at least some states, this methodology will generate an estimated 2015 adjusted monthly premium for the second-lowest-cost silver plan that is significantly less than the comparable, *actual* adjusted monthly premium. This could conceivably also be true in future years.

Many state marketplaces with low premiums are concerned their low premiums may be due to introductory pricing as insurance carriers are aggressively competing for market share in the individual health insurance market in the Exchanges. While aggressive competition is good, as evidenced by the 2014 premiums, it can also lead to high loss ratios and the need to raise premiums in future years. We are concerned that the current situation in the individual insurance market is similar to the conditions in the Medicare Part D market when that program was implemented. As with the Medicare Part D program, there will likely be significant variations from one year to the next in market competitors and premium pricing. It will be impossible to account for these short-term market impacts using the National Health Expenditure projections as the premium trend factor.

Given the dramatic transformations that state individual markets are experiencing, we urge CMS to modify the BHP payment methodology to provide an option for states to have BHP payments retrospectively reconciled for the actual premiums for the second-lowest-cost silver plans in the market. The actual premiums for the BHP program year 2015 must be known by the start of the 2014 open enrollment period. CMS could use its proposed methodology to estimate the first quarter adjusted monthly premium for BHP funding. Beginning in the second quarter of the BHP program year, CMS could reconcile the adjusted monthly premium for actual market premiums and use the actual premiums for the remainder of the program year. The use of actual premiums would also

significantly reduce the likelihood of federal under/over spending as the result of not accurately accounting for state-specific premium drivers.

Alternatively, if CMS insists on only using a prospective method of estimating the adjusted monthly premium for the second-lowest-cost silver plan, including using the National Health Expenditure projections, we request the CMS offer states the option of using a national average monthly premium for the second-lowest-cost silver plan as the reference premium. The National Health Expenditure projections are a blend of state insurance market conditions and circumstance. The projections mute the impact of any particular state's market in favor of a national average. Consequently, it would be appropriate to also use a national average monthly premium for the second-lowest cost silver plan, which also averages and mutes state-specific insurance market conditions and circumstances. An analysis on September 25, 2013 by the Office of Health Policy within the Office of the Assistant Secretary for Planning and Evaluation (ASPE) showed that a weighted national average of the second-lowest cost silver plan in 48 states was $328.[1]

When Using Actual Reference Premiums is not Possible, States Should Be Permitted To Use a State-Specific Premium Trend Factor to Project the Reference Premium
Using the National Health Expenditure projections estimated to be 3.5% for 2015 as the premium trend factor for a state reference premium has limitations. Since it is a national average, it does not account for cost drivers that are unique to each state, such as significant population movements within the state's insurance market. For example, in the case of Minnesota, the National Health Expenditure projection will fail to reflect the closure of the Minnesota's high risk pool in 2015. An analysis for Minnesota by Gorman Actuarial and Dr. Jonathan Gruber (Gruber analysis), using actual cost and experience data, estimated that moving Minnesota's high-risk pool into the individual market would raise the average individual market health insurance premiums by 19 to 21% - significantly higher than the National Health Expenditure projection of 3.5%.

Additionally, the National Health Expenditure projections would not accurately account for the relative amount of short-term competition in a state marketplace. The ACA has created a unique opportunity for insurance carriers through new market rules (e.g., guarantee issue and no pre-existing conditions), premium tax credits, and the creation of Health Insurance Marketplaces. This unique opportunity for insurance carriers has been accompanied by substantial market uncertainty, both in the population that will be served and the health care costs associated with the enrolled population. CMS will administer programs related to reinsurance, risk corridors, and risk adjustment to mitigate the impact of potential market uncertainty as insurance reforms are implemented. However, we must anticipate that insurance carriers will also react to changes in the individual insurance market by modifying the premiums and cost-sharing of their plans.

[1] ASPE Issue Brief: Health Insurance Marketplace Premiums for 2014, Department of Health & Human Services, September 25, 2013.

Provide a Population Health Factor for BHP program year 2015 (Discussion of Specific Variables used in Payment Equations Section II.D. 3. Population Health Factor)

Section 1331 of the ACA specifies the relevant factors the Secretary must take into account including "the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange". The proposed BHP funding methodology uses a population health factor (aka, risk adjustment) to account for potential differences in health status between persons eligible for BHP and those enrolled in the individual market, because the two populations may not have the same average health status. This is particularly important since CMS has stated in proposed rules that pooling of BHP and Exchange populations will not be permitted. Unfortunately, CMS has proposed to set the population health adjustment factor to 1.00 for program year 2015. This proposed methodology is the equivalent of not doing risk adjustment and equating the health status of the BHP and individual market populations.

While we can appreciate the analytical challenges expressed by CMS in the proposed payment notice, the CMS rationale for setting the population health factor to 1.00 for 2015 is likely to be incorrect for some states. For example, Minnesota is the one state planning to implement the BHP in 2015; we support the analysis provided in comments from that state that the BHP risk pool is likely to be substantially different from that of the individual market

CMS should provide an option for states to have BHP payments retrospectively reconciled for the actual population health adjustment. CMS could build on its existing federal risk adjustment methodology that it will be using for each state's individual market.

The individual market risk adjustment methodology will allow CMS to calculate an overall risk score for the individual market. The individual market risk adjustment methodology requires insurance carriers to collect experience and claims data for use in a CMS prescribed risk adjustment calculation. The federal methodology provides a retrospective assessment of the individual market's overall risk profile. CMS should provide States the option of collecting comparable data for BHP enrollees and then use the same, CMS-prescribed risk adjustment calculation as required in the individual market. This calculation would allow a state to calculate an overall risk profile for the BHP population. The overall risk profile of the BHP population could be compared with the overall risk profile of the individual market. Based on differences in the population health of BHP enrollees and individual market enrollees the BHP reference premium can then be increased or decreased by the percentage difference in the two risk profiles.

Account for state efforts to reassess eligibility when beneficiaries' income changes and for caps on reconciliation payments in the Income Reconciliation Factor (IRF) (Discussion of Specific Variables used in Payment Equations Section II.D. 6. Income Reconciliation Factor)

The proposed methodology would reduce payments to all states using an adjustment factor for reconciliation of Premium Tax Credits (PTCs). As described, the application of this factor could unfairly reduce payment to some states. The factor is based on IRS data showing how people's taxable income differs from year to year, which would subject them to reconciliation of their PTC subsidies at year end. HHS proposes that because reconciliation does not apply in BHP, there must be a compensating adjustment to BHP payments. We assume this would typically be a reduction in payments to states, as the population's income would generally increase over time.

We are concerned that use of this factor would result in underpayment to a BHP state that monitors its enrollees' eligibility during the course of a tax year. For example, a BHP state could review databases and/or require reporting of changes in enrollees' income and household composition. It could then shift people exceeding the 200% FPL threshold from BHP to Exchange coverage. This shift of threshold-income individuals out of BHP has an effect similar to reconciliation: the average income of the remaining enrollees will be lower. Their average PTC eligibility would be higher. It would be unfair to apply a full reconciliation factor to this state, since that factor assumes that no income changes in the course of the payment year will affect eligibility. Therefore, we propose that for states that have policies to adjust eligibility based on changes in income, the reconciliation factor should be smaller. A state BHP blueprint could describe its policy to put adjustment in place and thus qualify for a reduced reconciliation factor.

Conversely, some states may choose to review income changes only during the annual open enrollment period, thereby promoting continuity of coverage, reducing disruptions in health care, and reducing a state's administrative costs. CMS could apply the full reconciliation factor to such states, but should then allow them to apply a "continuous eligibility" policy as we recommended in our comments on the proposed regulations.

Also, we would appreciate confirmation that the reconciliation factor takes into account that some individuals in the Exchange are not required to fully repay PTCs, as amounts are capped. 26 C.F.R. 1.36B-4(a)(3).

Allow for a state-specific value for the Factor for Removing Administrative Costs to more accurately reflect actual health insurance market conditions in many states (Discussion of Specific Variables used in Payment Equations Section II.D.8. Factor for Removing Administrative Costs (FRAC))

The BHP Funding Methodology proposes to use a factor for removing administrative costs (FRAC) to represent the average proportion of the total premium that covers allowed health benefits. The product of the adjusted reference premium and the FRAC

approximates the estimated amount of Essential Health Benefit claims expected to be paid by a health plan and factors out costs as taxes, fees, and administrative expenses. The FRAC is equivalent to an expected loss ratio and is correspondingly set at the minimum loss ratio (MLR) allowed under the ACA at 0.80.

Setting a prospective value of 0.80 does not accurately reflect actual health insurance market conditions in many states. Arbitrarily setting the FRAC to the MLR negates the efficiencies of some state marketplaces and results in under-valuing the average proportion of the total premium that covers benefits. In many states, Blue Cross Blue Shield plans dominate the individual market and recent Treasury guidance requires them to maintain MLRs of .85 to retain favored tax treatment. 79 Fed. Reg. 755 (Jan. 7, 2014). Further, some state laws require a higher medical loss ratio than .80 in the individual and small group market.

Setting the FRAC to the MLR of .80 also ignores the fact that one of the reasons some states have low premiums is that insurance carriers are aggressively competing for market share in the individual health insurance market. As stated previously, aggressive competition is good and is reflected in the 2014 premiums. However, insurance carriers that aggressively set premiums are much more likely to have high loss ratios, potentially even over 100%. As a market strategy, it is logical for carriers to use low premiums to garner market share. In doing so, the carriers will have a loss ratio significantly higher than .80.

To better reflect the health insurance market competition envisioned by the ACA, we urge CMS to have BHP payments retrospectively reconciled by using the actual individual market loss ratio for a BHP program year. CMS could use the 0.80 estimate for the FRAC for initial BHP payments, but needs to have a reconciliation process after the BHP program year. This reconciliation would better reflect the direct connection between premiums and loss ratios.

Allow for a state-specific value for the Induced Utilization Factor to more accurately reflect actual BHP beneficiaries' behavior in specific states (Discussion of Specific Variables used in Payment Equations Section II.D.10 Induced Utilization Factor (IUF))

The proposed methodology to calculate the CSR applies an Induced Utilization Factor to account for increased use of health services resulting from the increased Actuarial Value from the CSR. The methodology assumes an Induced Utilization Factor of 1.12 for all BHP beneficiaries in all states, but the proposed rule allows that this approach may "understate or overstate the impact of the effect of the subsidies on health care utilization." We request that CMS allow states flexibility to use their own IUF if they are able to demonstrate that the BHP population in their state increased utilization of health care services by more or less than 12% as a result of their cost-sharing reductions. This will help the formula more accurately reflect the health care market and actual health care use in the state.

Incorporate Reinsurance payments in the BHP methodology as provided under section 1331(d)(3) of the ACA. (Discussion of Specific Variables used in Payment Equations Section II.D.)

Section 1331 (d)(3) of the ACA requires that the BHP Funding Methodology take into account factors relevant to determine the value of the premium tax credits. One of the factors explicitly mentioned in this Section is the "*Reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan…"* The reinsurance payments under the ACA are intended to mitigate the impact of potential adverse selection and stabilize premiums in the individual market. The reinsurance payments allow insurance carriers to set lower premiums, because the insurance carriers understand that there is a level of protection against unusually high-cost enrollees.

Given that the existence of reinsurance program has likely reduced individual market premiums with the potential for reimbursement for high-cost cases, we believe that the BHP funding methodology should have a corresponding payment factor, as provided for under section 1331of the ACA. We request that CMS provide a reinsurance payment using the same mechanism and conditions used in the individual market. In the absence of a state establishing a BHP program, an otherwise BHP-eligible, high-cost individual would be enrolled in an individual market plan. The individual market plan would be able to use the reinsurance payments to help support high-cost individuals. We urge CMS to make an equivalent payment as part of its BHP funding methodology.

Thank you for the opportunity to provide comments on this proposed rule, and for keeping consumers a priority as you continue your important work implementing the Affordable Care Act. If you have any questions regarding our comments, please contact me.

Sincerely,

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Washington State Health Care Authority

Report to the Legislature

FEDERAL BASIC HEALTH PROGRAM OPTION

Engrossed Second Substitute House Bill 2319
Chapter 87, Laws of 2012

December 1, 2012

Washington State Health Care Authority
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Executive Summary

The Patient Protection and Affordable Care Act (ACA) presents new opportunities to further partnerships between states and the federal Department of Health and Human Services (HHS) to make affordable, high quality health coverage available to low income individuals. Section 1331 creates state flexibility to establish a *federal* basic health program option (BHPO) for low-income individuals with income up to 200 percent of the federal poverty level (FPL), who are not otherwise eligible for Medicaid. Effectively, this federal option replaces subsidized coverage that would otherwise be available in the Health Benefit Exchange (Exchange), and relies on federal funding that would otherwise be used for those subsidies. Given the long pioneering history with a *state* Basic Health program in Washington State, interest in implementing a Washington BHPO remains high.

Section 15, Part VI, of Engrossed Second Substitute House Bill 2319, enacted as Chapter 87, Laws of 2012, and codified as RCW 70.47.250, directs the Health Care Authority (HCA) to submit a report to the legislature on whether to proceed with implementation of a BHPO. The report is required to address whether:

(a) Sufficient funding is available to support the design and development work necessary for the program to provide health coverage to enrollees beginning January 1, 2014;
(b) Anticipated federal funding under section 1331 will be sufficient, absent any additional state funding, to cover the provision of essential health benefits and costs for administering the basic health plan with premium levels below what enrollees otherwise would have paid in the Exchange; and
(c) Health plan payments will be sufficient to ensure enrollee access to a robust provider network and health homes.

In consultation with legislative policy and fiscal staff, on June 18, 2012, the HCA submitted a proposal to HHS for a "proof of concept" plan for a Washington state BHPO. The full proposal is included in this report as Attachment 1. It includes federal and state statutory references; it reviews the history of engagement between Washington State executive and legislative leadership and HHS, beginning in February 2012; and it highlights several elements for which federal technical assistance is essential to finalize design and assess the merits of proceeding with implementation (see shaded text box.)

Absent federal guidance and regulations for interpreting ACA requirements, we made many design assumptions in the proposal that would allow the BHPO to be implemented on January 1, 2014 as a viable insurance affordability program (IAP) and model for other states. Based on experience with the current Basic Heath program, we believed the approach to be generally workable, consistent with ACA provisions and able to demonstrate the value of the BHPO going forward. We endeavored to provide sufficient substance so that Washington could implement the BHPO pending release of formal federal guidance and regulation. We also hoped that the identification of gaps in critical design elements would inform a targeted HHS response and enable Washington State to achieve certification and approval of the BHPO design, which is required if we are to

Major questions not clearly addressed in the ACA but essential for designing a program that avoids additional state fiscal risk include:

- Federal approach to administrative funding and potential hold-backs
- Limitations to state fiscal exposure with 3 years hold harmless provision
- Projection of a silver-plan premium as the basis for the tax credit calculation and subsequent federal funding reconciliation
- Medicaid benchmark benefits design details
- Alignment of cost sharing subsidies and actuarial value between BHPO and the Exchange
- Allowable approaches to risk adjustment
- Criteria for validating American Indian/Alaskan Native status
- Need for BHPO managed care procurement, separate from Medicaid

move forward, by November 15, 2012. This is the latest date that would support completion of BHPO systems and business development, including integration with the Exchange, in time for open enrollment beginning October 2013 and BHPO coverage beginning January 2014.

Concurrent with the HCA's proposal to HHS, local advocates for BHPO employed the Urban Institute to conduct an independent analysis of the viability of a BHPO in Washington state. The analysis builds on the model previously used by the Urban Institute to estimate potential enrollment in Medicaid as a result of the ACA. It incorporates assumptions for desirable premiums and enrollee cost-sharing and take-up rates that reflect different levels of responsiveness to the ACA's individual mandate. The decision by eligible people to enroll takes into account out-of-pocket premiums and cost sharing, the risk of high health costs, and a family's disposable income[1]. Two different cost-sharing options were modeled[2].

- Package A provides coverage at 98 percent actuarial value with individual premiums set at $100 a year, representing approximately one percent of income for a single person at 133 percent of the FPL and less than one percent of income for larger families.
- Package B provides coverage with higher cost sharing at 94 percent actuarial value and premiums set at 2 percent of family income, as is the case for subsidized coverage in the exchange below 133 percent of the FPL.

The final report is included as Attachment 2. It finds that a BHPO would "likely be feasible in Washington State" with the caveat that a "final determination must take into account federal regulations that had not been issued at the time of writing.[3]" In general, it suggests that a Washington state BHPO "would cover about 100,000 lives, somewhat more with lower cost sharing and higher responsiveness to the individual mandate and somewhat fewer with higher cost sharing and lower responsiveness to the mandate."

Under the Package A high take-up scenario, the Urban Institute modeling estimates that about 105,000 people would enroll in the BHPO while only 96,000 would enroll in the Exchange without a BHPO available, a gain in coverage under the BHPO option of 9,000 lives more than would be enrolled through the Exchange. The higher cost sharing of Package B leads to slightly lower enrollment than in Package A, 103,000 in the high take-up scenario. Enrollees are also slightly younger in Package A - nearly 16 percent are between age 19 and 24, while just over 14 percent of Package B enrollees are in that age group.

In addition to the need for regulatory guidance, there are other sources of uncertainty noted in the report.

- Federal funding for premium subsidies in the BHPO are based on the second-lowest cost plan offered at the silver level (i.e., 70 percent actuarial value) in the Exchange but specific details will not be known until plan offerings and rates have been filed and approved by the Office of the Insurance Commissioner (OIC) in 2013.
- "Churning", the involuntary movement of individuals across insurance affordability programs when their income changes makes programs more costly to administer and interrupts continuity of coverage and care[4]. The potential impact of "churning" on enrollment, on financing, and on

[1] Buettgens, M. and Carroll, C. Urban Institute, "The ACA Basic Health Plan in Washington State: Eligibility and Enrollment." 2 March, 2012.
[2] These differ from assumptions made in Washington's proposal to HHS (see page 10 of attachment 1) which align with specific ACA parameters as closely as possible.
[3] For example, "exact projections for provider rates must wait for federal regulations on the exact computation of BHPO payments."
[4] For a national analysis that takes into account the presence of affordable offers of employer sponsored coverage, see Buettgens, M., Nichols, A., and Dorn, S. Urban Institute, "Churning under the ACA and State Options for Mitigation." 14 June, 2012.

opportunities for whole-family coverage through the same health plan and provider networks when circumstances of individual family members change, depends on federal guidance.

Given the importance of federal guidance and considering that no official communication from HHS was received in response to Washington's June BHPO proposal and request for technical assistance, in August a follow-up request to the Center for Medicare and Medicaid Services (CMS) was sent jointly from the HCA, the Office of the Insurance Commissioner (OIC), and the Exchange, to reiterate specific questions and concerns. This is included as Attachment 3. CMS did not respond to this follow-up request.

The most critical gaps for finalizing design and assessing the merits of proceeding with implementation of a Washington BHPO have significant implications for state fiscal risk, in the short and long term. These are summarized in the text box on page 3; they are described fully in our proposal (Attachment 1); they are consistent with many areas of uncertainty raised in the Urban Institute independent analysis and in a California HealthCare Foundation analysis of a BHPO in California (see www.chcf.org); and they reflect areas of common concern discussed by legislative and executive staff in a conversation with colleagues in Massachusetts.

Consequently, at this time, the HCA is unable to adequately assess the extent of funding available to support the design and development work necessary for the program to provide health coverage to enrollees beginning January 1, 2014. Neither can we determine with any certainty that federal funding will be sufficient to fully cover the provision of essential health benefits and costs for administering the BHPO, or that health plan payments will be sufficient to ensure enrollee access to a robust provider network and health homes. We remain concerned at the fiscal ramifications introduced by individuals whose income changes result in movement into and out of BHPO eligibility. For many of these individuals, "their final actual income for the calendar (taxable) year will differ from their projected income used to determine their eligibility, leaving considerable uncertainty about the amount of federal funding the state would receive for each person who enrolls in BHPO"[5].

As a result, on September 11, 2012, Governor Gregoire, in consultation with the legislative health committee chairs, Senator Karen Keiser and Representative Eileen Cody, placed the BHPO design and development project on hold. Community stakeholders sent a follow-up letter to HHS to confirm their "strong and enthusiastic support" for a Washington State BHPO and to encourage federal decision making. While HHS acknowledged Washington's interest and efforts to define an operational BHPO, no guidance was provided nor was any indication of when it might be available.

The decision not to proceed absent federal guidance has freed up resources to devote to successful implementation of other critical coverage pathways, including the Medicaid expansion and its interface with the Exchange-based "no wrong door" web-portal to subsidized coverage. The initial message to members of the legislative health care committees explaining the decision to suspend BHPO development is included as Attachment 4. Explanation has also subsequently been provided to legislative fiscal and policy committees and other stakeholders during presentations around the state and in testimony provided at legislative hearings September –October 2012. Materials are included on the HCA web site at: http://www.hca.wa.gov/hcr/me/stakeholdering.html.

Although we continue to hear from consumer stakeholders who oppose the decision to suspend our work, until federal guidance allows completion of analysis to determine otherwise, the only prudent path for Washington State is to not proceed with development of a Washington State BHPO. The magnitude and timing of further effort remains yet to be determined.

[5] Curtis, R. and Neuschler, E. Institute for Health Policy Solutions, "Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program in California." 2 September, 2011.

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
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June 18, 2012

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20101

Dear Secretary Sebelius:

The Affordable Care Act (ACA) presents new opportunities to further partnerships between States and the Department of Health and Human Services (HHS) to make affordable, high quality health coverage available to low income individuals. Section 1331 establishes the *federal* basic health program option (BHPO) as an alternative to offering certain eligible individuals coverage through the Exchange. In Washington State the BHPO continues to be an option under strong consideration, given a long history with our own *state* Basic Health program and its robust public support.

Based on our experience, we are submitting this proposal for a workable approach to BHPO implementation that is consistent with the statute and able to demonstrate the value of the BHPO going forward. We have endeavored to provide sufficient substance so that Washington could implement the BHPO pending release of formal guidance and regulation by CMS. We recognize that this is a novel approach, but believe that it strikes an appropriate balance between the major ACA implementation workload demands confronting HHS and our state's need to have the information it needs for the Legislature to determine whether BHPO will be implemented in Washington State by January 1, 2014. We welcome your initial reactions in August and ask for ongoing conversations that will enable us to reach certification and approval by November 15, 2012. This is the latest date that still will allow completion of BHPO systems and business development in time for open enrollment beginning October 2013 and BHPO coverage beginning January 2014.

Since 1988, the current *state* Basic Health program has provided coverage for many thousands of individuals for whom there were no alternative, affordable options. Over the past 18 months our partnership with HHS, through the Washington Transitional Bridge 1115 Demonstration, has been essential to sustaining this coverage option. At the same time it continues to inform detailed planning for the transition to 2014 when most Transitional Bridge enrollees will be eligible for coverage through Medicaid, the Exchange or a BHPO. With that in mind, during the recent 2011 Legislative session, the Governor and Legislature directed the Health Care Authority to submit a report by December 1, 2012, with recommendations on whether to proceed with the implementation of a BHPO. Their goal is to leverage our experience with the current Basic Health program as affordable coverage for low-income individuals.

Consistent with guidance provided in the Exchange Rules and Regulations of March 27, 2012, our preliminary design supports Washington's BHPO by leveraging operational functionality already being developed for the Exchange. For example, we expect that eligibility determination, plan selection and financial management for the BHPO will use a common Information Technology and business rules infrastructure. Detailed design discussions are occurring with our systems integrator vendor this month to finalize specifications for further development that will begin in July. During the 2013 Legislative session, concurrent with systems development, Washington's Governor and Legislature must make their final policy and funding decision on proceeding with a BHPO.

Your response to our proposal will be the key factor in that decision and will greatly inform our efforts to design and develop a BHPO that is consistent with Congressional intent and formal guidance yet to be published. I would appreciate the opportunity to discuss this further with you and your staff, and respectfully urge your immediate attention to our proposal.

Sincerely,

Doug Porter
Director

Enclosure

cc: The Honorable Christine O. Gregoire, Governor's Office
The Honorable Eileen Cody, House Health Care and Wellness Committee
The Honorable Karen Keiser, Senate Health and Long Term care Committee
Cindy Mann, Director, Centers for Medicare and Medicaid Services (CMS)
Jonathan Seib, Executive Policy Advisor, Governor's Office

Washington State Proposal

for a

Federal Basic Health Option

June 18, 2012

Washington State Health Care Authority

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Background and Goals

Section 1331 of the Patient Protection and Affordable Care Act creates state flexibility to establish a *federal* basic health program option (BHPO) for low-income individuals up to 200% of the federal poverty level (FPL), who are not otherwise eligible for Medicaid. The BHPO is an alternative to the Exchange for certain eligible individuals and continues to be an option under strong consideration in Washington state.

This document presents Washington's proposal for operationalizing the BHPO requirements embedded in section 1331 of the ACA. Appendix A provides a cross walk of section 1331 to applicable references in the proposal. Absent guidance and regulations for interpreting ACA requirements we have identified an approach we expect would allow the BHPO to be implemented on January 1, 2014 as a viable insurance affordability program (IAP) model. In effect, this is a proof of concept plan that highlights several areas for which CMS technical assistance would be critical to finalize the design and proceed with implementation.

Current State Basic Health Program

Since its inception in 1987, there has been broad legislative, executive and stakeholder support for the current *state* basic health program (Basic Health), for individuals up to 200% of the FPL. Today's program covers nearly 35,000 adults through managed care entities that also serve the Medicaid population. In its 25-year history, enrollment has been as large as 136,000 individuals, and today there is a waiting list of over 166,000 due to an enrollment freeze necessitated by budget reductions.

The historic success and popularity of Washington's Basic Health program informed Senator Maria Cantwell's involvement in development of the ACA. Like many Basic Health supporters she believes that Basic Health is a mechanism to provide comprehensive, cost-effective coverage to low income individuals and families not eligible for Medicaid, and that it could be a model for other states.

Since January 1, 2011, Basic Health has been financed through the Transitional Bridge, an 1115 demonstration waiver that allows Washington to sustain subsidized coverage, with the support of federal financing, until the full expansion of the Medicaid program takes effect in 2014. At that time, individuals with family incomes up to 133 percent of the federal poverty level (FPL) will be covered under the Medicaid State plan; those with incomes between 133 and 200 percent of the FPL would receive subsidized coverage in either the Exchange or the *federal* basic health option if it is available. Without the Transitional Bridge, Washington's fiscal crisis would have undoubtedly resulted in the elimination of the Basic Health program. Instead, it continues to be a platform through which Washington is learning and preparing for the 2014 transition. Approximately 75 percent of current enrollees can be expected to transition to the expanded Medicaid program and the remainder would predominantly be eligible for coverage via the BHPO.

Further details of the current program are available at www.basichealth.hca.wa.gov.

Federal Basic Health Program Option (BHPO)

Beginning in 2014, the BHPO provides an opportunity, through active state purchasing of coverage, to offer essential health benefits on an affordable basis to individuals with incomes between 133 and 200 percent of the FPL. As a result of the 5% income disregard applied in the determination of Medicaid eligibility, the BHPO income range would effectively be 138-200 percent of the FPL. This is the range used throughout the rest of this document. Individuals and families in this income range have limited discretionary income, making them highly price sensitive with respect to obligations for monthly premiums and out-of-pocket cost sharing. In addition, active state purchasing through managed competition encourages innovations to improve the quality of care provided to these enrollees.

Availability of the BHPO could help avoid the steep eligibility "cliffs" between effectively "free" Medicaid coverage and qualified health plans offered through the Exchange, which will carry a significant premium responsibility.

Consistent with section 1331 of the ACA, Washington State's goal in requesting approval of this BHPO approach is to:

- Ensure that BHPO consumers receive less costly and equally generous coverage than they could have obtained in the Exchange;
- Build a state/federal financing methodology to support reliable and predictable funding that will cover BHPO costs, assuming an efficiently administered program;
- Ensure that federal costs, per BHPO enrollee, are less than the federal costs that would have been incurred in the Exchange for tax credits and out-of-pocket cost-sharing reductions;
- Safeguard low-income consumers' access to coverage and care, while being mindful of the current Washington State coverage context[i];
- Leverage Washington's long history and robust public support for serving low-income populations through managed competition; and
- Enhance opportunities for common data collection to better understand and improve the value of coverage purchased for low income populations.

To this end Washington's proposed BHPO meets ACA requirements and is enhanced by the flexibility made available for design elements such as benefits, premiums, point of service cost-sharing and provider rates. In combination with the state's purchasing leverage, this flexibility is key to implementing more affordable coverage for a very cost sensitive population.

Washington's Proposed Basic Health Program Option

1. Administration

Governance and Administrative Infrastructure

The Health Care Authority (HCA) is Washington State's "Single State Agency" responsible for administration and supervision of the Medicaid program. The HCA is also responsible for purchasing state employee benefits and oversees the Transitional Bridge waiver programs, including Basic Health. A single procurement was recently completed for Medicaid, CHIP and Basic Health coverage effective July 2012.

For maximum continuity and administrative alignment, we anticipate that the HCA will be responsible for governance of the federal BHPO. The HCA is the state's largest health care purchaser with significant experience coordinating with local delivery systems and responding to the health care needs of low income populations. Operational linkages across programs have been developed to maximize seamlessness as individuals, pregnant women and children in particular, move across programs when their eligibility status changes. Through the current Transitional Bridge waiver, individuals who are determined eligible for Medicaid coverage are transferred from the current Basic Health program and constitute a priority population for purposes of re-enrollment in Basic Health if their Medicaid eligibility circumstances change.

We recognize that development of an *operational* BHPO infrastructure is Washington State's responsibility. With respect to seamless linkage with the Exchange, ACA establishment grants awarded to Washington have provided an occasion to maximize efficiencies and positive consumer experience by developing an Information Technology infrastructure that supports eligibility and enrollment for seamless connectivity among the Exchange, BHPO, and Medicaid/CHIP programs.

The State Legislature, through enactment of HB2319[ii], authorized approximately $2 million to "*support the design and development work necessary for the program to provide health coverage to enrollees beginning January 1, 2014.*" Appendix B presents the statutory direction for development of Washington's BHPO. Included is the requirement that the director of the Health Care Authority "*submit a report to the legislature on whether to proceed with implementation of a federal basic health option."* This report is required on or before December 1, 2012 and hinges on the details of the federal response to Washington's BHPO proposal. As described in the cover letter, certification and approval of Washington's BHPO would be needed from the Department of Health and Human Services (HHS) by November 15, 2012, to facilitate timely recommendations to the Legislature and Governor, and ensure that viable systems infrastructure and business processes can be in place to support BHPO coverage beginning January 2014.

The BHPO Trust Fund

As directed by the ACA, Washington would establish a trust fund into which federal BHPO payments would be deposited for the purchasing of health coverage provided to BHPO enrollees. These funds would not be used to meet the matching requirements of any other federally-funded program such as Medicaid or CHIP. They would be used to "*reduce the premiums and cost-sharing of, or to provide additional benefits*" for BHPO enrollees only.

We propose that funds also be used to administer the BHPO at the state level as requested in the letter to Secretary Sebelius, dated February 7, 2012, and included in Appendix C. Consistent with current operation of the CHIP program,[iii] this would mean that no more than 10 percent of federal BHPO funds would be used for administrative expenses needed for BHPO program operations. Administrative costs for operating the current Basic Health program are a useful yardstick, budgeted at less than 5 percent in recent years as a result of efficiencies such as the joint procurement of Basic Health and Medicaid

managed care delivery systems. This approach is no different than the application of advanced premium tax credits to support the administration of the Exchange, given that individuals have capped premium obligations.

Once the BHPO is operational and stable, we propose that trust funds provided for a particular year be used to finance health coverage provided to BHPO enrollees during that year. This would allow Washington to consider holding back a portion of the estimated BHPO payments to managed care plans that offer BHPO coverage pending final determination of federal payment levels. For this to be acceptable to CMS we would ensure that:

- Any "hold back" amount is reasonably related to uncertainties about federal payment levels;
- Any "hold back" amount is paid promptly, with interest, once it has been adjusted to reflect final determination of federal payment levels; and
- The payment method is structured to benefit BHPO enrollees.

We would also wish to retain flexibility to build administrative expenses into premium calculations in the future so that the BHPO Trust Funds could ultimately be fully directed to elements of coverage for BHPO enrollees. Final design of the Exchange sustainability model will also need to consider potential administration fees, but no decision has been made at this time. A final decision related to administration of the BHPO would ideally be informed by future decisions made by the Exchange board or Legislature.

2. Eligibility

Target Population

The population targeted for BHPO coverage includes Washington residents up to 200% of FPL who are under age 65 and not eligible for Medicaid coverage but who would otherwise be eligible for an advanced premium tax credit in the Exchange. Because seamless coverage for children up to 300% of the FPL is available in Washington state through Apple Health for Kids[iv], Washington's BHPO would not be a program for children. Potential enrollees would include:

- Currently uninsured parents and childless adults with incomes between 138-200 percent of the FPL (citizens and documented immigrants);
- Parents and childless adults currently enrolled in the Basic Health program, with incomes between 138-200 percent of the FPL (i.e., higher income enrollees in the Transitional Bridge demonstration waiver);
- Currently uninsured, documented parent and childless adult immigrants not eligible for Medicaid, with incomes under 138 percent of the FPL;
- Parents and childless adults with incomes between 138-200 percent of the FPL and currently enrolled in the individual market;
- Parents and childless adults with incomes between 138-200 percent of the FPL whose employers choose to not offer coverage or whose coverage is not affordable (i.e., they would have to pay premiums that total more than 9.5% of income, or their employer pays less than 60% of the cost of coverage).

We would expect promising take-up given our experience with the current Basic Health program and the likelihood that BHPO premiums and out of pocket cost sharing would be somewhat lower in the BHPO[v]. Estimates reported by the Urban Institute[vi] suggest about 160,000 individuals could be eligible for coverage through BHPO. Subsequent analysis estimates a range of 75,000 – 103,000[vii] of those eligible would be likely to actually enroll based on cost sharing at 94% actuarial value and premiums at 2% of income. Take-up estimates are sensitive to price and thus highly dependent on the establishment of

premiums and cost sharing for the BHPO, which cannot be determined until more is known about the cost of the second lowest cost silver benchmark plan in the Exchange.

Eligibility Determination Methodology

The development of Washington's Exchange has centered on a fundamental requirement that the "consumer experience" be seamless and informed, regardless of the coverage financing source. Guidance included in the final March 2012 Exchange rules[viii] looks for development of procedures, electronic interface and a single streamlined application through which low-income individuals can ultimately be enrolled in the subsidized coverage available. Specific references excerpted from the March 27, Federal Register are included in Appendix D.

As previously reported to CMS, the HCA envisions a single, streamlined, electronic application for individuals who apply for an insurance affordability program (Medicaid, CHIP, BHPO or APTC) through the Exchange[ix]. In general, the Exchange eligibility portal is planned as the single door for application, verification, eligibility determination and renewal processes. The streamlined electronic application process will be efficient and will leverage automated processing to support the quality assurance function. Although states may implement the application to be developed by HHS, timing of its availability is uncertain. Application design and development specifications are needed quickly for the Exchange and new rules engine to meet an October 2013 implementation date for coverage beginning January 2014. Washington is therefore designing its own application recognizing that eligibility methodologies for Washington's BHPO must be consistent per section 155.345 (g) of the federal register rules and regulations, referenced in Appendix D.

By virtue of the common eligibility door, modified adjusted gross income (MAGI) methods for determining income, household composition and family size would be consistent; theoretically and practically. Excerpted from guidance by the Centers for Medicare and Medicaid Services, May 17, 2012, definitions that would apply to all IAPs, BHPO in particular, include:

- MAGI = Adjusted Gross Income plus any foreign earned income excluded from taxes; tax-exempt interested and tax-exempt social security income;
- Family = taxpayer, which includes married taxpayers filing jointly, and all claimed tax dependents;
- Family size = number of individuals in the family; and
- Household income – the sum of the taxpayer's MAGI plus the MAGO of tax dependents in the family who are required to file.

To avoid overlapping eligibility between Medicaid and the BHPO, we would apply the same income disregard of 5 percent of the FPL that is applied to the Medicaid program. In effect, the BHPO would therefore provide coverage for eligible low income individuals with income between 138 and 200 percent of the FPL. Aligned with eligibility policy for the Exchange (above 200 percent of the FPL) and Medicaid (below 138 percent of the FPL), insurance affordability would be continuous, i.e., MAGI-based eligibility for IAPs would extend without interruption from 0 to 400 percent of the FPL.

In its capacity as a subsidized coverage option for individuals who have no alternative affordable option, the BHPO would not be available to individuals who already have employer sponsored coverage or who are eligible for some other affordable coverage option. Unlike coverage through the Exchange, the BHPO would not be available for anyone to choose to buy-into and pay the full cost. We believe that this approach is consistent with the intent of the ACA.

Anticipated Churn

There is widespread concern in Washington state that dynamic changes in income, employment and family composition (including pregnancy) will trigger shifts in coverage eligibility, in particular between

Medicaid and the Exchange. Where Medicaid managed care organizations and their associated provider networks differ from Exchange or employer coverage, significant problems occur from such "churn". They include:

- Discontinuity of provider relationships and care, with associated quality and cost problems, including the undermining of medical homes;
- Distress, inconvenience, and confusion for enrollees/patients whose access to care is compromised;
- Increased administrative expense for managed care organizations as enrollees disenroll and reenroll frequently;
- Reduced incentives/cost-effectiveness for managed care organizations and providers to invest in longer-term health improvements for individuals whose coverage duration is disrupted or intermittent; and
- Reduced affordability of coverage for some tax-credit eligibles, particularly those whose resources are already depleted and whose current income increases[x].

With the assistance of the Institute for Health Policy Solutions, we conducted extensive analysis of the potential implications of this phenomenon. Longitudinal data on income and health insurance were selected from the United States Census Bureau's Survey of Income and Program Participation for a Washington sample of adults age 19-64. Eligibility was simulated for income ranges under an ACA definition, to measure the degree to which individuals in different income ranges retained the same cover status over time.

Given fluctuations in wages, incomes and family circumstances, table 1 indicates that a little over 30% of individuals whose income would have placed them in Medicaid at the beginning of the year (i.e., under 138 percent of the FPL) would have not been eligible for Medicaid at the end of the year[xi]. We expect that income churning will be particularly acute for people whose income (eligibility status) fluctuates between the Exchange and Medicaid over time.

For example, individuals who cross over the Medicaid threshold from one year to the next are about 3 times as likely to go back to their original income range in the third year, compared to the likelihood that individuals who stayed in the same income range for the first two years will cross the threshold in the third year. In addition, it appears that over 2-3 years the population that actually stays in the 138-200 percent of the FPL range is virtually nonexistent. This is a fairly dynamic group for whom eligibility churn has important implications for continuity of affordable coverage.

Individuals meet an affordability "cliff" as they move across the Medicaid income threshold, at which they have no cost-sharing obligations, to new coverage options in which cost sharing and premiums could dampen enthusiasm for enrollment (e.g., in the Exchange). Conversations with managed care organizations and stakeholders confirm that there are few approaches to *fully* resolve the implications of churn for consumers, providers and managed care organizations. We are continuing to discuss a variety of options to increase the continuity of coverage for individuals and family members whose circumstances result in churn. The opportunity to reduce the impact of churning at the 138 percent of FPL level is an appealing feature of the federal BHPO. Recent research has shown that moving the churn threshold to 200% of FPL through the federal BHPO could reduce the population churning between Medicaid and the Exchange by up to 4%[xii]. The expectation is that, as in the current Basic Health program relationship with Medicaid, individuals would be able to keep their same providers and managed care organizations as their income fluctuates above and below Medicaid eligibility levels.

In addition we remain interested in the option for continuous enrollment of adults in a Medicaid or BHPO managed care organization to mitigate eligibility churning. And we are interested in the potential opportunity for the Exchange to certify Medicaid managed care options (or possibly BHPO plan

offerings) as limited qualified health plans in the Exchange that are open only to Medicaid/BHPO enrollees whose changing circumstances move them over the 138 percent or 200 percent of FPL thresholds. Experience with the current Basic Health suggests that a BHPO would effectively mitigate the implications of movement across IAPs below 200% of the FPL where income stability and resources are the most in question.

Whatever the construction of IAPs in Washington state, additional policies will be needed to mitigate and contain churn to ensure a positive and seamless experience for the consumer in a new continuum of coverage. Most importantly, Washington cannot make an informed decision on churn policy solutions or the BHPO option itself without specific federal approval and the timely technical assistance requested in this proposal.

Table 1:

Actual Annual Income for Enrollment Year v. Income at Initial Determination
NO Employer-Sponsored Insurance (ESI) at Initial Determination
Adults Age 19-64, WASHINGTON STATE

Row Percent	[---------- Final FPL Range ----------]					
Initial FPL Range	**<139% FPL**	**139%-200% FPL**	**201%-400% FPL**	**>400% FPL**	**TOTAL**	**Pop'n Count (millions)**
<139% FPL	68.9%	11.2%	12.5%	7.4%	100.0%	0.73
139%-200% FPL	33.0%	24.2%	35.8%		100.0%	0.14
201%-400% FPL	15.8%	14.2%	54.2%	15.7%	100.0%	0.28
>400% FPL	13.5%	8.1%	38.0%	40.3%	100.0%	0.16
TOTAL	47.0%	12.9%	27.0%	13.1%	100.0%	1.30

Source: IHPS analysis of churn conducted for Washington state, May 2012.

3. Delivery System Contracting

Application of 2012 Contracting Process

The ACA identifies important objectives for BHPO contracting, including a competitive process, innovation in care delivery, allowances for health and resource differences, managed care, performance measures, multiplicity of health plans, and coordination with other state programs. Strategies for advancing these objectives have been tested through the increasing alignment of purchasing requirements for Washington's Medicaid and current Basic Health programs.

For coverage that will begin July 2012, a competitive joint procurement process resulted in contracts being awarded to five managed care organizations that will offer coverage to enrollees in the Medicaid, CHIP and current Basic Health programs. Provider network adequacy standards are set, reviewed, and carefully monitored by the HCA. The 2012 procurement process established the baseline for managed care organizations that we anticipate will continue to provide coverage for these low income populations in 2014. Details of the entire competitive procurement process are available at http://www.hca.wa.gov/procurement.html.

Contracts that govern coverage for the Medicaid/CHIP (i.e., Healthy Options) and current Basic Health delivery systems have been reviewed and approved by CMS as part of determining operational readiness for a July 1, 2012 implementation. In general, these contracts include the high standards for Medicaid managed care plans set out in section 1903(m) of the Social Security Act.

We anticipate that final contracts for the 2012 procurement will undergo a renewal process for 2014. As is the case with all contract renewals, opportunities exist for changes in payment rates, benefits covered, and new performance metrics. The 2012 procurement was designed to meet all the objectives provided in Section 1331 of the ACA and will obviate the need for an additional procurement exercise prior to January 1, 2014. Not only is the 2012 procurement the baseline for 2014, but its joint nature will effectively test Medicaid /CHIP and BHPO managed care organizations' delivery systems alignment, and will enable Washington state and its managed care partners to make any necessary adjustments and improvements prior to the implementation of the BHPO.

Alignment with the Exchange

To minimize uncertainties related to federal financing as described in section 5, Washington proposes to align the timing of critical BHPO operational elements with those of the Exchange, such as open enrollment in particular. For coverage beginning January 2014, BHPO open enrollment would occur in October – November 2013.

In addition, although a coordinated strategy has not been determined, we might consider requesting an Exchange qualified health plan certification process that obtains alternative rates for products in the Exchange with and without participation of the BHPO. This would allow the State to adjust BHPO elements in response to unanticipated Exchange results; for example, if very low rates were to be associated with the benchmark, silver level plan.

Innovations

Current 2012 contracts for the Medicaid managed care and Basic Health programs set the stage to test ACA innovation expectations prior to 2014. For example, the current 2012 procurement incorporates extensive requirements for performance measurement, care management through advancement of health home networks[xiii] and expectations for delivery of specific health home services, and preventive service incentives. We would expect these innovations to continue with managed care organizations leveraging their experience over the next 18 months to prepare for the Medicaid and BHPO expansions in 2014.

4. Benefits Package

Flexible Benefit Design

Consistent with the ACA, Washington's BHPO will cover all essential health benefits (EHBs)[xiv] and will not charge enrollees more in premiums or out-of-pocket costs than would have applied had the individual been covered through the Exchange. Our goal is to minimize confusion and ensure continuity of care when individuals churn into BHPO coverage as their circumstances change - up from Medicaid or down from the Exchange for example. For the foreseeable future we would expect to offer one "standard health plan" through multiple managed care organizations since it would not be administratively feasible to attempt multiple standard health plans from the get-go.

BHPO Covered Services

Although the current Basic Health program provides a Secretary-approved benefit package targeted to the Transitional Bridge waiver population, we recognize that it does not meet the requirements of Medicaid benchmark or an EHB reference plan under the ACA[xv] and therefore would not be applicable to the BHPO.

We are continuing to look at the potential alignment of BHPO benefits with EHBs, Medicaid standard benefits, and Medicaid benchmark options defined by the Deficit Reduction Act of 2005 (DRA). The latter include three plans from which we could select one (or more) EHB reference plan(s):

- The standard Blue Cross/Blue Shield PPO service plan under the Federal Employees Health Benefits Program (FEHBP);
- A generally available state employee plan, such as the Uniform Medical Plan offered by Washington state's Public Employees' Benefits Board (PEBB); or
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state (Washington state's Group Health master contract).

We are interested in an administratively efficient and affordable BHPO design that would result in more consistent and consumer-oriented transitions across IAPs for individuals with incomes under 200 percent of the FPL. It is not our intent to cover services in the BHPO beyond those defined as EHBs. However, to finalize the BHPO benefits' design we will need technical assistance to reconcile ambiguities in service requirements among EHBs, Medicaid standard and Medicaid benchmark options. This will be essential for any state wishing to make a BHPO available with a benefit design that is not more expansive than standard Medicaid coverage which would make it unaffordable or considerably different from what is familiar. For example:

- If a service is included in an EHB reference plan it would seem, by definition, that it is a required service in Medicaid benchmark coverage and the BHPO. However, if the service is not traditionally mandated in the state's Medicaid State Plan, (e.g., chiropractic care) must it still be included in Medicaid benchmark coverage and the BHPO? This could potentially establish a situation where the lowest income individuals receive fewer benefits in standard Medicaid coverage than individuals enrolled in Medicaid benchmark , the BHPO or the Exchange. Washington would want to avoid such inequities, especially because they would exacerbate consumer confusion across IAPs.
- Mental health and substance abuse disorder services are included among the 10 ACA-required services that must be included in EHBs and therefore in Medicaid benchmark coverage. Currently federal Medicaid does not allow coverage of services provided to patients of institutions for mental disease (IMDs). If EHB reference plans include IMD coverage must the BHPO (and Medicaid benchmark) follow suit even though this would seemingly be in conflict with requirements for standard Medicaid? This same question arises for room and board for alcohol and substance abuse detoxification. In addition to the coverage confusion, the financial implications for the federal and state governments are potentially substantial.

BHPO Cost-Sharing Reductions

The ACA also contains ambiguities regarding the maximum amount of cost-sharing that can be charged and the minimum actuarial value that must be provided to BHPO enrollees. Subsection (a)(2)(A)(ii) references the gold- and silver-level actuarial value standards that, when section 1331 was being added to the ACA, represented the cost-sharing reductions for enrollees in the Exchange with incomes of 100 to 150 percent FPL and 150 to 200 percent FPL, respectively.[xvi] Congress' clear intent was that BHPO enrollees not pay more, in premiums or in out-of-pocket cost-sharing, than they would be charged if enrolled in the Exchange. While we assume it was not intended, the ACA established two different versions of cost-sharing reductions, for the BHPO standard populations and the Exchange, as shown in table 2.

Table 2: Cost Sharing Reductions

Income Range	BHPO	Exchange
Under 150% FPL	Based on 90% actuarial value of Exchange platinum plan	Based on 94% actuarial value of Exchange 2nd lowest cost silver plan
150-200% FPL	Based on 80% actuarial value of Exchange gold plan	Based on 87% actuarial value of Exchange 2nd lowest cost silver plan

Unfortunately, the discrepancy between what the ACA says and what was presumably intended would result in a situation where individuals enrolled in the BHPO could have greater cost sharing contributions than if they were enrolled in the Exchange. In addition, operational complexities and confusion would be generated for enrollees, managed care organizations, and care providers through the existence of two different cost sharing methodologies for subsidized populations.

To minimize the impact, we propose to establish a single cost sharing approach for BHPO enrollees, not less than 92 percent of the actuarial value of the 2nd lowest cost silver plan in the Exchange. In addition, no BHPO enrollees would receive coverage with annual out-of-pocket limits higher than the amounts permitted nationally for individuals with comparable income levels.[xvii] We believe that this provides a balanced approach to cost sharing that is operationally efficient and more closely aligned with the ACA intent.

As with cost-sharing subsidies in the Exchange, BHPO's cost-sharing subsidies would prevent enrollees from incurring health care costs above specified levels, rather than reimburse low-income enrollees for out-of-pocket spending that exceeded applicable limits. However, until there is a federal actuarial value calculator available based on the national standard BHPO health plan, we are unable to propose a definitive cost sharing design for the BHPO. Based on experience with our current Basic Health program we would anticipate that a cost sharing structure under the BHPO would look similar to the current Basic Health structure, however we recognize that refinements would be needed to meet the actuarial value standard we propose. In addition, we would hope to design cost sharing details around value-based principles.

Since the inception of the Basic Health program, cost sharing at the point-of-service has been an explicit policy decision, designed to encourage efficient utilization of appropriate services and shared financial responsibility. All enrollees have been subject to the same requirements, ensuring administrative consistency and clarity for managed care organizations and Basic Health enrollees. To provide context for the BHPO cost sharing design, cost sharing under the current Basic Health is shown in table 3. While it has changed over time, as shown in table 4, the distribution of the enrollees across income bands has shown no impact from the changes.

Table 3: Current Basic Health Cost Sharing Components

Coinsurance, deductibles and annual out-of-pocket maximum:

- Enrollees are responsible for a $250 annual deductible.
- Once that is met they pay a 20 percent coinsurance on select services, e.g., inpatient and outpatient hospital services, inpatient mental health, ambulance services, up to an out-of-pocket maximum of $1,500 per person.

Additional copayments are not subject to the deductible:

- A $15 copayment applies to office visits but no co-pay is required for preventive services, to encourage routine physicals, immunizations, PAP tests, mammograms and other screening and testing provided as part of a preventive care visit.
- A $100 copayment applies to non-emergent use of hospital emergency rooms or out-of-area emergency services, but there is no copayment if the individual is admitted.
- A $10 pharmacy copayment (or less where drug costs are lower) applies to the utilization of generic drugs in each managed care organization's preferred drug list (formulary). For brand name drugs the copayment is 50 percent of the drug cost. The intent has been to encourage utilization of cost-effective generic drugs that are therapeutically equivalent to more expensive brand name drug options.

Table 4: Evolution of current Basic Health Cost Sharing

Time Period	No POS Cost Sharing	Copayments (not subject to deductible or OOP Max)	Deductible and Coinsurance up to Annual Out-of-Pocket Maximum
Prior to 2004	• Preventive care • Maternity care (provided through Medicaid) • Oxygen	• $10 – office visits, hospital outpatient visits • $100 per hospital admission (up to $500 annual maximum) • Pharmacy: – tier 1 $3 (e.g., generic in formulary) – tier 2 $7 (e.g., generic alternative) – tier 3 50% drug cost (formulary brand name)	• No deductibles or coinsurance
2004-2009	Same	• $15 – office visits, hospital outpatient visits • $100 per non-emergency hospital visit (i.e., no admission) • Pharmacy - previous tiers 1-2 combined – tier 1 $10 (e.g., generics) – tier 2 50% drug cost (formulary brand name)	• $150 deductible introduced Once deductible met: • 20% coinsurance – hospital inpatient, ambulance, chiropractic/PT, CD, organ transplants • $1,500 Annual OOP maximum
2010-current	Same	Same	• $250 deductible • Same coinsurance and annual OOP maximum

An individual whose changing circumstances result in churning across IAPs may trigger the restart of cost sharing obligations if their choice of managed care organization changes (or is simply unavailable in the new IAP they find themselves). If a coverage change results in the selection of a new managed care organization, we would anticipate that any annual out-of-pocket or deductible calculations would start over. This is an area in which technical assistance is needed to align BHPO requirements with those of the Exchange, given that federal guidance is not yet available.

BHPO Premium Contributions

Current Basic Health premiums vary by family size, age, income and managed care organization choice. All enrollees bear the responsibility of contributing toward the cost of their health coverage based on

their ability to pay. Enrollee premiums are based on a sliding scale with contributions determined at the mid-point of the income band in which the enrollee's income falls and defined relative to a "benchmark" managed care plan available in all Washington counties. Enrollees with higher incomes pay a higher percentage of the total premium cost and a higher proportion of their income. Premium contributions in effect as of July 2012 and details for the benchmark 40-54 year old as a percent of median income, are included for reference purposes in Appendix E.

To provide perspective on the maximum premiums defined by the ACA for the BHPO, table 5 uses the Kaiser Family Foundation subsidy calculator to back into premium estimates based on annual income that corresponds with income bands. Income bands would continue the current Basic Health program marketing strategy for simplifying premium determination for individuals shopping for Basic Health coverage. These bands form the underlying construct of "You-Pay" tables that allow individuals to easily determine premiums based on their personal circumstances. Maximum premiums under the ACA are considerably lower than those shown in Appendix E for current Basic Health enrollees with incomes below 200 percent of the FPL. Washington would like to consider a mechanism for income banding premiums in the BHPO similar to that in operation today under the Basic Health program. Premiums paid to individual enrollees are pegged to the midpoint of the applicable income range, under the assumption that individual incomes progress through each band – in both directions – as employment options change.

Table 5. Maximum BHPO Premiums as a Percent of Income for a Single Adult Age 40, 2014
(Based on the Kaiser Family Foundation health reform subsidy calculator)

ACA-Based Income band	FPL	*Approximate* Person/Family Maximum Annual Required Premium	Premium as % of *Maximum* Income	Approximate Annual Income
A	0-138%	~$526	3%	$16,000
	Midpoint 69%	~$158	2%	$7,900
B	139-154%	~$739	4.2%	$17,700
	Midpoint 147%	~$645	3.82%	$16,900
C	155-169%	~$955	4.9%	$19,500
	Midpoint 162%	~$844	4.54%	$18,600
D	170-184%	~$1,182	5.6%	$21,200
	Midpoint 177%	~$1,072	5.26%	$20,400
E	185-199%	~$1,433	6.3%	$22,900
	Midpoint 192%	~$1,312	5.94%	$22,100

Tribal Cost Sharing

Although the ACA is silent with respect to cost sharing applicable to the American Indian/Alaska Native (AI/AN) population, we would expect to honor ACA expectations for the Exchange. Individuals determined to be AI/AN would be exempt from point of service cost sharing, but would be required to pay premiums.

As for the current waiver and for operationalizing the requirement in the Exchange, technical assistance will be needed to correctly define a common AI/AN definition that applies across all IAPs. To meet terms and conditions of the Transitional Bridge waiver for the current Basic Health program we conducted a workgroup exercise in partnership with the Washington American Indian Health Commission in early 2011. Discussions focused on the definition of American Indian/Alaska Native (AI/AN) at 25 USC 1603(c), 1603(f), or 1679(b), or who has been determined eligible as an Indian, pursuant to 42 CFR 136.12. This

drives the identification and tracking of individuals for whom cost sharing exemptions apply. Appendix F documents the workgroup's progress pending technical assistance from CMS to finalize. It clarifies the federal definition of an American Indian/Alaska Native Indian, and identifies an array of official documents that would support an individual's claim to be an Indian.

5. Financing

BHPO Payment Determination

For the BHPO to be a viable and sustainable coverage choice in Washington state (or any state), federal funding would need to be predictable and stable. The ACA bases BHPO funding on the amounts the federal government would otherwise have spent on tax credits and cost-sharing reductions for the second lowest cost silver-level plan in the Exchange. We understand this to include 95 percent of the advance premium tax credits plus 100 percent of the out-of-pocket cost-sharing reductions that would have applied.

The cost of the second lowest cost silver-level plan available in the Exchange provides the basis for determining the value of the advance premium tax credits for BHPO enrollees. Since it is possible for the design of this silver-level plan to be leaner than anticipated, margins for BHPO affordability and viability could turn out to be limited. However, we will not know these details until 2013. If we wait until then to begin BHPO systems design and development in earnest we will lose any ability to establish an operational program by 2014 and forego the opportunity to leverage development that would be the foundation of a full array of seamlessly coordinated IAPs in the future.

The value of the cost-sharing reductions would need to be estimated by the federal government, based on available information. It is conceivable that various methodologies would be feasible, similar to the array of methodologies proposed by HHS as an alternative to a per enrollee determination of the claimable FMAP for MAGI-eligible Medicaid enrollees. However, until alternatives could be tested, a *prospective* calculation, determined on a per capita basis and not capped at any aggregate level, would be ideal.

In the Exchange it is possible to make monthly payments to managed care organizations based on their estimate of the cost of applicable reductions[xviii] and then reconcile payments at the end of each year based on actual cost-sharing reduction expenses incurred. For the BHPO, an alternative approach would clearly be necessary. As is the case today in the Basic Health program, the BHPO would not include any direct payments from the federal government to individual managed care organizations. Instead, federal payments would be made to Washington's state's BHPO (i.e., the BHPO Trust Fund), and payments to BHPO managed care organizations would be made by the state's BHPO program[xix].

We therefore propose a BHPO payment determination based on the following high-level description of steps:

1. **First Quarter Estimate**: Washington State would develop a *preliminary* estimate of BHPO payments for the coming year, based on a methodology to be developed by the Secretary of HHS to ensure equity across all states' BHPO programs. This methodology would:
    - Estimate the number and characteristics of individuals eligible for the BHPO, using the best national survey data with state-specific estimates[xx].
    - Include a model (e.g., formula) for Washington to calculate the average, per capita BHPO payment (with separate premium and cost-sharing reduction components) and the BHPO enrollment level that could be expected to result from:
        - The cost of the second-lowest-cost silver-value plan in the Exchange;

- Factors affecting subsidy levels in the Exchange (e.g., whether premiums vary based on tobacco use);
- Policy design factors that could influence individual decisions to purchase BHPO coverage (e.g., level of premium and potential cost sharing contributions).

- Be flexible enough to accommodate relevant experience with IAPs in Washington state including the current Basic Health program that has operated since 1988.

2. **Preliminary Payment**: Once the Secretary approves the BHPO payment estimate, a preliminary payment to fund premiums for the first quarter of the managed care organizations' BHPO contracted plan year (i.e., January – December) would be transferred to Washington's BHPO Trust Fund. Aligned with open enrollment in the Exchange, this initial payment would need to be made to the State in the year prior to the applicable BHP funding year to ensure that managed care organizations are paid for coverage that would begin in January.

3. **Post Open Enrollment Adjustment:** Once the open enrollment period ends, the State would adjust its estimates of BHPO payments for the coming year to reflect the number and characteristics of *actual* BHPO enrollees. These adjustment factors would likely include income, age, and whether individual or family coverage was purchased. Washington would then report to the Secretary summary information about BHPO enrollment and receive an adjusted BHPO payment for the remainder of the year. The first adjusted payment would also need to account for anticipated ramp up and month-to-month changes in enrollment as a result of eligibility churn and further enrollment outside of the initial open enrollment period

For administrative simplicity, actual premiums charged in the Exchange would determine federal BHPO payments. However, until the pricing of qualified health plans participating in the Exchange has been determined, there is no way to determine the adequacy of BHPO payments. In addition, BHPO payments could be affected by caseload changes over the course of the year. As happens in the current Basic Health program, changes could occur as new individuals enroll in BHPO; as existing enrollees find alternative insurance and leave the program; and as enrollee circumstances change and result in increased or decreased subsidies within the BHPO framework. If the aggregate effect of such changes increases costs, Washington would expect to claim supplemental federal BHPO payments. If the aggregate effect of changes reduces BHPO costs, reserve funds could be set aside as a contingency to accommodate unanticipated enrollment patterns and the potential for early adverse risk. Ultimately, there is no way to predict the financial impact of changes in enrollee circumstances and the corresponding adjustments to BHPO payments.

Initial BHPO Payment Reconciliation

BHPO enrollees who did not receive advance payment of health insurance tax credits are exempt from reconciliation, under IRC section 36B(f). Nonetheless, BHPO payments would be affected if BHPO enrollees would have been subject to reconciliation if they had enrolled in the Exchange. To be consistent with ACA intent, reconciliation effects would also include consideration of:

- The age and income of the enrollee;
- Whether enrollment is for self-only or family coverage;
- Geographic differences in average spending for health care across rating areas;
- The health status of the enrollees for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had been enrolled in the Exchange;
- Other states' experiences.

This is a complex technical undertaking and until a BHPO and Exchange have been operational for at least 3 years, data robust enough to reasonably support reconciliation will not have been collected. The impact of reconciliation is therefore unclear. Because the BHPO shifts the risk of adjustments to premium tax credits due to changes in income from the individual to the state, options to address the issue are limited until there is substantial experience to quantify potential effects.

It is imperative that the reconciliation and adjustment process hold the state harmless for the first three years of BHPO operations. Just as is the case for the Exchange, there are considerable unknowns related to size and make-up of BHPO enrollment in the initial years.

We intend to work with CMS to build and test a methodology for reconciliation and adjustment that balances the state and federal liability over time. One mechanism for achieving shared liability could be a contingency reserve for the first three years to accommodate instability in enrollment and risk selection. A shared risk payment could be built into the enrollee's portion of the BHPO premium for the explicit purpose of building the reserve. This could be partially or fully refunded in succeeding years once it was established that the federal BHPO payment was sufficient to cover the full cost of the program. Regardless of the mitigation device, the state General Fund does not have the means to bear any financial risk for the initial years of BHPO operations.

Without any sufficient mechanism for overpayment recovery or the availability of individual year-end tax reconciliation for BHPO enrollees, it is our assumption that individual enrollees will also be held harmless for unreported income or changes in circumstance that would have impacted their subsidy amount.

Consideration for Future BHPO Payment Reconciliation after a 3-year Hold Harmless Period

Once enrollment stabilizes, reconciliation effects could be aggregated across the entire BHPO caseload. As a result, increased federal payments for BHPO enrollees whose income declined during the year would offset reduced payments for enrollees whose income rose. Reconciliation would affect only the component of BHPO payments related to tax credits, since cost-sharing reductions in the Exchange are not subject to IRS reconciliation.

By 2017, we would expect that the Exchange and BHPO would be operationally stable and data collected to the degree that reconciliation could be performed with some limit to the State's exposure. For example, we could set aside a certain amount of subsidy payments for the adjustment process. If there were a liability, the state would pay up to the maximum amount set aside. We propose consideration of two methods for testing the incorporation of reconciliation effects into Washington's BHPO fund payment. These would need further federal technical assistance to finalize, but are offered here to begin a discussion for development of a methodology that reasonably limits and shares the state and federal government's future exposure.

1. *Retrospective determination of reconciliation amount*. Reconciliation effects would be analyzed after the end of the year, based on a statistically valid sampling of BHPO enrollees. For each sampled enrollee, we would identify differences between the income determination that established BHPO eligibility and the enrollee's final, annual income. If a sampled individual received BHPO coverage for only part of the year, reconciliation would be based on average monthly income during the portion of the year in which the individual was covered by the BHPO. We would then extrapolate from this sample to determine Washington's reconciliation amount - 95 percent of the net increase or decrease in tax credit amounts that would have applied if BHPO enrollees had been covered in the Exchange.

2. *Prospective reconciliation adjustment*. HHS would prospectively estimate the likely reconciliation effects across Washington's entire BHPO population. The estimate would account for projected changes to the State's economy for the year, household changes that are typical of BHPO-eligible individuals, and relevant characteristics of the BHPO program. Before the start of the year, HHS would specify the percentage by which Washington's federal BHPO payment would increase or fall due to reconciliation, reflecting the best available estimate of net effects for the entire BHPO program.

Duration of BHPO Commitment

We propose that, so long as we provide HHS with at least 90 days' notice prior to the annual open enrollment period, Washington could terminate the BHPO for any reason. During the initial 3-year hold harmless period proposed, the state would be allowed to discontinue the BHPO without any financial penalty or ongoing liability. After 2017, if Washington terminates its BHPO program before full recoupment of excess federal BHPO payments has occurred, the State should be able to continue the recoupment schedule that was selected while it operated the BHPO. Following the termination of the BHPO, any remaining recoupment obligation could be paid through reductions in other HHS grants to the State or through direct payments from the State to HHS.

Risk Adjustment, Risk Corridors, Reinsurance – the 3 R's

We propose that federal BHPO payments not be adjusted to reflect any differences in risk level between BHPO enrollees and individuals covered in Washington's individual insurance market. However, as risk adjustment, reinsurance and risk corridor mechanisms are defined for the Exchange we would like to discuss their potential application to Washington's BHPO. We have used risk adjustment in our Medicaid and state employees' coverage programs for many years. Risk in the current Basic Heath program is to some degree "adjusted" by the inclusion of differential age factors in the rates. Whether there would be value for the market place and enrollees in pooling risk between BHPO enrollees and individual market enrollees served by a common managed care organization is one question that needs further analysis. We include the concept here as a placeholder for future discussions concerning the 3 R's.

Appendix A: Cross Reference of ACA Section 1331 to Proposal Contents

ACA Section 1331 Contents	Proposal Reference
Section 1331(a)(2) of the Affordable Care Act provides that the Secretary certify that the amount of the monthly premium charged to eligible individuals enrolled in a plan under contract under this program, called a standard health plan, does not exceed the amount of the monthly premium that an eligible individual would have paid if he or she were to receive coverage from the applicable benchmark plans (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986 [IRC]) through the Exchange. Section 1331(a)(2) also directs the Secretary to certify that out-of-pocket cost-sharing does not exceed specified levels.	BHPO Premium Contributions – p12 BHPO Cost Sharing Reductions – p10
Section 1331(b) of the Affordable Care Act defines a standard health plan as one selected by the State that: (1) only enrolls applicants who are determined eligible using the eligibility standards specified in section 1331(e) of the Affordable Care Act; (2) covers at least the essential health benefits described in section 1302(b) of the Affordable Care Act; and (3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, has a medical loss ratio of at least 85 percent.	Eligibility – p5 Flexible Benefits Design – p9
Section 1331(c) of the Affordable Care Act specifies various elements of the competitive process through which a Basic Health Program enters into contracts with standard health plans, including negotiation of premiums, cost-sharing, and benefits (if any) in addition to the essential health benefits.	Delivery System Contracting – p8
Section 1331(c)(2) requires inclusion of 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. It also requires the State to take into consideration, and make suitable allowances for, the differences in the health care needs of enrollees and the differences in local availability of, and access to, health care providers. This paragraph further requires contracting with managed care systems or with systems that offer as many of the attributes of managed care as are feasible in the local health care market. It also requires the establishment of specific performance measures and standards that focus on quality of care and improved health outcomes.	Delivery System Contracting – p8
Section 1331(c)(3) provides that a State shall, to the maximum extent feasible, seek to make multiple standard health plans available to ensure that individuals have a choice of such plans. It also provides that a State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States through agreements with issuers of standard health plans.	Flexible Benefit Design – p9

ACA Section 1331 Contents	Proposal Reference
Section 1331(c)(4) of the Affordable Care Act directs a State choosing to establish a Basic Health Program to coordinate the administration of that program with Medicaid, the Children's Health Insurance Program (CHIP), and other State-administered health programs to maximize the efficiency of all such programs and to improve continuity of coverage and care.	Governance and Administrative Structure – p4
Section 1331(d)(1) of the Affordable Care Act allows the Secretary to transfer Federal funds to a State that establishes a Basic Health Program in accordance with the standards of the program under section 1331(a). Section 1331(d)(2) of the Affordable Care Act directs that a State establish a trust fund for the deposit of the Federal funds it receives for its Basic Health Program 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 Basic Health Program.	The BHPO Trust Fund – p4
Section 1331(d)(3) of the Affordable Care Act specifies that a State that operates a Basic Health Program will receive, in federal funding, 95 percent of the amount of premium tax credits, and the cost sharing reductions, that would have been provided to (or on behalf of) eligible individuals enrolled in standard health plans through a Basic Health Program, if the eligible individuals were instead enrolled in qualified health plans (QHP) through the Exchange and receiving premium tax credits and cost-sharing reductions. The amount of payment is determined on a per capita basis, taking into account all relevant factors necessary to determine the subsidies that would have been provided to or on behalf of eligible individuals as specified in 1331(d)(3), including, but not limited to, the enrollee's age and income, whether the enrollment is for self-only or family coverage, geographic differences in average health care spending, and whether any reconciliation of the credit would have occurred if the enrollee had been enrolled in a QHP through the Exchange.	Financing – p14
Section 1331(d)(3) also provides that the determination shall also take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty. Additionally, the Secretary shall adjust the amount of payment for particular fiscal years to reflect errors in the determinations for preceding fiscal years.	Financing – p14
Section 1331(e) of the Affordable Care Act specifies eligibility standards for a Basic Health Program. To be determined eligible for a Basic Health Program, an individual must:	Eligibility section – p5
(1) be a resident of a State participating in a Basic Health Program;	Target Population – p5

ACA Section 1331 Contents	Proposal Reference
(2) be eligible for enrollment in a QHP through the Exchange but for the existence of a Basic Health Program, as provided in Affordable Care Act 1312, which limits enrollment to U.S. citizens and non-citizens lawfully present;	Target Population – p5
(3) not be eligible to enroll in the State's Medicaid program under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b) of the Affordable Care Act;	Target Population – p5 Flexible Benefit Design – p9
(4) either (A) be a U.S. citizen or lawfully present non-citizen with a household income that exceeds 133 percent but does not exceed 200 percent of the Federal poverty level (FPL) or (B) be a non-citizen lawfully present who has a household income that is not greater than 133 percent of the FPL and who is ineligible for Medicaid because of immigration status;	Federal Basic Health Program Option (BHPO) – p2 Eligibility Determination Methodology – p6
(5) either (A) not be eligible for minimum essential coverage or (B) be eligible for an employer-sponsored plan that does not meet the standards for affordability and minimum value described in IRC section 36B(c)(2)(C); and	Federal Basic Health Program Option (BHPO) – p2 Flexible Benefit Design – p9
(6) not have attained age 65 as of the beginning of the plan year.	Target Population – p5
Section 1331(f) of the Affordable Care Act directs the Secretary to conduct an annual review of each State Basic Health Program to ensure that it complies with the standards of section 1331. Through this annual review, the State will provide information to demonstrate that its Basic Health Program meets: (1) eligibility verification standards for participation in the program; (2) standards for the use of Federal funds received by the program; and (3) quality and performance objectives.	Assumed to be defined by the Secretary
As specified in section 1331(g) of the Affordable Care Act, a standard health plan offeror may be a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program; the statute provides authority for the State to determine eligibility to offer a standard health plan.	Delivery System Contracting – p8

Appendix B: Washington State 2012 BHPO Statute

Excerpt from Engrossed Second Substitute House Bill 2319
Chapter 87, Laws of 2012
(http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2319&year=2011 pages 18-20

PART VI
THE BASIC HEALTH OPTION

NEW SECTION. **Sec. 15.** A new section is added to chapter 70.47 RCW to read as follows:

(1) On or before December 1, 2012, the director of the health care authority shall submit a report to the legislature on whether to proceed with implementation of a federal basic health option, under section 1331 of P.L. 111-148 of 2010, as amended. The report shall address whether:

(a) Sufficient funding is available to support the design and development work necessary for the program to provide health coverage to enrollees beginning January 1, 2014;

(b) Anticipated federal funding under section 1331 will be sufficient, absent any additional state funding, to cover the provision of essential health benefits and costs for administering the basic health plan. Enrollee premium levels will be below the levels that would apply to persons with income between one hundred thirty-four and two hundred percent of the federal poverty level through the exchange; and

(c) Health plan payment rates will be sufficient to ensure enrollee access to a robust provider network and health homes, as described under RCW 70.47.100.

(2) If the legislature determines to proceed with implementation of a federal basic health option, the director shall provide the necessary certifications to the secretary of the federal department of health and human services under section 1331 of P.L. 111-148 of 2010, as amended, to proceed with adoption of the federal basic health program option.

(3) Prior to making this finding, the director shall:

(a) Actively consult with the board of the Washington health benefit exchange, the office of the insurance commissioner, consumer advocates, provider organizations, carriers, and other interested organizations;
(b) Consider any available objective analysis specific to Washington state, by an independent nationally recognized consultant

30 that has been actively engaged in analysis and economic modeling of the
31 federal basic health program option for multiple states.

32 (4) The director shall report any findings and supporting analysis
33 made under this section to the governor and relevant policy and fiscal
34 committees of the legislature.

35 (5) To the extent funding is available specifically for this
36 purpose in the operating budget, the health care authority shall assume
37 the federal basic health plan option will be implemented in Washington
38 state, and initiate the necessary design and development work. If the
1 legislature determines under subsection (1) of this section not to
2 proceed with implementation, the authority may cease activities related
3 to basic health program implementation.

4 (6) If implemented, the federal basic health program must be guided
5 by the following principles:

6 (a) Meeting the minimum state certification standards in section
7 1331 of the federal patient protection and affordable care act;

8 (b) To the extent allowed by the federal department of health and
9 human services, twelve-month continuous eligibility for the basic
10 health program, and corresponding twelve-month continuous enrollment in
11 standard health plans by enrollees; or, in lieu of twelve-month
12 continuous eligibility, financing mechanisms that enable enrollees to
13 remain with a plan for the entire plan year;

14 (c) Achieving an appropriate balance between:
15 (i) Premiums and cost-sharing minimized to increase the
16 affordability of insurance coverage;
17 (ii) Standard health plan contracting requirements that minimize
18 plan and provider administrative costs, while incentivizing
19 improvements in quality and enrollee health outcomes; and
20 (iii) Health plan payment rates and provider payment rates that
21 are sufficient to ensure enrollee access to a robust provider network
22 and health homes, as described under RCW 70.47.100; and

23 (d) Transparency in program administration, including active and
24 ongoing consultation with basic health program enrollees and interested
25 organizations, and ensuring adequate enrollee notice and appeal rights.

Appendix C: February Letter to Secretary Sebelius and May 24, 2012 Response

STATE OF WASHINGTON

February 7, 2012

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Sebelius:

States have long been laboratories of innovation in providing affordable, high quality health services to low income individuals, and we have valued our partnership with the Department of Health and Human Services in these efforts. Your continued willingness to work with states is evident in implementation of the Affordable Care Act (ACA). Proposed regulations regarding Exchanges and Medicaid expansion reflect HHS' intent to interpret the law to provide states with flexibility and protection against unanticipated costs.

The federal basic health program (BHP) option in section 1331 of the ACA presents a new opportunity to further this partnership. Our state is carefully considering this option, given its potential to offer more affordable coverage to the highly price-sensitive population above Medicaid eligibility levels but below 200 percent of federal poverty. However, HHS' interpretation of section 1331 will be a key factor in our decision whether to go forward with it.

We appreciate the opportunity that the recent BHP request-for-information provided to comment on a broad range of implementation issues and were among those states that responded. However, as we move further into our 2012 legislative session, where a number of decisions related to ACA implementation will be made, we wanted to convey to you our most significant issues regarding the BHP. We hope the enclosed information is helpful to HHS as it prepares any guidance for the states or proposed regulations related to section 1331.

While we recognize that the ACA has generated an enormous workload for HHS staff, we urge you to issue guidance on these key issues in the near future. In the absence of such guidance, we will be unable to make an informed decision regarding this option.

We look forward to hearing from you, and to further discussions on this important policy issue.

Sincerely,

Christine O. Gregoire
Governor

Lisa Brown
Senate Majority Leader

Frank Chopp
Speaker of the House

Karen Keiser
Chair, Senate Health & Long Term Care Committee

Eileen Cody
Chair, Health Care & Wellness Committee

Enclosure

Issues for Washington regarding adoption of the federal Basic Health Plan under the ACA
State financial risk

1. Costs of BHP administration: Section 1331(d)(2) appears to address two key issues: ensuring that federal BHP funds are not used by states for purposes unrelated to the federal BHP program and that federal BHP funds are not claimed by states as the non-federal match for federal programs requiring states matching funds. It would be an overly narrow interpretation of this provision to preclude states from using a reasonable percentage of federal BHP funds to administer the BHP at the state level. However, states should be expected to minimize BHP administrative costs through activities such as integrating BHP eligibility and plan enrollment into the system already under development for Exchange subsidy and Medicaid determinations, or through joint procurement of BHP and Medicaid managed care services.

2. Interpretation of the funding formula and subsequent reconciliation: States require predictability and stability of federal BHP funding. One of the factors in setting the funding formula in section 1331(d)(3)(ii) is whether any reconciliation of the credit or cost-sharing would have occurred if the BHP enrollee had been enrolled in the Exchange. States will be unlikely to adopt a federal BHP if this reconciliation factor or the adjustment process in section 1331(d)(3)(B) could generate a significant unfunded liability.

   States have no way of anticipating how many individuals will see their income change during the plan year. For example, if 10% of BHP enrollees file tax returns with higher income than anticipated upon enrollment, the federal government will have paid more in subsidies than it should have. At this point, does it charge the client higher subsidies, or charge the state for a portion – even though the state has no control over how enrollee incomes change? How can adjustments due to increases in BHP enrollee income be offset against adjustments due to those with decreased income? Unless states are protected from unanticipated expenditures, few states will be willing to establish a BHP.

   The rules should describe how the federal government will handle payment reconciliation and adjustments under section 1331 if the state has been paid too much in subsidies. Options to address this include:
   - Recover funds from enrollees. The federal government will conduct its reconciliation based on income tax filings it receives. At that time, the IRS could handle the situation as it would in the Exchange – i.e., require the tax filer to pay the amount owed.
   - Hold states harmless for past plan years. HHS could use the revised payment history to modify future payments, but not try to recover past payments.
   - Hold states harmless the first years. To encourage participation, hold states harmless in the reconciliation process for the first few years. Then, use the adjustment process to calculate a discount (or enhancement) rate for future subsidy payments.
   - Limit states' exposure. Require states to set aside a certain amount of subsidy payments for the adjustment process. If there were a liability, the state would pay up to the maximum amount in that account. This option would, however, reduce available funding for direct services.

3. Funding formula "Per enrollee" calculation in section 1331(d)(iii): The Medicaid expansion regulations issued on August 12, 2011, proposed several methodologies as an alternative to a per enrollee determination of the appropriate FMAP percentage to claim. HHS should

consider a comparable approach for BHP funding. After the first year of the program's operation, a statistical method could be used to determine the income, age and health risk distribution of the BHP population. Like the proposed Medicaid regulations, during initial years, more than one methodology could be tested by states, with a goal of identifying the most accurate and feasible methodology.

Flexibility in BHP implementation

As states consider whether to adopt the BHP option, they will be trying to determine the amount of funding that would be received from the federal government under section 1331(d) and how to spend those funds to provide affordable coverage. The key variables will be:

- Enrollee premiums;
- Enrollee cost-sharing;
- Provider payments; and
- Covered benefits (to the extent they exceed the EHB)

For each state, the balance between these variables might be a bit different. The ACA sets a floor with the essential health benefits. Any regulations related to implementation of the BHP option should not impose additional requirements for plan design. To receive BHP funding, a state must assure that monthly premiums, cost-sharing and benefits are at least as generous as those the individual would receive in the Exchange. That standard, in and of itself, is sufficient. One of the critical factors behind the success of the Basic Health Plan in Washington State is the flexibility that the administering agency has had to design the benefit package, cost-sharing and premiums to live within the fixed amount of funding appropriated by the legislature. Such flexibility would also allow innovative plan designs such as selectively *reducing* cost-sharing to encourage people with chronic diseases to fill prescriptions.

The language of section 1331(a)(2) directs the states to pursue innovative purchasing strategies related to care management, the use of preventive services and accountability for performance. Flexibility with respect to these purchasing goals will both provide an opportunity to bring more predictability to our BHP expenditures and improve the health outcomes for BHP enrollees.

BHP participation in ACA reinsurance and risk adjustment programs

The ACA addresses risk selection in the individual market through reinsurance, risk corridor and risk adjustment mechanisms. It is not clear how the federal BHP option will interact with those mechanisms. HHS should interpret the ACA to allow BHP enrolled lives to be considered individual market insured lives for purposes of the reinsurance and risk adjustment programs, essentially extending to the state, and carriers providing BHP coverage, the same protections against undue risk available to those outside the BHP, including the federal government.

It is also not clear at this point whether the BHP enrollees would have health risks more or less favorable than those above 200% FPL who will be purchasing coverage through the Exchange. Including BHP enrolled lives in the risk adjustment mechanisms would spread this risk across all carriers in the individual market, thus minimizing the likelihood that adopting the federal BHP would adversely impact state Exchanges.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 24, 2012

RECEIVED
JUN 01 2012
Office of the Governor

The Honorable Christine O. Gregoire
Governor of Washington
Olympia, WA 98504

Dear Governor Gregoire:

Thank you for your letter providing information on your state's most significant areas of uncertainty regarding the Basic Health Program (BHP) option in section 1331 of the Affordable Care Act. I understand Washington's need for guidance as the state makes decisions regarding the implementation of the Affordable Care Act.

The specific areas you have identified, including BHP administrative funding, the funding formula and reconciliation process, and options for risk adjustment, are issues that other stakeholders have also raised with regard to BHP. We are working to ensure that all states have sufficient guidance and flexibility in order to implement the Affordable Care Act and ensure affordable coverage for all state residents. As you noted in your letter, we have worked closely with states to develop guidance, and we are committed to continuing this work.

Thank you for sending comments in response to the Request for Information that the Centers for Medicare & Medicaid Services published last fall and for sharing additional information in your letter. We are continuing to give close consideration to the issues you have raised, and I appreciate your continued commitment to providing affordable, high quality health services to Washingtonians. I will also provide this response to the cosigners of your letter.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Appendix D: BHPO Reference from March Exchange Rules

Excerpt from Federal Register /Vol. 77., No. 59/Tuesday, March 27, 2012/ Rules and Regulations p18461

§ 155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan.

(g) *Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP, or the BHP.*

The Exchange, in consultation with the agencies administering Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, must establish procedures to ensure that an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit and cost-sharing reductions is performed when an application is submitted directly to an agency administering Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange. Under such procedures, the Exchange must—

(1) Accept, via secure electronic interface, all information provided on the application and any information obtained or verified by, the agency administering Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, for the individual, and not require submission of another application;

(2) Not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this subpart;

(3) Not request information of documentation from the individual already provided to another insurance affordability program and included in the transmission of information provided on the application or other information transmitted from the other program;

(4) Determine the individual's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, promptly and without undue delay, and in accordance with this subpart; and

(5) Provide for following a streamlined process for eligibility determinations regardless of the agency that initially received an application.

(h) *Standards for sharing information between the Exchange and the agencies administering Medicaid, CHIP, and the BHP.*

(1) The Exchange must utilize a secure electronic interface to exchange data with the agencies administering Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, including to verify whether an applicant for insurance affordability programs has been determined eligible for Medicaid, CHIP, or the BHP, as specified in §155.320(b)(2), and for other functions required under this subpart.

§ 155.405 Single streamlined application.

(a) The application.

The Exchange must use a single streamlined application to determine eligibility and to collect information necessary for:

(1) Enrollment in a QHP;

(2) Advance payments of the premium tax credit;

(3) Cost-sharing reductions; and

(4) Medicaid, CHIP, or the BHP, where applicable.

(b) Alternative application. If the Exchange seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary for the purposes identified in paragraph (a) of his section.

Appendix E. Current Basic Health Program Premiums

Current Basic Health Program Enrollee premium contributions by age range and income band (July 2012)

Age Range	A 0-65 % FPL	B 65-100 % FPL	C 100 –125 % FPL	D 125-140 % FPL	E 140-155 % FPL	F 155-170 % FPL	G 170-185 % FPL	H 185-200 % FPL
19-39	$17	$45	$60	$66.16	$82.70	$101.30	$122.84	$144.72
40-54	$17	$45	$60	$83.74	$104.68	$128.23	$155.49	$183.19
55-64	$17	$45	$60	$143.20	$179.00	$219.28	$265.89	$313.25

Current Basic Health Program Benchmark 40-54 year old premium cost sharing as a percent of median income (July 2012)

Income band	FPL	Enrollee Premium	Premium as % of *Median* Income[xxi]
A	0 - 65%	$17	2.81%
B	65 - 100%	$45	5.86%
C	100 - 125%	$60	5.73%
D	125 - 140%	$66.16	6.79%
E	140 - 155%	$82.70	7.62%
F	155 - 170%	$101.30	8.48%
G	170 - 185%	$122.84	9.41%
H	185 - 200%	$144.72	10.22%

Appendix F. Definition of American Indian/Alaska Native for Cost Sharing Exemption

American Indian Health Commission Workgroup

SUMMARY OF CURRENT DISCUSSION

Introduction

Special Terms and Conditions (STCs) for the Transitional Bridge Demonstration require that individuals enrolled in the Basic Health program "who have been determined to be American Indians/Alaska Natives" be exempt from cost sharing. This is consistent with requirements of the Patient Protection and Affordable Care Act (ACA).

The American Indian Health Commission (AIHC) facilitated a work group to support Washington state's efforts to implement this requirement. Initial discussions focus on operationalizing the definition of American Indian/Alaska Native (AI/AN) so that individuals to whom the cost sharing exemption applies can be clearly identified and tracked.

Implementation of the work group's findings requires CMS approval. Discussions continue on this front.

---

a. Definition of American Indian/Alaska Native *Indian*

STCs (i.e., page 12 footnote) use a definition of "Indian" consistent with Section 5006 of the American Recovery and Reinvestment Act (ARRA) and with the ACA. This definition is presented in the following box, with references to current law bolded and relevant excerpts shaded in grey in the text that follows for 42 CFR 136.12, and 25 USC 1603(c), 1603(f), 1679(b).

> Indian means any individual defined at **25 USC 1603(c), 1603(f), or 1679(b)**, or who has been determined eligible as an Indian, pursuant to **42 CFR 136.12**. This means the individual:
>
> (1) Is a member of a Federally recognized Indian tribe;
>
> (2) resides in an urban center and meets one or more of the four criteria:
>
> (a) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the
>
> State in which they reside, or who is a descendant, in the first or second degree, of any such member;
>
> (b) is an Eskimo or Aleut or other Alaska Native;
>
> (c) is considered by the Secretary of the Interior to be an Indian for any purpose; or
>
> (d) is determined to be an Indian under regulations promulgated by the
>
> Secretary;
>
> (3) is considered by the Secretary of the Interior to be an Indian for any purpose; or
>
> (4) is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

42 CFR 136.12 - Persons to whom services will be provided.

(a) *In general.* Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program. Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. The Service will also provide medically indicated services to non-Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.

(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

(b) *Doubtful cases.* (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the medical officer in charge shall obtain from the appropriate BIA officials in the jurisdiction information that is pertinent to his/her determination of the individual's continuing relationship to the Indian population group served by the local program.

(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

(c) *Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services.* Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

Sec. 1603. Definitions

For purposes of this chapter--

(a) ``Secretary'', unless otherwise designated, means the Secretary of Health and Human Services.

(b) ``Service'' means the Indian Health Service.

(c) ``Indians'' or ``Indian'', unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) of this section, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) ``Indian tribe'' means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) ``Tribal organization'' means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) ``Urban Indian'' means any individual who resides in an urban center, as defined in subsection (g) of this section, and who meets one or more of the four criteria in subsection (c)(1) through (4) of this section.

(g) ``Urban center'' means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under subchapter IV of this chapter, as determined by the Secretary.

(h) ``Urban Indian organization'' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of this title.

(i) ``Area office'' means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

(j) ``Service unit'' means--

(1) an administrative entity within the Indian Health Service,
or
(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C. 450f et seq.], through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

(k) ``Health promotion'' includes--

(1) cessation of tobacco smoking,
(2) reduction in the misuse of alcohol and drugs,
(3) improvement of nutrition,
(4) improvement in physical fitness,
(5) family planning,
(6) control of stress, and
(7) pregnancy and infant care (including prevention of fetal alcohol syndrome).

(l) ``Disease prevention'' includes--

(1) immunizations,
(2) control of high blood pressure,
(3) control of sexually transmittable diseases,
(4) prevention and control of diabetes,
(5) control of toxic agents,
(6) occupational safety and health,
(7) accident prevention,
(8) fluoridation of water, and

(9) control of infectious agents.

(m) ``Service area'' means the geographical area served by each area office.

(n) ``Health profession'' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.

(o) ``Substance abuse'' includes inhalant abuse.

(p) ``FAE'' means fetal alcohol effect.

(q) ``FAS'' means fetal alcohol syndrome.

Sec. 1679. Eligibility of California Indians

(a) Report to Congress

(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after November 23, 1988, prepare and submit to the Congress a report which sets forth--

(A) a determination by the Secretary of the number of Indians described in subsection (b)(2) of this section, and the number of Indians described in subsection (b)(3) of this section, who are not members of an Indian tribe recognized by the Federal Government,

(B) the geographic location of such Indians,

(C) the Indian tribes of which such Indians are members,

(D) an assessment of the current health status, and health care needs, of such Indians, and

(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.

(2) The report required under paragraph (1) shall be prepared by the Secretary--

(A) in consultation with the Secretary of the Interior, and

(B) with the assistance of the tribal health programs providing services to the Indians described in paragraph (2) or (3) of subsection (b) of this section who are not members of any Indian tribe recognized by the Federal Government.

(b) Eligible Indians

Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

(1) Any member of a federally recognized Indian tribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant--

(A) is living in California,

(B) is a member of the Indian community served by a local program of the Service, and

(C) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(c) Scope of eligibility

Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

b. Options for Documenting American Indian/Alaska Native *Indian* Status

To support an application for coverage as an *Indian,* for which an exemption from cost sharing will apply, an applicant must have documentation to confirm Tribal:

a. Membership,
b. Descendancy, or
c. Affiliation.

The following table provides 3 tiers of documents, with tiers representing increasing complexity of documentation requirements. Tier I documents are likely to be the most readily available; tier III may require the assistance of Tribal organizations to locate details.

DOCUMENTS THAT CONFIRM INDIAN STATUS (per Washington State Transitional Bridge Demonstration)		
TIER I	**TIER II**	**TIER III**
1. Tribal Membership Card with picture from a federally recognized tribe. state recognized tribe or the Bureau of Indian Affairs (BIA) 2. Tribal Sponsorship Agreement with the Health Care Authority for participation in the Basic Health program*	1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND a. A US American Indian/Alaska Native tribal membership card or tribal enrollment letter, without picture OR b. A certificate of tribal membership / affiliation, OR c. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood, OR d. A document issued by the Indian Health Service (IHS), a Tribal health program or an Urban Indian Program, attesting to an individual's eligibility (as an AI/AN) to receive health services at the IHS or Tribal health facility. ** 2. Indian and Northern Affairs Canada (INAC) Card; AND Documentation of 50% Native blood, such as: a. A Certificate of Indian blood issued by the Bureau of Indian Affairs OR b. A document issued by a federal or state recognized tribe verifying 50% Native blood***	1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND a. Documentation showing native descent, such as a birth certificate or relative tribal ID cards; OR b. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood. 2. Current state driver's license or state identity card for a non-native mother carrying the child of an eligible native****; AND a. Proof of marriage to an eligible native father who must also provide tier I,II, or III documentation that confirms his AI/AN status; OR b. In cases where the mother is not married to the eligible native father - proof of paternity (in writing), from the father or by order of a court, including a tribal court. The father must also provide tier I, II, or III documentation that confirms his AI/AN status (unless there is a tribal court order).

* Tribal Sponsors are expected to obtain and maintain complete documentation of eligible native status as part of their sponsorship agreement with the Health Care Authority.

** In the state of Washington there are currently 2 Urban Indian Health Centers, 3 Indian Health Service Clinics, and 34 Tribal Health Programs.

***May be Canadian citizens but remain eligible for Basic Health and zero cost sharing if 50% native blood. The right of American Indians to freely cross the Canadian Border is based on the Jay Treaty signed by the US and Great Britain in 1794. In 1952, the Immigration and Naturalization Act limited the rights of Indians born in Canada to those with at least 50% native blood.

**** Non-Native women pregnant with the child of an eligible Native remain eligible for zero cost sharing only during pregnancy and up to six weeks post-partum.

Endnotes

[i] Washington State's Legislature recently enacted statute that clearly articulates a definition of low-income coverage intended to be available to individuals and families up to 200 percent of the federal poverty level (FPL). Pending appropriation, the current Basic Health program actually caps eligibility at 250% of the FPL but funding has never been available to support this level of eligibility.

[ii] http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2319&year=2011

[iii] Social Security Act section 2105(c)(2)(A).

[iv] Funding for coverage under Apple Health for Kids includes Title XIX (Medicaid) for children up to 200% FPL, Title XXI (CHIP) for children 133-200% FPL and state-only funding for children not eligible for Medicaid or CHIP as a result of their immigration or citizenship status. Apple Health for Kids encompasses several programs administered by DSHS to create seamless coverage for children under age 19. Coverage is financed through multiple federal funding sources. For example:
Children in families with income between 200-300 percent of the FPL are financed by Title XXI CHIP. These children also have modest premium requirements; $20 per child in families with income between 200-250 percent of the FPL; $30 per child in families with income between 250-300 percent of the FPL. To ensure affordability, the premiums are capped at two per family.

[v] At the present time enrollment in the Basic Health is closed and the waiting list has grown to just over 166,000 as of May 2012.

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

[vii] Buettgens, M. and Carroll, C. Urban Institute, "The ACA Basic health Plan in Washington State: Eligibility and Enrollment." 2 March, 2012.

[viii] CMS-9989-F, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers". The regulations are effective 60 days after their publication in the Federal Register, March 27, 2012.

[ix] Those applying for Medicaid through the Exchange will include children, pregnant women, families, and the newly eligible. Their eligibility will be determined via electronic data matches.

[x] This also sets up an adverse risk incentive where individuals who have health issues are more likely to purchase coverage and those who are healthy choose to go bare.

[xi] Estimates do not include potential churn from employer sponsored insurance (ESI). Preliminary estimates suggest that including ESI churn could increase churn for the population under 138% of the FPL to about 40%.

[xii] Hwang, A., Rosenbaum, S., and Sommers, B. Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges. Health Affairs 2012; 31(6):1314-1320.

[xiii] Standards and qualifications for network relationships expected to provide intensive health home services are being developed and discussed with CMS.

[xiv] Section 1302(b)(1) of the ACA provides that EHBs include items and services within the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

[xv] Analysis conducted in preparation for the submission of Washington's Transitional Bridge 1115 Demonstration waiver indicated that current Basic Health benefits (i.e., services covered) set Basic Health at close to 90% of the actuarial value of Medicaid.

[xvi] Senate Finance Committee, Report 111–89, 111th Congress. America's Healthy Future Act of 2009 (S. 1796), p. 42-43. Available at: http://www.gpo.gov/fdsys/pkg/CRPT-111srpt89/pdf/CRPT-111srpt89.pdf; Section 1402(c)(1)(B) in Patient Protection and Affordable Care Act (November 19, 2009). Available at: http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590as/pdf/BILLS-111hr3590as.pdf

[xvii] Based on the Kaiser Family Foundation health reform subsidy calculator available online at http://healthreform.kff.org/subsidycalculator.aspx, individuals/families at 200% of the FPL will be responsible for

maximum annual out-of-pocket costs (not including the premium) of $2,083 in 2014. Whether a person or family reaches this maximum level will depend on the amount of care they use.

[xviii] Estimated reductions would first be approved by the Secretary of HHS.

[xix] Actual payment processing would be incorporated into the Exchange premium collection and payment processing.

[xx] Urban Institute estimates suggest that the ACS provides the most robust data source.

[xxi] Median income is based on a family size of one and is the dollar amount in the middle of each income band. Maximum income was used for income band A rather than the median because the band begins at

Health Insurance Policy Simulation Model

Health Policy Center
The Urban Institute
2100 M St NW
Washington DC 20037
http://www.healthpolicycenter.org

The ACA Basic Health Program in Washington State

Using the Washington State Population Survey (WSPS) augmented with results from the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we estimated eligibility, enrollment, and costs for a Basic Health Program (BHP) for Washington State under the rules defined in the Affordable Care Act (ACA). Important findings include these:

- More than 160,000 Washington residents would be eligible for BHP.
- If BHP cost sharing were based on 98 percent actuarial value and $100 annual premiums (member contributions), between 90,000 and 111,000 of those eligible would enroll in BHP. If exchange plans are comparable to those in the current small group market, federal BHP payments would exceed costs by $550 to $600 per enrollee. This could be used to lower beneficiary cost sharing, or would allow reimbursement to providers to be raised 11 to 12 percent above Medicaid levels.
- BHP enrollment in the WSPS regions would vary from 22,400 in King County to 6,800 in the Yakima Tri-Cities region.
- If BHP cost sharing were based on 94 percent actuarial value with premiums set at 2 percent of family income, enrollment would be between 75,000 and 103,000. Federal BHP payments would exceed costs by $1,250 to $1,350 per enrollee. This surplus could be used to decrease cost sharing, increase provider reimbursement by 31 to 34 percent over Medicaid, or some combination of lowered cost sharing and increased reimbursement.
- The size of the nongroup market would be larger under the ACA than it is now, even with BHP (nearly 400,000 versus about 300,000).
- With health reform fully implemented, the exchange would cover about 250,000 lives, even with BHP.
- Moving BHP enrollees out of the nongroup market would not affect premiums notably.

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April 2012, Updated August 2012

Contents

BHP Eligibility

We estimate that 162,000 Washington residents would be eligible for BHP (Table 1). The vast majority (142,000) would be legal residents between 138 and 200 percent of the federal poverty level (FPL) not eligible for any form of public coverage and not having an affordable offer of employer-sponsored insurance (ESI).[1] About 14,000 would be legal immigrants below 138 percent of FPL who do not have an affordable employer offer and are ineligible for public coverage because they have been resident less than five years. About 6,000 would be adults with modified adjusted gross income (MAGI) above 138 percent FPL who are currently covered under the state's Medicaid bridge waiver (Basic Health) and who do not have an affordable ESI offer. MAGI does not include income disregards currently used in eligibility determination, so some who are currently eligible would have MAGI levels that high. Beginning in 2014, the state could end Medicaid eligibility for these people and transfer them to BHP.

Table 1. BHP Eligibility and Enrollment in Washington State, by Eligibility Category

	Eligible for BHP	
	N	%
Total	161,578	100.0%
Subsidy Eligible, 138%–200% FPL	141,652	87.7%
Legal Immigrants Below 138% FPL	13,869	8.6%
MOE Adults in Waiver Programs	6,056	3.7%
		100.0%
North Sound Region	11,454	7.1%
West Balance Region	11,080	6.9%
King County	26,787	16.6%
Puget Metro Region	16,360	10.1%
Clark County	16,442	10.2%
East Balance Region	13,986	8.7%
Spokane County	11,083	6.9%
Yakima Tri-Cities Region	9,320	5.8%
Snohomish County	11,642	7.2%
Pierce County	33,423	20.7%
		100.0%

Source: UI Analysis of Augmented Washington State Database.
MOE = maintenance of eligibility.
1. BHP Package A has $100 premiums and 98 percent actuarial value.

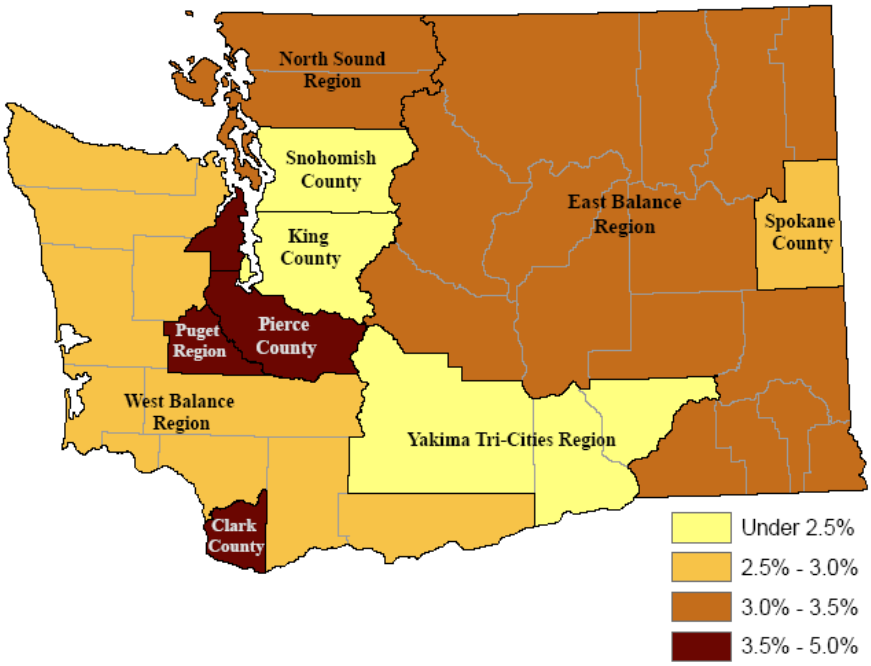
[1] As defined in the law, a family is barred from subsidized coverage if one member has an offer of coverage for which the single premium is less than 9.5 percent of family MAGI.

2. High BHP take-up indicates that 29 percent of people with baseline ESI take up BHP and 90 percent of the baseline uninsured take up BHP.

3. Low BHP take-up indicates that 22 percent of people with baseline ESI take up BHP and 71 percent of the baseline uninsured take up BHP.

More than 33,000 would be eligible for BHP in Pierce County alone. This is followed by King County, with nearly 27,000 eligibles. The Yakima Tri-Cities region would have just over 9,000, the fewest of any region. In Figure 1, we show the concentration of BHP eligibles in each region. Fewer than 2.5 percent of residents in King County, Snohomish County, and Yakima Tri-Cities would be eligible for BHP. By contrast, more than 3.5 percent of residents in Pierce County, Clark County, and the Puget Region would be eligible. Regional variation is due primarily to differences in the income distribution and the prevalence of employers that offer coverage to their workers. Note, for example, that King County has the second highest number of those eligible for BHP, but has one of the lowest concentrations of eligibles. Residents of this county are more likely have incomes above or below the BHP eligibility range than in other areas. Both very high and very low incomes are more prevalent in King County.

Figure 1: Percent of Nonelderly that are Eligible for BHP by Washington State Region



BHP with Lower Cost Sharing

We estimated take-up and costs under two different BHP packages. Package A would provide coverage at 98 percent actuarial value with annual per person premiums set at $100 a year. The premium represents approximately one percent of income for a single person at 133 percent FPL and less than one percent of income for larger families. Package B would have higher cost sharing: 94 percent

actuarial value with premiums at 2 percent of family income. These are the same actuarial value and premium levels as for subsidized coverage in the exchange below 133 percent of FPL.[2] For simplicity, we will go through our results for the lower cost sharing of Package A first, and then Package B.

The decision by eligible people to enroll in BHP is based on HIPSM. This decision takes into account out-of-pocket premiums and cost sharing, the risk of high health costs, and a family's disposable income. A given dollar amount of additional cost sharing would discourage enrollment more for a lower-income family than for a higher-income family. The decision is also heavily influenced by other factors, such as the effect of the individual mandate. See Methods section below for details.

Table 2. BHP Eligibility and Enrollment in Washington State, by Eligibility Category

	Eligible for BHP		Enrolled in BHP Package A[1]			
			High Take-Up[2]		Low Take-Up[3]	
	N	%	N	%	N	%
Total	161,578	100.0%	110,692	100.0%	90,446	100.0%
Subsidy Eligible, 138%–200% FPL	141,652	87.7%	95,129	85.9%	78,634	86.9%
Legal Immigrants Below 138% FPL	13,869	8.6%	9,507	8.6%	5,755	6.4%
MOE Adults in Waiver Programs	6,056	3.7%	6,056	5.5%	6,056	6.7%

Source: UI Analysis of Augmented Washington State Database.

1. BHP Package A has $100 premiums and 98 percent AV.

2. High BHP take-up indicates that 29 percent of people with baseline ESI take up BHP and 90 percent of the baseline uninsured take up BHP.

3. Low BHP take-up indicates that 22 percent of people with baseline ESI take up BHP and 71% of the baseline uninsured take up BHP.

We estimated take-up of BHP Package A under two scenarios. The difference between low and high take-up scenarios reflects different levels of responsiveness to the individual mandate. No person above the tax filing threshold eligible for BHP would qualify for an affordability exemption to the mandate because BHP coverage would be deemed affordable. Most of those eligible for Medicaid, on the other hand, are below the tax filing threshold, and thus exempt from the mandate. Mandate penalty amounts would generally be less than premium and out-of-pocket costs in subsidized exchange coverage, but would still be substantial for a low-income family. National estimates show that people between 138 and 200 percent FPL would spend on average $1,200 on premiums and $400 on other out-of-pocket medical expenses.[3] Tax penalties usually have an effect on behavior larger than the actual amount of the penalty would suggest. Also, tax penalties are simply money spent, while the purchase of health

[2] In the exchange, this cost sharing would apply to adult legal immigrants who are resident less than five years and thus ineligible for Medicaid.

[3] Stan Dorn, Matthew Buettgens, and Caitlin Carroll, *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States* (Washington, DC: The Urban Institute, 2011). http://www.urban.org/health_policy/url.cfm?ID=412412.

coverage provides the purchaser with a product that has value. Under the 2006 Massachusetts health reform law, the mandate had a significant effect on people in this income range. The high take-up rate assumes that the mandate will be enforced for low-income families and that their behavior will be similar to that observed in Massachusetts, adjusting for differences in cost sharing between Commonwealth Care in Massachusetts and our BHP packages.

On the other hand, the effect of the mandate could be lower for several reasons. Low-income families subject to the mandate could be granted hardship exemptions, enforcement efforts could be lower for them than for the higher-income uninsured, or there could be less of a desire to comply with the law, particularly given the cost sharing of exchange coverage. Any of these would reduce take-up. Note that we did not simulate the effect of eliminating the individual mandate.[4]

Enrollment in BHP will vary considerably depending on the type of health insurance coverage, if any, a person currently has. Nearly 80,000 of those eligible are currently uninsured (Table 6). They would take up coverage at the rate of 90 percent under the high scenario and 71 percent under the low scenario. The low scenario is comparable to the take-up rate that we used for those currently uninsured who become Medicaid eligible under the ACA. Given the low cost sharing of Package A, take-up behavior would be similar.

Nearly 60,000 of those eligible for BHP report having ESI on the survey while not having an affordable ESI offer in the family. This is a legitimate circumstance for some. There are people with coverage through the employer plan of someone outside the household—separated couples, for example. Early retirees are also in this category. Some misreporting may be involved as well, but it is impossible to tell how much.[5] Since they already have coverage that is presumably paid for by someone else, they would take up BHP at a much lower rate. We estimate take-up at 28 percent for the high scenario and 23 percent for the low scenario. These estimates are consistent with assumptions made when we modeled Medicaid take-up.[6]

Just over 20,000 BHP eligibles currently have nongroup coverage. The “no-wrong-door interface” would screen these people automatically for BHP eligibility and could automatically enroll them. Thus take-up among this group would be very high in both scenarios.

Finally, about 6,000 of those eligible are currently enrolled under the Medicaid bridge waiver (Basic Health) and have MAGI above 138 percent FPL without affordable employer offers. The state could terminate their Medicaid eligibility and automatically enroll them in BHP. We are assuming a BHP package that would not differ markedly from their current coverage, so there would not be an affordability issue for those affected. The state would realize savings, since their BHP coverage would be entirely federally funded. However, if the state simply ended maintenance of eligibility for adults above 138 percent FPL, some of those losing Medicaid eligibility would have employer offers deemed affordable. They would be ineligible for BHP or exchange subsidies. To avoid terminating eligibility for

[4] For a national analysis, see Matthew Buettgens and Caitlin Carroll, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care* (Washington, DC: The Urban Institute, 2012), http://www.urban.org/health_policy/url.cfm?ID=412480.

[5] Many of these families report having a member formerly in the Armed Forces. A possible hypothesis is that such families are reporting TRICARE as ESI, but we did not recode the survey responses.

[6] Matthew Buettgens, Randall Bovbjerg, Caitlin Carroll, and Habib Moody, Memorandum to Washington State Office of Financial Management, *Task 2: The Medicaid Expansion and Hospital Utilization* (June 2011).

those not eligible for subsidized coverage, Washington could alter its Section 1115 waiver to continue eligibility for those with affordable offers but not for other adults above 138 percent FPL. The no-wrong-door interface would already have the means to determine the presence of an affordable offer, so it may not be difficult to administer.

Altogether, of the 162,000 eligible for BHP, we estimate that 111,000 would enroll with a higher effect of the individual mandate on behavior, and 90,000 would enroll with a lower effect (Table 2). Lower enrollment would mean modestly higher risk. A little less than 16 percent of enrollees would be in fair/poor health with high take-up, compared with just over 17 percent with lower take-up (Table 7). With higher take-up, nearly 16 percent would be 19 to 24 years old, compared with just over 11 percent with lower take-up.

As we saw earlier, Pierce County and King County have the highest number eligible for BHP (Table 3). Take-up rates in these counties would be very different. Only 13,200 of the 33,400 eligible in Pierce County would enroll, contrasting with 22,400 enrolling out of 26,800 eligible in King County. This difference is due to several factors. A much higher percentage of Pierce County BHP eligibles currently have ESI coverage than in King County.[7] Also, those eligible in Pierce County tend to have somewhat higher incomes and are more likely to have workers in the family than those in King County.

Table 3. BHP Enrollment and Eligibility by Region[1] in Washington State

	Nonelderly Population		Eligible for BHP		Enrolled in BHP Package A[23]	
	N	%	N	%	N	%
Total	5,911,733	100.0%	161,578	100.0%	110,692	100.0%
North Sound Region	349,506	5.9%	11,454	7.1%	8,599	7.8%
West Balance Region	377,014	6.4%	11,080	6.9%	8,910	8.0%
King County	1,727,438	29.2%	26,787	16.6%	22,368	20.2%
Puget Metro Region	446,055	7.5%	16,360	10.1%	9,699	8.8%
Clark County	391,109	6.6%	16,442	10.2%	13,477	12.2%
East Balance Region	425,472	7.2%	13,986	8.7%	11,127	10.1%
Spokane County	400,478	6.8%	11,083	6.9%	8,712	7.9%
Yakima Tri-Cities Region	429,474	7.3%	9,320	5.8%	6,807	6.1%
Snohomish County	640,694	10.8%	11,642	7.2%	7,763	7.0%
Pierce County	724,493	12.3%	33,423	20.7%	13,230	12.0%

Source: UI Analysis of Augmented Washington State Database.

1. Regions that include multiple counties are North Sound (Island, San Juan, Skagit, Whatcom), West Balance (Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum), Puget Metro (Kitsap, Thurston), East Balance (Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Walla Walla, Whitman), and Yakima Tri-Cities (Benton, Franklin, Yakima).
2. High take-up scenario.

[7] There may be a data reporting problem among Pierce County respondents. Most of those found to be BHP eligible but currently covered by ESI also report having a current or former active duty military person in the family. Some of these might actually have TRICARE coverage rather than employer coverage, despite their survey responses. Note that this primarily affects eligibility for rather than take-up of BHP, since take-up rates are low for this group.

3. BHP Package A has $100 premiums and 98 percent AV.

A Basic Health Program would be funded by the federal government. Payments to the state would be 95 percent of the premium and cost-sharing subsidies that BHP enrollees would have gotten had they been in the exchange.[8] Federal guidance on the exact method of computing payments was not available at the time of writing. We follow the intent of the language in the law, adding BHP enrollees to the exchange risk pool in order to obtain the premiums used to compute payments. We then take 95 percent of premium and cost-sharing subsidies. The private insurance spending levels are based on those currently in the small firm ESI market, since the state's Essential Health Benefits benchmark package will be drawn from that market. We find that BHP payments would be $5,850 per enrollee with high take-up and $5,950 with low take-up (figure 2). If the second-lowest premium in the market were notably lower than current pricing in the small firm market, these payments would be lower. See Conclusions below for more on this issue.

We then estimate the costs of covering people under BHP. We began with the Medicaid package used in our earlier work for the Washington State Office of Financial Management (OFM). Our focus was to ensure that total Medicaid spending—the net result of provider payment rates, service utilization, and moral hazard—was consistent with current spending levels in Washington. Since private spending was also important for this work, we performed an additional verification that the Medicaid spending levels relative to commercial coverage were appropriate for BHP enrollees. See Methods section below for details. For BHP Package A, we adjusted the actuarial value down to 98 percent and reduced the resulting insured cost by the amount collected in premiums ($100 per person per year). Finally, a 15 percent administrative load was added to obtain the BHP cost per enrollee.[9] We find that BHP enrollees would cost $5,300 on average with high take-up and $5,350 with low take-up (figure 2).[10]

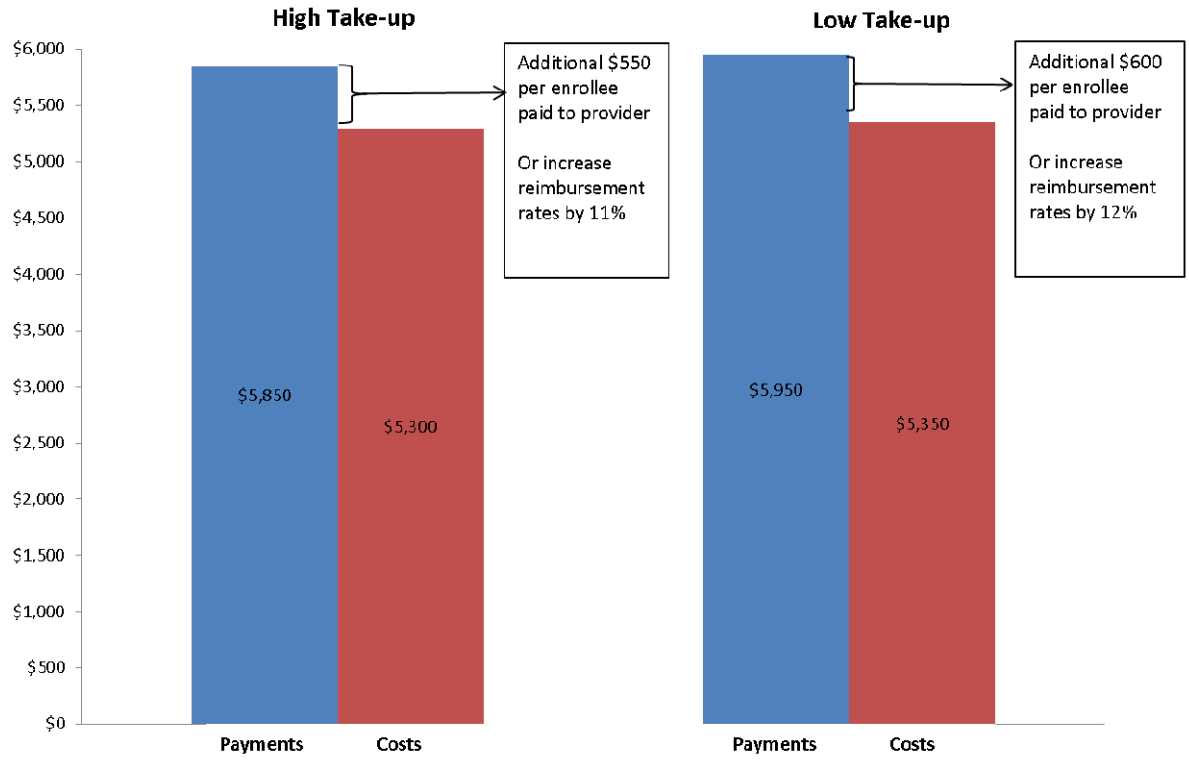
Hence, federal payments would exceed BHP costs by about $550 per enrollee with high or $600 with low take-up. By law, this surplus must be spent on beneficiary care. It could be used to lower beneficiary cost sharing and/or increase provider reimbursement. If the entire amount were devoted to provider reimbursement, it could be increased over Medicaid levels by 11 percent with high take-up or 12 percent with low take-up. When computing this, we kept the administrative load constant except for the portion used to pay premium taxes.

[8] Some have argued that the law could be interpreted to mean that payments would be 95 percent of premium subsidies and 100 percent of cost-sharing subsidies.

[9] We realize that many Medicaid managed care plans have administrative loads significantly lower, and that Washington State has long emphasized efficiency in delivering care through Medicaid. However, there would be greater churning in BHP than in Medicaid managed care, so we chose a higher load. Closer integration between Medicaid managed care and BHP could reduce the administrative costs of BHP.

[10] The main difference between this version and the prior one is that BHP costs are 6 percent lower for BHP plan A and 5 percent lower for BHP plan B. This change is based on updated 2012 data and forecasts of Medicaid costs obtained from the Washington State Office of Financial Management which better reflect spending patterns than the earlier data provided to us.

Figure 2. BHP Payments and Costs with Package A



Source: UI Analysis of Augmented Washington State Database. *Note*: Results show effects as if policies were fully implemented in 2011. Coverage based on a 98 percent actuarial value and $100 annual premiums. Results assume premiums in the exchange much like those in current markets.

BHP with Higher Cost Sharing

The cost sharing in BHP Package A is comparable to that in the Children's Health Insurance Program (CHIP) and some Medicaid managed care programs. Cost sharing could be increased to make the plan closer to exchange coverage, while keeping an advantage in affordability. To show this, we constructed BHP Package B with 94 percent actuarial value and premiums of 2 percent of family MAGI. These are exactly the values in the ACA for the subsidized exchange coverage available to legal immigrants below 138 percent FPL who are ineligible for Medicaid because they have lived in the country for less than five years. Subsidized coverage in the exchange for those from 138 to 150 percent FPL is at 94 percent actuarial value, but the premiums would be between 3 and 4 percent of income. For those between 150 and 200 percent FPL, the exchange would provide coverage at 87 percent actuarial value with premiums at 4 to 6.3 percent of income. Thus, Package B would provide lower premiums for all and lower cost sharing for those above 150 percent FPL.

Table 4. BHP Eligibility and Enrollment in Washington State, by Eligibility Category

	Eligible for BHP		Enrolled in BHP Package B[1]			
			High Take-Up		Low Take-Up	
	N	%	N	%	N	%
Total	161,578	100.0%	103,422	100.0%	74,250	100.0%
Subsidy Eligible, 138%–200% FPL	141,652	87.7%	91,610	88.6%	67,107	90.4%
Legal Immigrants Below 138% FPL	13,869	8.6%	5,755	5.6%	1,620	2.2%
MOE Adults in Waiver Programs	6,056	3.7%	6,056	5.9%	5,523	7.4%

Source: UI Analysis of Augmented Washington State Database.

1. BHP Package B sets premiums at 2 percent of MAGI and 94 percent AV.

The higher cost sharing of Package B leads to lower enrollment than Package A: 103,000 with high take-up and 74,000 with low take-up (Table 8). Package B enrollees are slightly older than Package A enrollees. While nearly 16 percent of Package A enrollees are between 19 and 24, just over 14 percent of Package B enrollees are in that age group (Tables 7 and 8). In general, though, the distribution of risk factors for health care cost is quite similar for both packages.

As in take-up of Package A, the largest numbers of enrollees under low take-up of BHP Package B reside in King County (13,300) and Clark County (9,600). Again, take-up rates vary greatly within regions. Snohomish County would experience the lowest BHP Package B take-up and contribute only 2,800 enrollees. Spokane County, on the other hand, has a relatively high take-up rate and would enroll almost three times as many residents into BHP as Snohomish County, despite having slightly fewer eligibles. Compared to enrollment under Package A, North Sound, Clark County, Spokane County, and the Yakima Tri-Cities Region would account for larger percentages of overall BHP enrollment, while the other regions would see a decreased relative contribution. For example, 7.8 percent of BHP Package A enrollees reside in the North Sound Region. This figure increases to 9.8 percent under BHP Package B.

Table 5. BHP Enrollment and Eligibility by Region[1] in Washington State

	Nonelderly Population		Eligible for BHP		Enrolled in BHP Package B[2,3]	
	N	%	N	%	N	%
Total	5,911,733	100.0%	161,578	100.0%	74,250	100.0%
North Sound Region	349,506	5.9%	11,454	7.1%	7,244	9.8%
West Balance Region	377,014	6.4%	11,080	6.9%	5,817	7.8%
King County	1,727,438	29.2%	26,787	16.6%	13,321	17.9%
Puget Metro Region	446,055	7.5%	16,360	10.1%	5,622	7.6%
Clark County	391,109	6.6%	16,442	10.2%	9,615	12.9%
East Balance Region	425,472	7.2%	13,986	8.7%	7,381	9.9%
Spokane County	400,478	6.8%	11,083	6.9%	7,659	10.3%
Yakima Tri-Cities Region	429,474	7.3%	9,320	5.8%	5,966	8.0%
Snohomish County	640,694	10.8%	11,642	7.2%	2,752	3.7%
Pierce County	724,493	12.3%	33,423	20.7%	8,873	11.9%

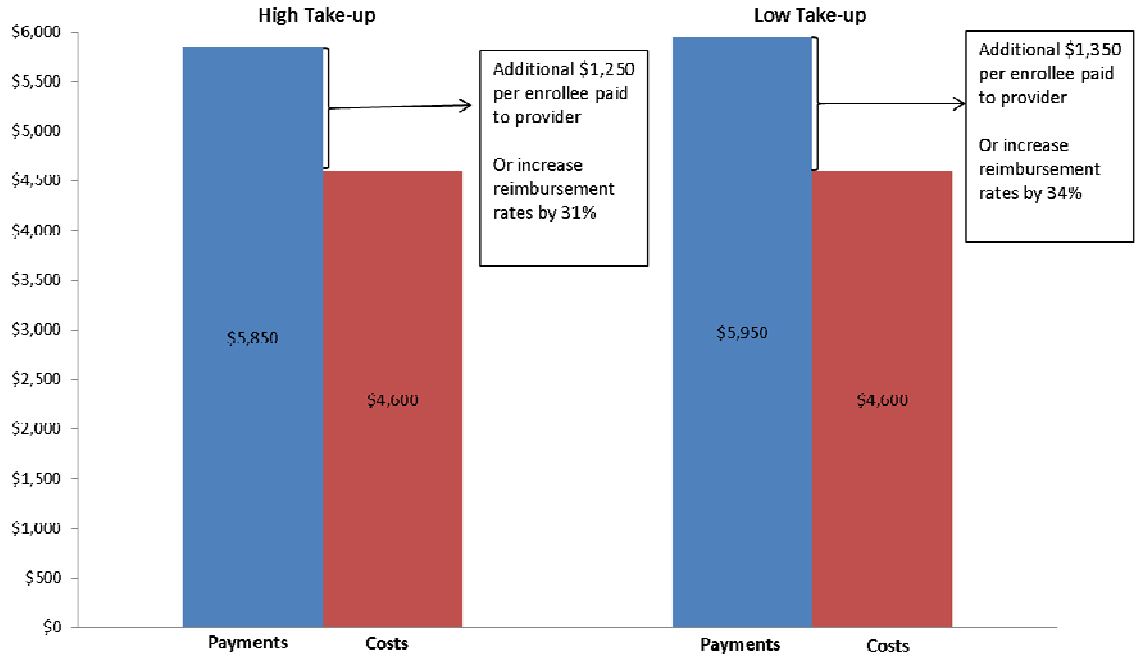
Source: UI Analysis of Augmented Washington State Database,

1. Regions that include multiple counties are North Sound (Island, San Juan, Skagit, Whatcom), West Balance (Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum), Puget Metro (Kitsap, Thurston), East Balance (Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Walla Walla, Whitman), and Yakima Tri-Cities (Benton, Franklin, Yakima).
2. Low take-up scenario.
3. BHP Package B has premiums at 2 percent of family MAGI and 94 percent AV.

BHP payments for Package B are computed in the same way as Package A, except, of course, that the population of enrollees is different. Due to higher enrollee cost sharing and the resulting moral hazard, BHP costs are significantly lower for Package B. We estimate that they would be $4,600 for both take-up scenarios, rounded to the nearest $50 (Figure 3).[11] Thus, payments would exceed costs by $1,250 per enrollee with high take-up and $1,350 per enrollee with low take-up. This surplus, which must be spent on the health care of BHP beneficiaries, could be used to raise provider reimbursement and to reduce cost sharing for beneficiaries. If all of it is applied to provider reimbursement, payments to providers could be increased by 31 percent with high take-up and 34 percent with low take-up. The state could choose any mixture of lower cost sharing and higher provider reimbursement in order to spend the surplus of payments over costs. For example, provider reimbursement could be raised to Medicaid plus 15 percent, while reducing cost sharing (both premiums and out-of-pocket costs) by an average of $600 per beneficiary.

[11] Based on updated Medicaid cost data. See footnote 10.

Figure 3. BHP Payments and Costs with Package B



Source: UI Analysis of Augmented Washington State Database. *Note*: Results show effects as if policies were fully implemented in 2011. Coverage based on a 94 percent actuarial value and annual premiums at 2% of MAGI. Results assume premiums in the exchange much like those in current markets.

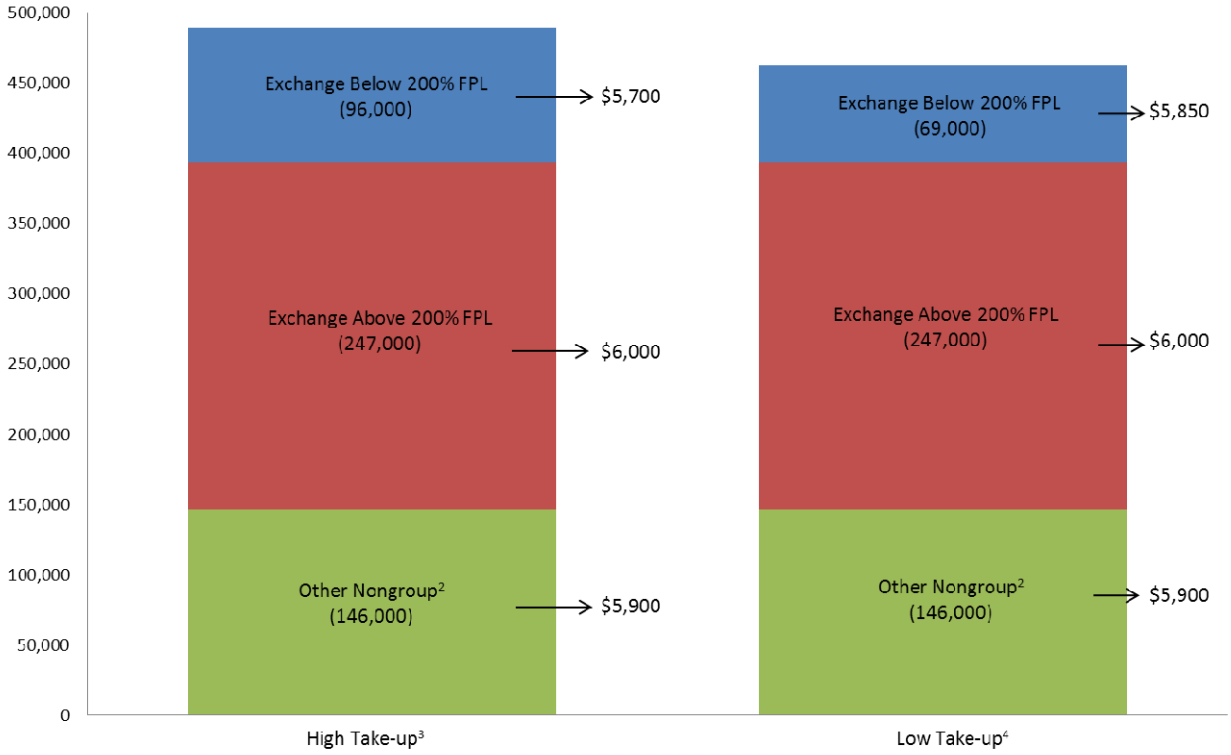
BHP and the Exchange

Next, we address some common concerns regarding BHP and the health insurance exchange. Will the exchange be too small to be viable if a BHP is established? Will the nongroup market in general be smaller and less attractive? Will premiums in the exchange be higher after BHP enrollees are taken out? To address these questions, we estimated take-up of exchange coverage for those above and below 200 percent FPL who would be eligible for subsidies using a method similar to that described above for BHP. We estimated high and low take-up scenarios for those eligible for subsidies with family income below 200 percent FPL. As with BHP, these reflect different responsiveness of low-income families to the individual mandate. Take-up for those currently uninsured ranged from 81 percent in the high scenario to 45 percent in the low scenario. We also estimated enrollment for the remainder of the exchange above 200 percent FPL.

Without BHP, there would be more than 300,000 in the exchange (Figure 4). From 69,000 to 96,000 people below 200 percent FPL would be covered, depending on responsiveness to the mandate, along with 247,000 above 200 percent FPL. This includes those eligible for subsidies as well as those ineligible for subsidies but who would still enroll. Most of those enrolling but not eligible for subsidies are already covered by a policy in the nongroup market, but the mandate would bring in some higher-income uninsured as well. Note that our results represent Washington with health reform fully phased in, not during the first year or two after the exchange and BHP are established. There would also be 146,000

who currently have nongroup coverage who would not enter the exchange or public coverage. Thus, without BHP, the nongroup market would cover between 460,000 and 490,000 lives. There are currently only about 300,000 with nongroup coverage in Washington.

Figure 4. Nongroup Market without BHP Enrollment and Total Costs[1]

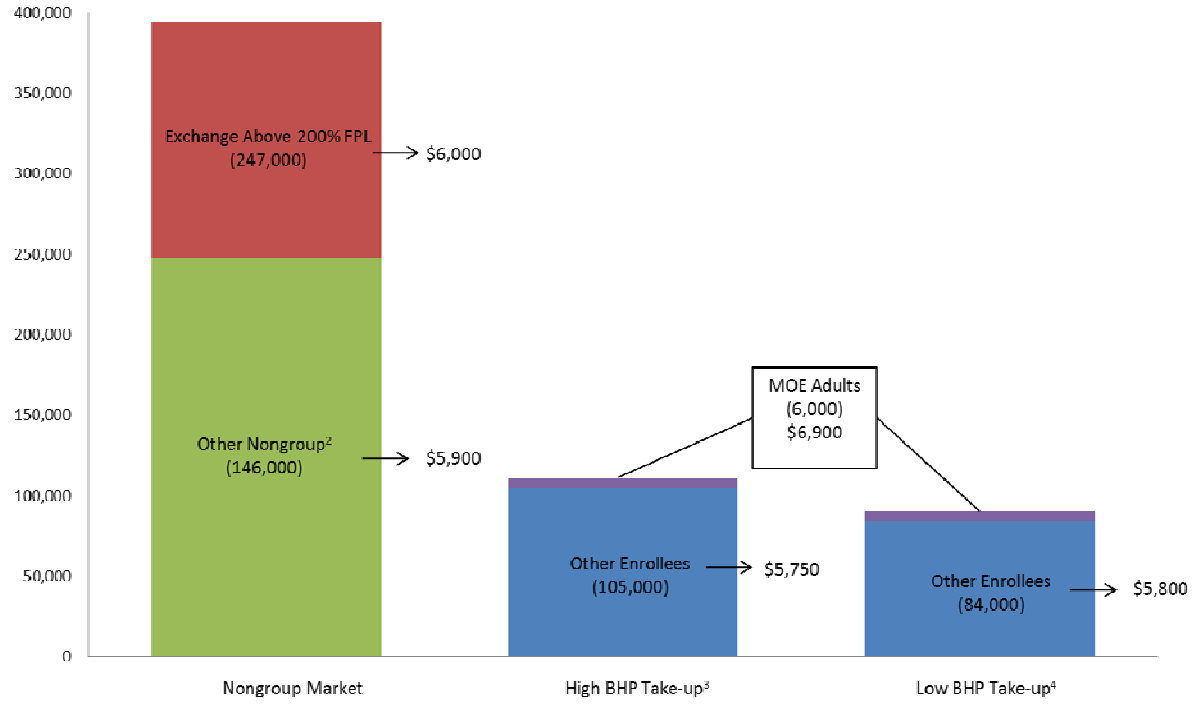


Source: UI Analysis of Augmented Washington State Database
1. Total costs indicates insured costs and out of pocket spending
2. Those with baseline NG that do not take up coverage in the Exchange, BHP or through Medicaid.
3. High Exchange take-up indicates a ~81% take-up of nongroup exchange coverage within the population of baseline uninsured subsidy eligibles between 100% and 200% of the FPL and a 21% take-up rate among baseline ESI subsidy eligibles.
4. Low Exchange take-up indicates a ~45% take-up of nongroup exchange coverage within the population of baseline uninsured subsidy eligibles between 100% and 200% of the FPL and a 16% take-up rate among baseline ESI subsidy eligibles.

The per capita annual health care spending—both insured and out-of-pocket spending—of exchange enrollees below 200 percent FPL would be $5,700 with high mandate effect and $5,850 with low mandate effect (Figure 4). This is consistent with other analysis that finds that a weakening or removal of the mandate induces adverse selection; however, the amount of adverse selection is modest.[12] Note that Figure 4 shows total spending on health care, both insured and out-of-pocket. Exchange enrollees above 200 percent FPL and other nongroup enrollees would have average total health care costs of $5,900. The overall average cost in the nongroup market without BHP would be $5,900.

[12] Buettgens and Carroll, *Eliminating the Individual Mandate*.

Figure 5. Nongroup Market with BHP Enrollment and Total Costs[1]



Source: UI Analysis of Augmented Washington State Database
1. Total costs indicates insured costs and out of pocket spending for BHP Package A
2. Those with baseline NG that do not take up coverage in the Exchange, BHP or through Medicaid.
3. High BHP take-up indicates that 29% of people with baseline ESI take-up BHP and 90% of the baseline uninsured take-up BHP.
4. Low BHP take-up indicates that 22% of people with baseline ESI take-up BHP and 71% of the baseline uninsured take-up BHP.

With BHP, the exchange would not have subsidized enrollees below 200 percent FPL. That would leave nearly 250,000 exchange enrollees and a total nongroup market size of 393,000 (Figure 5). The average health care costs of those with nongroup coverage would not differ noticeably with or without BHP, rounding to the nearest $50. Hence, BHP would still leave a substantial nongroup exchange and would not introduce noticeable adverse selection into the nongroup market.[13]

The small number of current Medicaid bridge waiver adults over 138 percent FPL who could be moved into BHP or the exchange would be much more expensive to cover, with average total costs of $6,900. Excluding these, the remaining BHP enrollees would have total health care costs of $5,750 to $5,800 on average depending on take-up, making them somewhat less expensive than those in the nongroup market.

Earlier estimates using the Washington State observations in the Current Population Survey (CPS) instead of the WSPS show a much larger difference in costs between BHP and the exchange.[14] The WSPS

[13] We assumed a 15 percent administrative load in the exchange both with and without BHP. This is consistent with the Massachusetts Connector. Note that the combined enrollment of Commonwealth Care and Commonwealth Choice in Massachusetts is less than our forecast exchange enrollment in Washington even with BHP. The presence of BHP would not by itself force an administrative load higher than 15 percent.
[14] Dorn et al., *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households*.

has a sample size roughly three times as large as two years of the CPS Washington State records merged together, so these new results would be much less subject to error due to small sample. Note that the earlier estimate of the number of Washington residents eligible for and enrolling in BHP is very close to our current numbers (163,000 eligible and 104,000 enrolled in Table 2 of that paper). The difference is thus in costs rather than population. The distribution of health care costs is well known to have a high variance and to be highly skewed, making average costs particularly susceptible to small sample error.

Overall Impact on the Number of Uninsured

Under the high take-up scenario, 105,000 people eligible for BHP would enroll in BHP Package A (excluding the 6,000 adults affected by Medicaid MOE), while only 96,000 would enroll in the exchange without BHP, a gain in coverage of 9,000. This scenario assumes a strong effect of the individual mandate on behavior. Without a strong mandate effect, take-up of both BHP and the exchange drops substantially, but the difference in enrollment, 15,000, is greater due to the greater importance given to affordability when deciding whether or not to enroll in coverage. The difference in take-up under the low scenario is dramatic for those currently uninsured—71 percent for BHP versus 45 percent for the exchange—but only half of those eligible for BHP are currently uninsured (Table 6). There would be a much smaller difference for those currently with ESI, who take up at a much lower rate anyway, and no difference for those currently in the nongroup market, who would take up at a very high rate due to the no-wrong-door interface and the fact that exchange coverage would be much more affordable than the coverage for which they are currently paying.

Thus, BHP could lead to up to 15,000 who would have been otherwise uninsured obtaining coverage, depending on mandate enforcement and compliance among low-income families. However, estimating the effect on the overall number of uninsured is more complicated. The presence of BHP could affect the take-up decisions of those not eligible in two ways. First, nongroup premiums could change when BHP enrollees are removed from the nongroup risk pool. We answered this concern by showing above that average costs, and therefore premiums, would not change significantly.

Second, the greater affordability of BHP will cause some low-income workers who currently have ESI to value BHP more highly than their current coverage. Since worker preferences are an important factor in employers' decisions whether to offer coverage, this may lead some employers with significant numbers of BHP-eligible workers to stop offering coverage.[15] This loss of ESI would cause some workers not eligible for BHP to become uninsured. We did not have access to the sophisticated modeling of the employer offer decision used in HIPSM on the WSPS data, but experience in modeling BHP has shown that the number of employers who would drop would be small. However, there would likely be enough to offset much of the small difference (9,000) in take-up under the high scenario. There would likely be fewer uninsured in Washington State with a BHP, particularly with lower enforcement or compliance with the mandate, but the difference would be modest.

[15] Linda Blumberg, Matthew Buettgens, Judy Feder, and John Holahan, *Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act* (Washington, DC: The Urban Institute, 2011), http://www.urban.org/health_policy/url.cfm?ID=412428.

Detailed Characteristics of Those Eligible and Enrolling

Several times above, we have used differences in age and health status to explain differences in coverage and costs. In this section, we include detailed characteristics of the populations relevant to BHP and subsidized exchange coverage. We show considerable detail in these characteristics; many estimates are based on relatively small numbers of survey observations. Rather than suppress them, we mark the relevant numbers. Estimates based on a small sample are italicized, and those with very small sample are grayed as well. These should be considered less reliable than other estimates.

Table 6 gives detailed characteristics of those eligible for BHP and exchange subsidies. The first six columns summarize those eligible for subsidized coverage in the exchanges. Those eligible for subsidies below 200 percent FPL would be eligible for BHP (first two columns). The next two columns show those between 200 and 400 percent FPL who would be eligible for subsidies, and the final columns in the block show all eligible for subsidies. For comparison, we then give the distribution of those currently with nongroup coverage and those currently uninsured. For example, just over 16 percent of BHP eligibles would be in fair or poor health, compared with 11 percent of those above 200 percent FPL eligible for subsidies and 20.5 percent of those currently uninsured. Almost 16 percent of BHP eligibles would be between 19 and 24 years old, compared with just over 22 percent of other subsidy eligibles with higher income.

Table 7 deals with enrollment in BHP Package A and in the exchange. The first four columns show enrollment in the BHP under the high and low scenarios. The share of BHP enrollees in fair or poor health would be 17.1 percent with low take-up and 15.9 percent with high take-up. As we saw in Table 6, 16 percent of eligibles are in fair or poor health, so those with better health status would be somewhat less likely to enroll with the lower effect of the individual mandate. Likewise, enrollees tend to be somewhat older with low take-up than with high take-up. We next show the small population of adults currently in Medicaid who could be moved into BHP. The next four columns show nongroup exchange enrollment of those below 200 percent FPL under high and low scenarios. Finally, we show our estimated enrollment in the exchange for those above 200 percent FPL. Note that exchange enrollment includes some not eligible for subsidies.

Table 8 shows the characteristics of those who would enroll in BHP Package B under high and low scenarios. Differences in the distribution of age and health status between packages A and B are small.

Table 6. Characteristics of Nonelderly Washington State Residents by Eligibility and Coverage Type

	Eligibility Type						Coverage Type			
	BHP Eligible		Not Eligible for BHP		All Subsidy Eligibles		Nongroup		Uninsured	
	N	%	N	%	N	%	N	%	N	%
Total Nonelderly	161,578	100.0%	383,715	100.0%	545,293	100.0%	293,164	100.0%	786,404	100.0%
Current Coverage										
Medicaid	6,056	3.7%	10,413	2.7%	16,469	3.0%	---	---	---	---
Medicare	0	0.0%	0	0.0%	0	0.0%	---	---	---	---
ESI	56,568	35.0%	161,490	42.1%	218,058	40.0%	---	---	---	---
NG	21,503	13.3%	58,626	15.3%	80,128	14.7%	---	---	---	---
Uninsured	77,451	47.9%	153,187	39.9%	230,637	42.3%	---	---	---	---
Health Status										
Excellent	40,780	25.2%	102,002	26.6%	142,781	26.2%	108,376	37.0%	161,626	20.6%
Very Good	29,361	18.2%	104,230	27.2%	133,591	24.5%	80,248	27.4%	162,302	20.6%
Good	65,323	40.4%	135,298	35.3%	200,620	36.8%	78,119	26.6%	301,426	38.3%
Fair	*21,232*	*13.1%*	*28,340*	*7.4%*	*49,572*	*9.1%*	21,687	7.4%	120,286	15.3%
Poor	*4,883*	*3.0%*	*13,846*	*3.6%*	*18,729*	*3.4%*	4,734	1.6%	40,764	5.2%
MAGI										
Under 138% FPL	*13,869*	*8.6%*	*0*	*0.0%*	*13,869*	*2.5%*	35,057	12.0%	353,263	44.9%
138% - 200% FPL	147,708	91.4%	0	0.0%	147,708	27.1%	24,703	8.4%	117,370	14.9%
200% - 300% FPL	0	0.0%	201,603	52.5%	201,603	37.0%	30,472	10.4%	140,803	17.9%
300% - 400% FPL	0	0.0%	182,112	47.5%	182,112	33.4%	54,273	18.5%	86,570	11.0%
400%+ FPL	0	0.0%	0	0.0%	0	0.0%	148,658	50.7%	88,398	11.2%
Age										
0 - 18	*12,021*	*7.4%*	*28,352*	*7.4%*	*40,373*	*7.4%*	49,557	16.9%	56,900	7.2%
19 - 24 years	25,613	15.9%	85,440	22.3%	111,053	20.4%	19,958	6.8%	166,041	21.1%
25 - 44 years	76,535	47.4%	126,433	32.9%	202,968	37.2%	98,835	33.7%	360,940	45.9%
45 - 64 years	47,408	29.3%	143,491	37.4%	190,900	35.0%	124,813	42.6%	202,523	25.8%
Race/Ethnicity										
White, Non-Hispanic	115,885	71.7%	295,846	77.1%	411,732	75.5%	241,872	82.5%	523,969	66.6%
Black, Non-Hispanic	*6,806*	*4.2%*	*17,091*	*4.5%*	*23,897*	*4.4%*	7,787	2.7%	27,813	3.5%
Hispanic	*23,848*	*14.8%*	*26,277*	*6.8%*	*50,125*	*9.2%*	10,711	3.7%	153,502	19.5%
Other[1]	*15,038*	*9.3%*	*44,501*	*11.6%*	*59,540*	*10.9%*	32,794	11.2%	81,119	10.3%
HIU Type[2]										
Single, No Dependents	72,693	45.0%	193,523	50.4%	266,216	48.8%	84,098	28.7%	395,261	50.3%
Single, With Dependents	*11,403*	*7.1%*	*20,648*	*5.4%*	*32,051*	*5.9%*	20,873	7.1%	86,599	11.0%
Married, No Dependents	19,767	12.2%	80,631	21.0%	100,398	18.4%	72,794	24.8%	90,716	11.5%
Married, With Dependents	57,528	35.6%	88,248	23.0%	145,776	26.7%	115,057	39.2%	208,579	26.5%
Kid Only	*187*	*0.1%*	*665*	*0.2%*	*852*	*0.2%*	342	0.1%	5,250	0.7%
Adult Nonelderly Population	149,557	100.0%	355,363	100.0%	504,920	100.0%	243,606	100.0%	729,504	100.0%
Employment Status[3]										
Unemployed/Not in Labor Force	89,278	59.7%	220,384	62.0%	309,662	61.3%	89,462	36.7%	350,966	48.1%
Employed - Unidentifiable Firm Size	28,244	18.9%	58,465	16.5%	86,709	17.2%	97,282	39.9%	143,251	19.6%
Small Firm (< 50 Employees)	22,451	15.0%	53,039	14.9%	75,491	15.0%	37,916	15.6%	139,696	19.1%
Medium Firm (50-500 Employees)	*5,920*	*4.0%*	*10,459*	*2.9%*	*16,380*	*3.2%*	6,858	2.8%	37,358	5.1%
Large Firm (500+ Employees)	*3,663*	*2.4%*	*13,016*	*3.7%*	*16,679*	*3.3%*	12,088	5.0%	58,233	8.0%
Tobacco Use										
Yes	39,197	26.2%	88,208	24.8%	127,405	25.2%	59,524	24.4%	182,978	25.1%
No	110,360	73.8%	267,155	75.2%	377,515	74.8%	184,083	75.6%	546,525	74.9%
Chronic Condition Prevalences[4]										
Angina	*1,978*	*1.3%*	*9,145*	*2.6%*	*11,123*	*2.2%*	7,148	2.9%	7,396	1.0%
Arthritis	*14,972*	*10.0%*	*49,232*	*13.9%*	*64,204*	*12.7%*	42,296	17.4%	81,621	11.2%
Asthma	*11,616*	*7.8%*	*27,220*	*7.7%*	*38,836*	*7.7%*	23,679	9.7%	69,000	9.5%
Coronary Heart Disease	*2,286*	*1.5%*	*10,907*	*3.1%*	*13,194*	*2.6%*	7,839	3.2%	10,831	1.5%
Diabetes	*4,693*	*3.1%*	*18,474*	*5.2%*	*23,167*	*4.6%*	17,812	7.3%	30,615	4.2%
Emphysema	*588*	*0.4%*	*3,741*	*1.1%*	*4,329*	*0.9%*	2,238	0.9%	6,276	0.9%
Heart Attack	*3,105*	*2.1%*	*9,417*	*2.7%*	*12,522*	*2.5%*	4,093	1.7%	14,693	2.0%
High Blood Pressure	21,846	14.6%	71,110	20.0%	92,956	18.4%	61,231	25.1%	109,075	15.0%
Other Heart Disease	*9,289*	*6.2%*	*25,764*	*7.2%*	*35,053*	*6.9%*	16,150	6.6%	42,586	5.8%
Stroke	*972*	*0.6%*	*4,743*	*1.3%*	*5,715*	*1.1%*	2,444	1.0%	7,806	1.1%

Source: UI Analysis of Augmented Washington State Database

1. Other includes, among the non-Hispanic population, American Indian/Alaskan Native, Native Hawaiian/ Other Pacific Islander, and Multiracial

2. "Married" includes health insurance units with a married individual even if the spouse is not within the unit

3. Employment subcategories include part-time workers. Self-employed workers are included in "Employed - Unidentifiable Firm Size"

4. Except for asthma, all prevalences reflect any diagnosis of the disease in question, regardless how long ago the diagnosis occurred. The asthma prevalence reflects a current asthma diagnosis.

Note: Italicized font indicates a weighted sample of the entire subsidy population under 70,000

Note: Italicized and grayed font indicates a weighted sample of the entire subsidy population under 30,000

Table 7. Characteristics of Nonelderly, Nongroup Exchange and BHP Enrollees in Washington State

	BHP Package A[1] without MOE Adults				MOE Adults Below 200% FPL		Nongroup Exchange Below 200% FPL				Other Nongroup Exchange (Above 200% FPL)	
	High Take-Up[2]		Low Take-Up[3]				High Take-Up[4]		Low Take-Up[5]			
	N	%	N	%	N	%	N	%	N	%	N	%
Total Nonelderly	104,636	100.0%	84,390	100.0%	6,056	100.0%	95,976	100.0%	68,981	100.0%	247,302	100.0%
Current Coverage												
Medicaid	0	0.0%	0	0.0%	6,056	100.0%	0	0.0%	0	0.0%	0	0.0%
Medicare	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
ESI	16,010	15.3%	11,945	14.2%	0	0.0%	11,717	12.2%	8,651	12.5%	50,254	20.3%
NG	20,571	19.7%	20,571	24.4%	0	0.0%	25,567	26.6%	25,567	37.1%	109,030	44.1%
Uninsured	68,056	65.0%	51,874	61.5%	0	0.0%	58,692	61.2%	34,764	50.4%	88,018	35.6%
Health Status												
Excellent	23,284	22.3%	16,522	19.6%	883	14.6%	21,595	22.5%	15,850	23.0%	78,161	31.6%
Very Good	19,914	19.0%	16,357	19.4%	1,325	21.9%	18,976	19.8%	14,660	21.3%	59,671	24.1%
Good	44,727	42.7%	37,041	43.9%	2,711	44.8%	42,599	44.4%	28,748	41.7%	82,237	33.3%
Fair	*14,053*	*13.4%*	*12,247*	*14.5%*	*533*	*8.8%*	*11,085*	*11.5%*	*8,603*	*12.5%*	*19,991*	*8.1%*
Poor	*2,658*	*2.5%*	*2,224*	*2.6%*	*604*	*10.0%*	*1,721*	*1.8%*	*1,119*	*1.6%*	*7,242*	*2.9%*
MAGI												
Under 138% FPL	*9,507*	*9.1%*	*5,755*	*6.8%*	*0*	*0.0%*	*9,691*	*10.1%*	*9,691*	*14.0%*	*0*	*0.0%*
138% - 200% FPL	95,129	90.9%	78,634	93.2%	6,056	100.0%	86,284	89.9%	59,290	86.0%	0	0.0%
200% - 300% FPL	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	103,607	41.9%
300% - 400% FPL	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	48,480	19.6%
400%+ FPL	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	95,214	38.5%
Age												
0 - 18	*0*	*0.0%*	*0*	*0.0%*	*0*	*0.0%*	*1,243*	*1.3%*	*1,243*	*1.8%*	*26,361*	*10.7%*
19 - 24 years	16,592	15.9%	9,481	11.2%	608	10.0%	11,960	12.5%	4,925	7.1%	29,374	11.9%
25 - 44 years	49,428	47.2%	42,336	50.2%	3,247	53.6%	49,664	51.7%	37,672	54.6%	85,723	34.7%
45 - 64 years	38,616	36.9%	32,573	38.6%	2,202	36.4%	33,109	34.5%	25,141	36.4%	105,844	42.8%
Race/Ethnicity												
White, Non-Hispanic	75,002	71.7%	61,844	73.3%	4,341	71.7%	70,292	73.2%	48,133	69.8%	202,676	82.0%
Black, Non-Hispanic	*5,756*	*5.5%*	*4,405*	*5.2%*	*0*	*0.0%*	*6,895*	*7.2%*	*5,544*	*8.0%*	*3,769*	*1.5%*
Hispanic	*12,354*	*11.8%*	*10,109*	*12.0%*	*1,111*	*18.3%*	*8,792*	*9.2%*	*6,384*	*9.3%*	*13,049*	*5.3%*
Other[6]	*11,524*	*11.0%*	*8,032*	*9.5%*	*604*	*10.0%*	*9,997*	*10.4%*	*8,920*	*12.9%*	*27,807*	*11.2%*
HIU Type[7]												
Single, No Dependents	55,697	53.2%	40,574	48.1%	2,227	36.8%	41,194	42.9%	18,208	26.4%	81,579	33.0%
Single, With Dependents	*6,293*	*6.0%*	*5,178*	*6.1%*	*943*	*15.6%*	*6,619*	*6.9%*	*6,619*	*9.6%*	*15,655*	*6.3%*
Married, No Dependents	17,763	17.0%	13,965	16.5%	1,038	17.1%	19,190	20.0%	15,392	22.3%	67,897	27.5%
Married, With Dependents	24,883	23.8%	24,672	29.2%	1,848	30.5%	28,973	30.2%	28,761	41.7%	82,171	33.2%
Kid Only	*0*	*0.0%*	*0*	*0.0%*	*0*	*0.0%*	*0*	*0.0%*	*0*	*0.0%*	*0*	*0.0%*
Adult Nonelderly Population	104,636	100.0%	84,390	100.0%	6,056	100.0%	94,733	100.0%	67,738	100.0%	220,941	100.0%
Employment Status[8]												
Unemployed/Not in Labor Force	55,205	52.8%	43,137	51.1%	2,035	33.6%	45,370	47.9%	31,367	46.3%	94,572	42.8%
Employed - Unidentifiable Firm Size	24,827	23.7%	24,191	28.7%	1,537	25.4%	22,951	24.2%	16,978	25.1%	64,091	29.0%
Small Firm (< 50 Employees)	18,316	17.5%	12,609	14.9%	608	10.0%	18,579	19.6%	13,732	20.3%	42,678	19.3%
Medium Firm (50-500 Employees)	*3,407*	*3.3%*	*2,056*	*2.4%*	*1,492*	*24.6%*	*3,726*	*3.9%*	*2,038*	*3.0%*	*12,135*	*5.5%*
Large Firm (500+ Employees)	*2,882*	*2.8%*	*2,397*	*2.8%*	*383*	*6.3%*	*4,107*	*4.3%*	*3,622*	*5.3%*	*7,466*	*3.4%*
Tobacco Use												
Yes	31,576	30.2%	24,840	29.4%	3,052	50.4%	27,321	28.8%	17,849	26.3%	53,084	24.0%
No	73,060	69.8%	59,549	70.6%	3,005	49.6%	67,412	71.2%	49,889	73.7%	167,857	76.0%
Chronic Condition Prevalences[9]												
Angina	*1,445*	*1.4%*	*1,274*	*1.5%*	*533*	*8.8%*	*1,445*	*1.5%*	*1,274*	*1.9%*	*6,832*	*3.1%*
Arthritis	*14,207*	*13.6%*	*12,823*	*15.2%*	*604*	*10.0%*	*14,358*	*15.2%*	*10,115*	*14.9%*	*42,206*	*19.1%*
Asthma	*8,439*	*8.1%*	*8,059*	*9.5%*	*697*	*11.5%*	*8,885*	*9.4%*	*6,168*	*9.1%*	*26,219*	*11.9%*
Coronary Heart Disease	*1,910*	*1.8%*	*1,740*	*2.1%*	*0*	*0.0%*	*1,339*	*1.4%*	*1,168*	*1.7%*	*5,717*	*2.6%*
Diabetes	*4,172*	*4.0%*	*3,070*	*3.6%*	*521*	*8.6%*	*4,172*	*4.4%*	*3,070*	*4.5%*	*18,910*	*8.6%*
Emphysema	*588*	*0.6%*	*588*	*0.7%*	*0*	*0.0%*	*588*	*0.6%*	*588*	*0.9%*	*3,372*	*1.5%*
Heart Attack	*2,196*	*2.1%*	*2,025*	*2.4%*	*533*	*8.8%*	*1,625*	*1.7%*	*815*	*1.2%*	*4,971*	*2.2%*
High Blood Pressure	17,703	16.9%	15,773	18.7%	1,054	17.4%	17,553	18.5%	13,332	19.7%	60,060	27.2%
Other Heart Disease	*6,583*	*6.3%*	*5,267*	*6.2%*	*1,476*	*24.4%*	*5,477*	*5.8%*	*3,995*	*5.9%*	*18,521*	*8.4%*
Stroke	*972*	*0.9%*	*972*	*1.2%*	*0*	*0.0%*	*468*	*0.5%*	*468*	*0.7%*	*3,027*	*1.4%*

Source: UI Analysis of Augmented Washington State Database

1. BHP Package A has $100 premiums and 98% AV.

2. High BHP take-up indicates that 29% of people with baseline ESI take-up BHP and 90% of the baseline uninsured take-up BHP.

3. Low BHP take-up indicates that 22% of people with baseline ESI take-up BHP and 71% of the baseline uninsured take-

4. High Exchange take-up indicates a ~81% take-up of nongroup exchange coverage within the population of baseline uninsured subsidy eligibles between 100% and 200% of the FPL and a 21% take-up rate among baseline ESI subsidy eligibles.

5. Low Exchange take-up indicates a ~45% take-up of nongroup exchange coverage within the population of baseline uninsured subsidy eligibles between 100% and 200% of the FPL and a 16% take-up rate among baseline ESI subsidy eligibles.

6. Other includes, among the non-Hispanic population, American Indian/Alaskan Native, Native Hawaiian/ Other Pacific Islander, and Multiracial

7. "Married" includes health insurance units with a married individual even if the spouse is not within the unit

8. Employment subcategories include part-time workers. Self-employed workers are included in "Employed - Unidentifiable Firm Size"

9. Except for asthma, all prevalences reflect any diagnosis of the disease in question, regardless how long ago the diagnosis occurred. The asthma prevalence reflects a current asthma diagnosis.

Note: Italicized font indicates a weighted sample of the entire subsidy population under 70,000

Note: Italicized and grayed font indicates a weighted sample of the entire subsidy population under 30,000

Table 8. Characteristics of Nonelderly, BHP Enrollees in Washington State

	BHP Package B[1] without MOE Adults			
	High Take-up		Low Take-up	
	N	%	N	%
Total Nonelderly	97,365	100.0%	68,727	100.0%
Current Coverage				
Medicaid	0	0.0%	0	0.0%
Medicare	0	0.0%	0	0.0%
ESI	14,230	14.6%	10,640	15.5%
NG	20,571	21.1%	20,571	29.9%
Uninsured	62,565	64.3%	37,517	54.6%
Health Status				
Excellent	20,303	20.9%	13,527	19.7%
Very Good	18,814	19.3%	14,267	20.8%
Good	42,830	44.0%	30,152	43.9%
Fair	*13,194*	*13.6%*	*9,158*	*13.3%*
Poor	*2,224*	*2.3%*	*1,622*	*2.4%*
MAGI				
Under 138% FPL	*5,755*	*5.9%*	*1,620*	*2.4%*
138% - 200% FPL	91,610	94.1%	67,107	97.6%
200% - 300% FPL	0	0.0%	0	0.0%
300% - 400% FPL	0	0.0%	0	0.0%
400%+ FPL	0	0.0%	0	0.0%
Age				
0 - 18	*0*	*0.0%*	*0*	*0.0%*
19 - 24 years	13,955	14.3%	6,223	9.1%
25 - 44 years	47,648	48.9%	34,088	49.6%
45 - 64 years	35,763	36.7%	28,417	41.3%
Race/Ethnicity				
White, Non-Hispanic	71,911	73.9%	50,211	73.1%
Black, Non-Hispanic	*5,756*	*5.9%*	*4,405*	*6.4%*
Hispanic	*11,495*	*11.8%*	*6,986*	*10.2%*
Other[2]	*8,203*	*8.4%*	*7,125*	*10.4%*
HIU Type[3]				
Single, No Dependents	49,540	50.9%	29,041	42.3%
Single, With Dependents	*5,178*	*5.3%*	*4,739*	*6.9%*
Married, No Dependents	17,763	18.2%	12,631	18.4%
Married, With Dependents	24,883	25.6%	22,316	32.5%
Kid Only	*0*	*0.0%*	*0*	*0.0%*
Adult Nonelderly Population	97,365	100.0%	68,727	100.0%
Employment Status				
Unemployed	49,144	50.5%	32,684	47.6%
Employed - Unidentifiable Firm Size	24,476	25.1%	21,234	30.9%
Small Firm (< 50 Employees)	17,457	17.9%	10,692	15.6%
Medium Firm (50-500 Employees)	*3,407*	*3.5%*	*1,719*	*2.5%*
Large Firm (500+ Employees)	*2,882*	*3.0%*	*2,397*	*3.5%*
Tobacco Use				
Yes	30,499	31.3%	18,765	27.3%
No	66,866	68.7%	49,962	72.7%
Chronic Condition Prevalences[4]				
Angina	*1,445*	*1.5%*	*1,274*	*1.9%*
Arthritis	*13,989*	*14.4%*	*11,194*	*16.3%*
Asthma	*8,439*	*8.7%*	*7,374*	*10.7%*
Coronary Heart Disease	*1,910*	*2.0%*	*1,085*	*1.6%*
Diabetes	*4,172*	*4.3%*	*2,987*	*4.3%*
Emphysema	*588*	*0.6%*	*588*	*0.9%*
Heart Attack	*2,196*	*2.3%*	*1,454*	*2.1%*
High Blood Pressure	17,703	18.2%	14,487	21.1%
Other Heart Disease	*5,724*	*5.9%*	*4,159*	*6.1%*
Stroke	*972*	*1.0%*	*972*	*1.4%*

Source: UI Analysis of Augmented Washington State Database

1. BHP Package B sets premiums at 2% of MAGI and 94% AV.

2. Other includes, among the non-Hispanic population, American Indian/Alaskan Native, Native Hawaiian/ Other Pacific Islander, and Multiracia

3. "Married" includes health insurance units with a married individual even if the spouse is not within the unit

4. Except for asthma, all prevalences reflect any diagnosis of the disease in question, regardless how long ago the diagnosis occurred. The asthma prevalence reflects a current asthma diagnosis.

Note: Italicized font indicates a weighted sample of the entire subsidy population under 70,000

Note: Italicized and grayed font indicates a weighted sample of the entire subsidy population under 30,000

Methods

Our ability to generate expedient estimates of BHP eligibility depended largely on previous research done in conjunction with OFM to enhance WSPS with data elements from the CPS and the Medical Expenditure Panel Survey (MEPS). Our work with OFM included the imputation of several key variables necessary to the determination of BHP eligibility, specifically Medicaid/CHIP eligibility types, MAGI, and immigration status. The methodology for imputing the preceding variables can be found in memos provided to OFM.[16] Building on this previous work, we determined the presence and affordability of an ESI offer as well as the length of U.S. residency for legal residents in order to estimate BHP eligibility.

Additionally, we took advantage of data from previous research with HIPSM. The core microdata file that defines HIPSM's population base is a pooled data set of the March 2008 and 2009 CPS Annual Social and Economic Supplement. The CPS lacks health care expenditure data, so health care expenditures are statistically matched to CPS interviewee records from the detailed cost information available in the MEPS household component. The resulting data sets from HIPSM contain the requisite demographic variables to determine affordability as well as premium information. HIPSM estimates ACA-level premiums faced by every employee, including both single and family packages where applicable. Our baseline national ESI premium estimates are calibrated to be compatible with premiums in the most recent MEPS-Insurance Component and Kaiser/Health Research and Educational Trust surveys. Average premiums by firm size are calibrated by adjusting the actuarial value of ESI plans. Premiums are calculated based on a blend between the weighted averages of actual and expected insured costs. Full documentation of HIPSM is publicly available.[17]

Given that previous research provided us with many of the determinants of BHP and subsidy eligibility, finalization these eligibility statuses depended on further imputation of only two variables: presence of affordable ESI offer and the length of U.S. residency of legal immigrants. The imputation methodology, used successfully in previous work to augment the WSPS, is described in more detail below.

ESI Offer Determination

We based our ESI offer estimates on a WSPS question that asks survey respondents whether a health plan is available through work. However, there were several limitations to the variable, in that the question is only posed to respondents who are working and have not already indicated that they have ESI.[18] We adjusted the variable such that all working adults who are policy holders of an ESI plan also have an ESI offer. After this correction, the distribution of ESI offer by firm size approximated that of the Washington observations in the CPS.

After constructing an accurate indicator of ESI offer, we determined the affordability of those offers. Given that the WSPS does not contain the necessary premium information to calculate affordability, we

[16] Matthew Buettgens, Randall Bovbjerg, and Caitlin Carroll, Memorandum to Washington State Office of Financial Management, *Construction of the Augmented Washington State Health Survey* (June 2011); Buettgens et al., Memorandum to Washington State Office of Financial Management, *Task .2*

[17] For more about HIPSM and a list of recent research using it, see http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf. In addition, detailed technical documentation is available: *HIPSM Methodology, 2011 National Version* (Washington, DC: The Urban Institute, 2011), http://www.urban.org/health_policy/url.cfm?ID=412471.

[18] http://www.ofm.wa.gov/sps/2010/dictionary2010v1.pdf

used a regression-based imputation to predict ESI offer affordability onto the WSPS from previously constructed HIPSM data. Conditioning on the presence on an ESI offer, we used a probit regression to predict affordability of those offers; dependent variables included industry, firm size, insurance unit type, MAGI as a percentage of FPL, and the logarithm of wages. We calibrated overall affordability levels to our full HIPSM results such that approximately 2 percent of all people with ESI offers have unaffordable offers and 16 percent of all people under 200 percent of FPL with ESI offers have unaffordable offers.

Length of Residence in the United States of Legal Residents

We again took advantage of previous work to impute the length of time that legally resident immigrants had been in the United States, specifically whether those with incomes below 138 percent FPL had met the five-year threshold necessary to qualify for Medicaid. Fortunately, our baseline data for HIPSM contains just such an indicator based on CPS variables. We performed a cell-based, "hotdeck" match between the WSPS and the HIPSM baseline file. As in the regression-based imputation, we analyzed both data sets and reconciled their variables for the characteristics to be used in the match. We then optimized the matching cells and performed the match, which allows data from the HIPSM baseline to be attached to the WSPS. Matching cells included age, insurance unit type, race, work status, education status, and income.

Imputation of Exchange and BHP Take-up

The decisions to take up BHP or exchange coverage made by families on the WSPS are based on the behavior of similar individuals and families in HIPSM. That behavior is based on an expected utility model that takes into account many characteristics of the individual or family involved. The value of each health coverage option (including being uninsured) takes into account factors such as the out-of-pocket premium costs, other out-of-pocket health care costs, the risk of high health care costs, and disposable income. All decisions are based on constant relative risk aversion, which means, among other things, that a given amount of money means more to a family with less disposable income than to one with more. Also, we take into account a family's reported preferences and choices on the original survey. For example, a person eligible for Medicaid but who is not enrolled has indicated a preference against Medicaid, and will be less likely to enroll than a similar person who has just gained eligibility. These individual and family utility functions are calibrated so that the overall price responsiveness matches targets drawn from the literature. For details, see the HIPSM Methodology Documentation.[19]

In order to predict take-up of nongroup exchange coverage, we again used a regression-based imputation to predict ACA level enrollment onto the WSPS from previously constructed HIPSM data. The models were restricted to nonelderly individuals who do not take up Medicaid and are not undocumented immigrants. We predicted nongroup exchange take-up separately for those who would be eligible for exchange subsidies and those who would not. Thus, we specified two probit models, both with the same covariates: family structure, age group, quintile of health expenditure, health status, work status, the logarithm of wages, presence of an ESI offer, MAGI as a percentage of FPL, and education status. In order to get sufficient variation in take-up due to current insurance status, we interacted all covariates with baseline insurance status, effectively running separate models for each

[19] Matthew Buettgens, *HIPSM Methodology Documentation, 2011 National Version* (Washington, DC: The Urban Institute, 2011), http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf.

baseline coverage type. We calibrated overall nongroup take-up levels by income, baseline coverage, and exchange subsidy eligibility to approximate our full HIPSM results. Our range of possible enrollment scenarios is driven by varying take-up of the subsidy eligible under 200 percent FPL. Within this population, low exchange enrollment is driven by a 16 percent take-up rate for those with baseline ESI and a 45 percent take-up rate among the baseline uninsured. In the high exchange scenario, there is a 21 percent take-up rate among those with baseline ESI and a 81 percent take-up rate for the baseline uninsured. The take-up rate of those with baseline nongroup coverage is 96 percent in both scenarios; take-up among Medicaid-ineligible legal immigrants below 138 percent FPL is also constant across take-up scenarios at 53 percent.

The methodology for predicting BHP take-up was very similar to that of the nongroup exchange. We again constructed a regression-based model to determine the coverage status of BHP eligibles who did not take up coverage in the nongroup exchange, assuming all BHP eligibles who took up coverage in the exchange would also take up BHP. Note that the high/low BHP take-up scenarios correspond to the high/low exchange take-up scenarios, and as such we assumed that anyone opting into exchange coverage in the high/low take-up scenario would choose BHP in its corresponding high/low take-up scenario. We used a probit model, restricting to BHP eligibles. We included the same covariates as in the nongroup exchange take-up model, but due to sample size limitations did not interact the independent variables with baseline coverage. We calibrated the results of the model to HIPSM estimates by baseline coverage. In both the high and low take-up scenarios, approximately 95 percent of those with baseline nongroup coverage take up BHP. Take-up of BHP among those with baseline ESI ranges from 22 percent to 29 percent in the low and high take-up scenarios, respectively, while take-up within the baseline uninsured population moves from 71 percent to 90 percent. Take-up within the population of Medicaid-ineligible legal immigrants below 138 percent FPL is about 42 percent with low take-up and 69 percent with high take-up (table 9).

Table 9. Take-up Rates for Each Health Coverage Option and Scenario

Insurance Product	Mandate effect	Take-up rate		
		Current Uninsured	Current nongroup	Current ESI
BHP Package A	High	29%	96%	90%
	Low	22%	96%	71%
BHP Package B	High	26%	96%	87%
	Low	19%	96%	55%
Exchange <200%	High	21%	96%	81%
	Low	16%	96%	45%

Source: UI Analysis of Augmented Washington State Database.
Note: Excludes undocumented immigrants below 138 percent FPL.

Estimating Health Care Costs in the Exchange and BHP Payments

We imputed health care spending under typical ESI and nongroup plans to all WSPS observations from HIPSM data using the same methodology as in our earlier work for OFM.[20] We then adjusted the resulting levels of spending to be consistent with Washington State ESI premiums from the MEPS-IC. Our HIPSM spending estimates were not state-specific, so this additional adjustment reflects differences in pricing and service utilizations in Washington. We focused on ESI not only because the MEPS-IC provides a reliable, representative history of ESI premiums, but, more important, because the Essential Health Benefits package in Washington will be based on a benchmark plan currently in the small group market. We computed ESI premiums from the WSPS and compared them to the MEPS-IC. To compute large firm premiums, we constructed a plan with a typical large firm actuarial value, computed the average costs of those reported in the WSPS to be covered by large firm ESI, and added an appropriate administrative load for large firm coverage. Spending levels were adjusted to match the MEPS-IC targets.

We then were able to compute total spending, insured costs, and out-of-pocket costs for a silver plan in the exchange by altering the actuarial value of the adjusted package to 70 percent. For those who would be eligible for cost-sharing subsidies in the exchange, we computed costs under the higher actuarial value to which they would be entitled and the amount of cost-sharing subsidies paid on their behalf.

The average silver premium in the exchange can then be computed by taking the average cost over all covered lives and adding a 15 percent administrative load. Since health care costs have a high variance and skewed distribution, we standardized them by age, gender, health status, and income in order to avoid distortions of average cost caused by small numbers of outlier observations. We computed premiums for several different populations of covered lives:

1. BHP enrollees (Package A or Package B, high take-up or low take-up) + exchange enrollees above 200 percent FPL + other nongroup. Used to compute BHP payments.
2. Exchange enrollees < 200 percent FPL (high take-up or low take-up) + exchange enrollees above 200 percent FPL + other nongroup. The nongroup market without BHP.
3. Exchange enrollees above 200 percent FPL + other nongroup. The nongroup market with BHP.

We then computed the premium and cost-sharing subsidies that BHP enrollees would have received had they been in the exchange for each combination of the two packages and two take-up scenarios. BHP payments are computed as 95 percent of these subsidies.

Estimating BHP Costs

BHP costs are based on observed Medicaid spending. In earlier research for OFM we estimated Medicaid costs for each individual on the WSPS using spending from the MEPS with enhancements from HIPSM and from Washington State administrative data.[21]

[20] Matthew Buettgens, Randall Bovbjerg, and Caitlin Carroll, Memorandum to Washington State Office of Financial Management, *Construction of the Augmented Washington State Population Survey (WSPS) Data Base* (June 2011).
[21] Buettgens et al., Memorandum to Washington State Office of Financial Management, *Construction of the Augmented Washington State Population Survey (WSPS) Data Base.*

Since the relative difference of Medicaid versus commercial spending is so important to estimating the cost-effectiveness of BHP, we performed an additional check. We again note that the difference in spending reflects more factors than payment rates. Total spending is the net of payment rates, utilization, and moral hazard. Holahan and Hadley estimated that, nationally, Medicaid expenditure is a little over 80 percent of comprehensive ESI expenditure.[22] However, the difference in payment rates between Washington and the nation as a whole should raise that percentage. The increase should not be the full difference in payment rates, due to utilization constraints and the efforts the state has made in pursuing managed care cost savings. We found that our previous estimates of Medicaid spending for BHP eligibles were about 90 percent of what would be spent on them in comprehensive ESI. We determined that no adjustment was necessary.

We constructed two different BHP cost-sharing scenarios. For Package A, we assigned 2 percent of cost sharing to the BHP enrollee and premiums at a constant $100. Package B has 6 percent cost sharing and premiums are set at 2 percent of MAGI. Note that in both scenarios, we took moral hazard into effect, recognizing that health care spending will decrease as out-of-pocket costs increase. These expenditure levels, inflated by 15 percent to account for the administrative load, equate to BHP costs. As noted earlier, this load may be a somewhat high estimate, since many Medicaid managed care plans operate at a lower load. However, BHP would have to deal with more churning in eligibility.

Conclusions

We find that a Basic Health Program would likely be feasible in Washington State, though a final determination must take into account federal regulations that had not been issued at the time of writing. A BHP under the ACA would cover about 100,000 lives, somewhat more with lower cost sharing and higher responsiveness to the individual mandate and somewhat fewer with higher cost sharing and lower responsiveness to the mandate. Were BHP to provide coverage at 98 percent actuarial value for a member premium of $100 per year, the resulting federal payments would exceed costs by $550 to $600 per beneficiary. This surplus could be used to reduce beneficiary cost sharing and/or raise reimbursement to providers. If the entire surplus were allocated to providers, reimbursement could be raised 11 to 12 percent above Medicaid rates and still cover costs. If, instead, BHP were provided at 94 percent actuarial value with premiums at 2 percent of family income—which would still be more affordable than subsidized exchange coverage—federal payments would exceed BHP costs by about $1,250 to $1,350 per beneficiary. Payments to providers could be raised up to 31 to 34 percent higher than Medicaid. Alternately, provider reimbursement could be raised to Medicaid plus 15 percent, while reducing cost sharing by an average of $600 per beneficiary. Exact projections for provider rates must wait for federal regulations on the exact computation of BHP payments, but our range of estimates shows that Washington should be able to adjust cost sharing in BHP so that provider rates are substantially higher than Medicaid.

[22] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40(4): 323–42, Winter 2003/2004.

The nongroup market would be larger than it currently is under the ACA, even with a Basic Health Program. In particular, there would be nearly 250,000 covered lives in the exchange. That includes a significant number of those not eligible for subsidies who seek coverage in the nongroup market. Most of them are already in the nongroup market. A successful exchange would be a true marketplace for private insurance, not just a vehicle for delivering subsidized coverage. In addition, there would be a significant amount of coverage in the nongroup market outside the exchange.

A Basic Health Program would not cause noticeable adverse selection in the nongroup market. This contrasts with our nationwide estimates.[23] The difference is in the characteristics of those eligible for subsidies in the exchange and the share of those below 200 percent of poverty, as captured by the Washington State Population Survey. This survey has a substantially larger sample than the multi-year pooled Current Population Survey data used in the nationwide estimates, and should better represent the eligible population in Washington. In other states, a larger share of those eligible for BHP would be young and have relatively low health care costs relative to those remaining in the exchange. In Washington State, the difference is much less. For example, the uninsured between 138 and 200 percent FPL are older on average in Washington than nationally.

In addition to the forthcoming regulatory guidance, there are other sources of uncertainty in these estimates. Premium subsidies are based on the second-lowest plan offered at the 70 percent actuarial value level in the exchange. This plan could have a narrower network of providers than plans typically offer in the small business market, leading to somewhat lower premiums. If the second-lowest premiums were 5 to 10 percent lower than what we estimate, that would mean federal BHP payments would be 4 to 8 percent lower.[24] That would be enough to cancel out much of the potential increase in provider reimbursement with low BHP cost sharing, but with higher cost sharing, there would still be a significant surplus of payments over costs that could be used to increase provider reimbursement and lower cost sharing for consumers.

Another source of uncertainty is churning, people gaining or losing eligibility for BHP over time. The magnitude of such churning is significant.[25] Transitions in eligibility will likely affect enrollment and could change average costs, both for BHP and the exchange. It is difficult to find enough longitudinal data on Washington residents to accurately estimate the characteristics of those most likely to gain or lose BHP eligibility over the course of a year. Also, we cannot accurately model how churning would affect enrollment without more federal regulatory guidance. Such an analysis is outside the scope of this paper.

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[23] Dorn et al., *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households*.
[24] The payment difference is lower because BHP payments consist of cost sharing subsidies as well as premium subsidies. To achieve a much larger difference in premiums, a plan would have to reimburse providers at a substantially lower rate than other commercial insurers, assuming that risk adjustment in the individual market is effective. It would be much more difficult to negotiate such rates with providers than to limit plan networks.
[25] For a national analysis that takes into account the presence of affordable offers of employer-sponsored coverage, see Matthew Buettgens, Austin Nichols, and Stan Dorn, *Churning under the ACA and State Options for Mitigation*, (Washington, DC; The Urban Institute, forthcoming)

About the Authors

Matthew Buettgens, Ph.D., is a mathematician leading the development of the Urban Institute's Health Insurance Policy Simulation (HIPSM) model. The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Topics have included the costs and savings of health reform for both federal and state governments, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the role of the individual mandate, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage. Dr. Buettgens was previously a major developer of the HIRSM model—the predecessor to HIPSM—used in the design of the 2006 roadmap to universal health insurance coverage in the state of Massachusetts.

Caitlin Carroll is a research assistant on the HIPSM team. Her research concerns domestic health care and insurance. Her current research includes the Medicaid expansion, exchange costs, and the uninsured population, and she was involved in health reform implementation technical assistance for Washington, Massachusetts, and New York. Carroll received a bachelor's degree from Tufts University.

STATE OF WASHINGTON

August 21, 2012

Cindy Mann, Director
Centers for Medicare and Medicaid Services (CMS)
Mail Stop S2-26-12
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

SUBJECT: Federal Basic Health Option Guidance

In June 2012, the Washington State Health Care Authority (HCA) submitted a comprehensive proposal to HHS to adopt the federal Basic Health Plan Option (BHPO) under Section 1331 of the Affordable Care Act (ACA). It identified what the state would do and what it would need from CMS, in order to begin providing BHPO coverage in 2014.

This letter is a joint follow-up to that proposal from two state agencies – HCA and the Office of the Insurance Commissioner (OIC), as well as the Health Benefits Exchange (HBE). All have a deep interest in the success of the ACA in Washington State.

In June, we suggested that CMS provide initial feedback on our proposal in August, with a final certification by November. This was to allow reasonable time to work out details with our federal partners and complete the design and development of key functional areas in compliance with federal requirements and forthcoming gate reviews. To date, we have not received any response.

We remain comfortable with the November deadline for the formality of final certification of our BHPO; however, the need for significant and meaningful dialogue with CMS, well before then, has now become more evident. We have exhausted our ability to make reasonable assumptions about what CMS will require, and yet our Exchange system integrator (Deloitte) has determined that, to stay on schedule and meet the October 2013 open enrollment deadline, the major design features of the BHPO must be locked in by September 30, 2012. This can still be accomplished if CMS engages with us immediately on the details of our proposal. While such conversations may identify other uncertainties, at this point, we need your help to address:

Health Care Authority

- Development, management and stabilization of the BHPO Trust Fund
- Ongoing funding for BHPO administration
- Confirmation of income eligibility (138% - 200% of the federal poverty level)
- Benefits design alignment with essential health benefits, Medicaid standard and Medicaid benchmark options
- Basis for cost-sharing reductions and out-of-pocket or deductible calculations in the event of churn
- Hold-harmless provisions for initial premium subsidy reconciliation and future requirements
- Flexibility on future BHPO commitment
- Application of risk adjustment, risk corridors, and reinsurance

Health Benefits Exchange – critical design deadlines are quickly approaching in the areas of plan and financial management referenced above.

Office of Insurance Commissioner – plans for reinsurance and risk adjustment must be finalized by November 15, 2012. Without immediate guidance on the potential for application to BHPO covered lives, we stand the risk of creating a reinsurance program based on faulty assumptions that could jeopardize the viability of both of these critical mechanisms for preventing adverse risk selection.

We very much appreciate the assistance you have provided to our state and others thus far on the path to ACA implementation. We continue to plan for Medicaid expansion and to develop our Exchange, and will commit any staff or resources necessary for an immediate engagement on critical BHPO design issues to ensure we meet our September deadline.

Please let us know how to best gain sufficient federal guidance in the next 6 weeks to complete design of the federal Basic Health Plan Option in Washington state.

Sincerely,

MaryAnne Lindeblad
Director
Health Care Authority

Mike Kreidler
Commissioner
Office of the Insurance Commissioner

Richard Onizuka
CEO
Health Benefits Exchange

cc: Susan Johnson, Regional Director, CMS Region X
Carol J.C. Peverly, Associate Regional Administrator, CMS Region X
Karen Keiser, Chair, Health and Long-Term Care Committee
Eileen Cody, Chair, Health Care and Wellness
Jonathan Seib, Executive Policy Advisor, Governor's Office
Barb Flye, Senior Health Policy Advisor, Office of the Insurance Commissioner
Nathan Johnson, Assistant Director, Health Care Policy, Health Care Authority
Molly Voris, Director of Policy, Health Benefits Exchange

Attachment 4: September Executive/Legislative Leadership Action

On Tuesday September 12, 2012 Governor Chris Gregoire, in consultation with the legislative committee chairs, placed the BHPO project on hold, eliminating any chance for implementation in 2014. As explained in an email from her health care policy lead, Jonathan Seib:

> *"Members of the legislative health care committees –*
>
> *As you know, for some time the state has been working towards the implementation of the Basic Health Plan Option (BHPO) under the federal Affordable Care Act. Beginning January 1, 2014, it would provide coverage for individuals between 133% – 200% of the federal poverty level in lieu of their enrollment in subsidized commercial coverage in the Health Benefit Exchange.*
>
> *In order to implement the BHPO, we need sufficient guidance from the federal Department of Health and Human Services (HHS) to assure that what we put in place will eventually meet their approval. So while we've been doing what we can on design and development, we've also been pushing HHS to provide that guidance. In June, we submitted a detailed proposal for their review, offering what we saw as a more viable approach than a time-consuming federal rules development process to get the feedback we needed.*
>
> *HHS has acknowledged our interest and efforts, but despite follow-up by us and others, has not responded with any guidance. Neither have they indicated when they might do so. Meanwhile, the Exchange has reached a point in its development where the major features of the BHPO need to be locked-in. And rather than lock-in features with no idea whether they will ever meet HHS approval, it made sense instead to suspend our work on the BHPO.*
>
> *This decision was made in consultation with Senator Keiser and Rep. Cody. It means that we will likely not be able to offer the BHPO in this state on January 1, 2014. While very disappointing, the decision frees up staff resources to commit to other pressing needs, particularly for the Exchange. It also brings some certainty to the required work being done by the Office of the Insurance Commissioner regarding reinsurance – which was struggling with what to assume regarding the BHPO.*
>
> *I will let you know if anything on this changes. In the meantime if you have any questions, please be in touch.*
>
> *Jonathan Seib, Executive Policy Advisor"*

Part II: Narrative Explanation

II. A - Brief Description of What the Measure Does That Has Fiscal Impact

As part of the new continuum of health care coverage established by the Patient Protection and Affordable Care Act (ACA) states have an option to establish a Federal Basic Health Option (FBHO) for individuals with incomes up to 200 percent of the federal poverty level (FPL.) Eligibility is limited to individuals who are not eligible for Medicaid but would otherwise be eligible for coverage through the Washington Health Benefit Exchange (the Exchange).

The Health Care Authority (HCA) must develop a design Blueprint that addresses features of the FBHO program - enrollee eligibility, cost-sharing and benefits design based on essential health benefits, funding, administrative processes, governance, consumer rights and protections, implications for American Indian and Alaska Natives, etc. It requires stakeholder engagement and Tribal consultation with econometric modeling of program enrollment; and costs/impacts to the state, enrollees and the insurance marketplace (i.e. the Exchange that would no longer cover individuals in the FBHO income bracket.) Final Centers for Medicare & Medicaid Services (CMS) rules are to be published in March 2014; preliminary rules were published in September 2013.

Concurrent with the program design (i.e., the Blueprint development) the HCA must consult with the Exchange and other impacted programs to identify system requirements to implement and operate the FBHO. This includes a timeline and funding estimate to complete the work once the design Blueprint is certified by CMS to meet federal law. HCA anticipates that CMS' final rules will establish a two-part Blueprint, with the first phase supporting preliminary certification of Washington State's FBHO design and the second phase certifying its operational readiness. The timeline and fiscal estimates must be shared with fiscal committees and, subject to appropriation, system [*design*] work may begin based on preliminary certification from CMS. The bill clearly intended this reference to allow system [*development*] work to begin based on CMS certification and Legislative expenditure authority, given that the design Blueprint would have already incorporated system [*design*] implications and options.

The design Blueprint must be submitted to the Governor for signature and submission to CMS for review and certification. The Blueprint certification by CMS documents program requirements and obligations and is intended to reflect the authority for the program to operate in Washington State. However, timing of the design Blueprint, CMS certification, and subsequent systems development does not consider the final Blueprint approval which is the official CMS authorization to implement and operate based on a "readiness review". The bill assumes that approval of this "operational readiness" Blueprint will occur in 2015 in time for an October 2015 open enrollment for coverage beginning January 1, 2016. To meet this implementation deadline, expenditure authority for system design, development and operational start-up would be needed in the FY2014 Supplemental budget.

II. B - Cash Receipts Impact

Indeterminate.

HCA continues to develop cost estimates related to the requirements of this bill. HCA currently assumes that all funding for the development and implementation of the FBHO would be

appropriated as General Fund – State, therefore HCA would not report any cash receipts for the funding provided.

II. C - Expenditures

Indeterminate

HCA continues to develop cost estimates related to the requirements of this bill. HCA currently assumes that all funding for the development and implementation of the FBHO would be appropriated as General Fund – State. For the purposes of this analysis, HCA has estimated the following administrative cost impacts associated with the development and implementation of the FBHO during Fiscal Year 2015.

KEY ASSUMPTIONS:

- Design, development, implementation and non-benefit operating costs for FBHO cannot be funded with federal dollars, per CMS regulations.
- Full state appropriation for design, development and implementation costs will be provided in the FY 2014 Supplemental Budget – this is necessary to meet the 2016 implementation schedule but is inconsistent with the provisions of Section 2(4) of the legislation.
- System design work would commence immediately upon passage of this bill to meet the October 1, 2015 open enrollment timeframe, concurrent with development of the CMS design Blueprint, econometric model and other design and development tasks.
- Ongoing benefit and administrative costs would be determined as part of the econometric modeling and actuarial rate setting process.
- FBHO eligibility, plan management, financial management (e.g. premium collection, distribution, etc.) would be fully integrated with the HealthPlanFinder, but the program would be administered by the HCA.
- FBHO trust funds would need to be sufficient to cover full benefit costs and a fund will be statutorily established for this purpose.
- CMS approval for Washington State's FBHO design, consistent with preliminary rules, will arrive on a timely basis to allow 2016 implementation.
- Individuals between 138-200% FPL and legal immigrants otherwise ineligible for Medicaid under 200% FPL would be required to transition out of the Exchange into FBHO effective January 1, 2016. All future enrollees with these characteristics would be served by FBHO.
- Implementation of FBHO impacts the HBE sustainability plan and enrollee risk pool with fiscal and program effects yet to be determined.

ANTICIPATED AREAS OF IMPACT - Overview:

1. Design and Development
    a. Preliminary Econometric and actuarial modeling, including CMS payment cell projections
    b. Policy Development and Stakeholdering
    c. Technical Systems Assessment (ProviderOne, ACES, HealthPlanFinder)
    d. Program Design and Development
    e. Benefits Design including Cost Sharing and unique American Indian/Alaska Native requirements
    f. CMS Preliminary Design and Operational Blueprints, including CMS approval
    g. Actuarial modeling and rate setting
    h. Procurement of FBHO plans

i. Customer Service for client transition to new FBHO plans
j. Staffing and resources to support full integration of the FBHO with Medicaid, CHIP and Exchange programs

2. Systems Impact
   a. System requirements development
   b. Systems Integration Contractor – at least one full Exchange system release schedule would be dedicated to design, development, integration testing, user acceptance testing and federal readiness review
   c. ProviderOne and ACES
   d. Federal certification for initial "operational readiness" and post implementation period of FBHO systems' stabilization and quality assurance interface between the Exchange and Medicaid

3. Transition of Exchange enrollees between 138% and 200% FPL (just over 45% of Exchange enrollment reported in the official December 2013 "Health Coverage Enrollment Report." – costs indeterminate given that FBHO options for continuity of coverage would not be known until procurement for 2016 FBHO coverage complete.

4. Non-Benefit Operating Costs - Administrative and staffing expenditures, ongoing communications costs, annual actuarial contracts, etc.

ANTICIPATED AREAS OF IMPACT - Costs:

1. DESIGN AND DEVELOPMENT COSTS

Staffing:

The following HCA staff would be needed effective July 1, 2014, to begin design and development of the FBHO infrastructure necessary for an October 1, 2015 open enrollment. It is assumed that the program would be operational January 1, 2016 with a projected initial enrollment of 80,000. Enrollment assumptions are from the *Planning Washington's Health Benefit Exchange* Milliman study.

- 1 FTE - Program Manager
- 1 FTE – Federal Compliance / Fiscal Manager
- 1 FTE - System Integrator
- 1 FTE - Communications Manager
- 1 FTE - Administrative Assistant
- 1 FTE - Policy / Rules Developer
- 1 FTE - Budget Analyst
- 1 FTE - Program Integrity Specialist
- 1 FTE - Procurement Specialist

Consulting Services:

Consulting services would be necessary to support design, development, and fiscal estimates of a FBHO, including the procurement of an econometric firm to complete an actuarial analysis of

benefits and cost sharing, rate development, and the modeling of projected State, federal, enrollee and marketplace impacts, including potential churn implications.

Cost: $500,000 one time.

HCA assumes additional Design and Development costs for the following:

- Communications - $556K one-time
- Attorney General – approximately $25,000 per year (moves to ongoing costs after the first FY)

2. SYSTEMS IMPACT COSTS

Significant costs would be associated with development of IT systems for the start-up and ongoing operation of the FBHO. Federal guidance allows the use of Exchange establishment grant funding for development activities that overlap or coordinate with the FBHO, such as a consumer call center. However, the guidance stipulates that no federal funds are available to support the operations or investigation (including systems design and development) of the FBHO.

The FBHO will require a system that is fully integrated with current Exchange and Medicaid functionality, using the HealthPlanFinder as the entry for eligibility and payment processing based on modified adjusted gross income logic. Changes will be needed to support specific FBHO functionality for full accounts receivable, accounts payable, eligibility and enrollment management, plan management, financial management (e.g. premium collection, distribution, etc.) and quarterly reconciliation and prospective adjustment of federal Trust payments to the state. FBHO functions will also be required to send and receive information from contracted managed care plans, billing and payment vendors, state systems such as AFRS, and other federally operated systems. While we assume that the systems that support the current Exchange-Medicaid-CHIP interfaces would also support the FBHO, considerable work will be needed to:

- Assess system requirements and their alignment with current Medicaid and Exchange interfaces,

  Estimated Cost: ~5,000 hours estimated at a standard average of $140 per hour - $700K

- Complete design and development,
  - Conduct integration testing and ensure compatibility with current Medicaid and Exchange interfaces,
  - Complete user acceptance design and testing.
  - CMS readiness review and operational certification.

  Estimated Cost: 40,000-60,000 hours estimated at a standard average of $140 per hour, with 70 full time contractors over a 6-9 month period - $5.6M - $8.4M

- Post implementation stabilization
  - Stabilize the systems operation
  - Complete Trust fund reconciliation and prospective payment adjustments
  - Assess potential future State and marketplace fiscal impact.

  Estimated Cost: ~ 5,000 hours estimated at a standard average of $140 per hour - $700K

- ProviderOne and ACES - areas of potential impact include:
    - The application process and interfaces with HealthPlanFinder including churn mitigation
    - Eligibility and enrollment rules and related functionality
    - Automated system-generated correspondence and consumer materials (including instructions for transitioning from the Exchange to the FBHO)
    - Plan definition, selection, and management functionality
    - Financial management, payment processing rules, and interfaces with state and federal financial systems
    - Reporting of enrollment estimates and Exchange reference plan data for CMS projections of annual trust fund payments and reconciliation
    - Alignment with current ProviderOne and ACES systems change requests and schedule.

    Estimated Cost: Change requests including specific design requirements are **indeterminate.**

Total systems impact costs are ***indeterminate*** at this time; however available preliminary estimates identified above have been included in the following table (goods and services.)

Design, Development, and System Costs		FY14	FY15	FY16	FY17	FY18	FY19
A	Salaries & Wages	-	734,000	-	-	-	-
B	Employee Benefits	-	211,000	-	-	-	-
E	Goods and Services	-	7,512,000	3,500,000	-	-	-
G	Travel	-	2,000	-	-	-	-
J	Capital Outlays	-	72,000	-	-	-	-
N	Grants, Benefits Services	-	-	-	-	-	-
Total		**-**	**8,531,000**	**3,500,000**	**-**	**-**	**-**

3. ONE-TIME TRANSITION COSTS

Communication and customer service will be required to support the transition of Exchange enrollees to the FBHO. This includes all exchange enrollees up to 200% of the FPL whose income and immigration status make them ineligible for Medicaid.

Cost: One-time – ***indeterminate*** – enrollee estimates will be incorporated in the econometric modeling noted above.

4. NON-BENEFIT ONGOING COSTS

Staffing:

In addition to the staffing levels to start up the FBHO infrastructure referenced above, HCA operations staff would be needed effective April 1, 2015, to begin training on the FBHO in preparation for an October 1, 2015 open enrollment. Consistent with the *Planning Washington's Health Benefit Exchange* Milliman study we assume enrollment of 80,000 members in 2016, increasing to 140,000 members by Fiscal Year 2019.

The staffing levels below are estimates for Fiscal Year 2019, based upon operational experience with the previous state Basic Health program. Medical Assistance Specialist level staffing may be reduced to incorporate efficiencies anticipated from the use of the Washington HealthPlanFinder system, however, FBHO systems requirements will need to be clearly defined before more precise staffing needs can be determined.

- 7 FTE - Fiscal Analyst 2 (1 per 20,000 enrollees)
- 93 FTE - Medical Assistance Specialist 3 (MAS3) (1 per 1,500 enrollees)
- 7 FTE - Medical Assistance Specialist 4 (1 per 14 MAS3)
- 7 FTE - Medical Assistance Specialist 5 (1 per 14 MAS3)
- 7 FTE - Office Assistant 3 (1 per 20,000 enrollees)

Additional staffing and operational expenditures external to HCA are currently indeterminate but may require funding dependent upon systems design and CMS Blueprint approval.

HCA assumes additional ongoing costs for the following:

- Actuarial Services (annual procurement @ $50K/yr)
- Attorney General – approximately $25,000 per year.
- Cost allocation from the Exchange to the HCA for IT operations, call center support, payment services, invoices, notices, printing, and other administrative support functions – costs ***indeterminate*** but expected to be directly proportionate to enrollment in the FBHO vs the Exchange base at that time. Current Exchange enrollment in the FBHO eligible income range is about 45% of the total Exchange enrollment.
-

Non-Benefit Ongoing Costs by Object		FY14	FY15	FY16	FY17	FY18	FY19
A	Salaries & Wages	-	1,048,000	4,308,000	5,100,000	5,849,000	6,597,000
B	Employee Benefits	-	408,000	1,583,000	1,894,000	2,189,000	2,482,000
E	Goods and Services	-	326,000	3,257,000	6,398,000	7,605,000	8,811,000
G	Travel	-	5,000	19,000	23,000	26,000	30,000
J	Capital Outlays	-	360,000	3,764,000	144,000	136,000	136,000
N	Grants, Benefits Services	-	-	-	-	-	-
Total		**-**	**2,147,000**	**12,931,000**	**13,559,000**	**15,805,000**	**18,056,000**

Total Estimated Costs (including indeterminate Systems Costs):

Estimated Costs by Project Phase:

Costs by Project Phase	FY14	FY15	FY16	FY17	FY18	FY19
Design and Development	-	2,231,000	-	-	-	-
Estimated System Costs	-	6,300,000	3,500,000	-	-	-
Non-Benefit Ongoing Costs	-	2,147,000	9,431,000	13,559,000	15,805,000	18,056,000
Total Cost by Fiscal Year	**-**	**10,678,000**	**12,931,000**	**13,559,000**	**15,805,000**	**18,056,000**
Total Cost by Biennium		**10,678,000**		**26,490,000**		**33,861,000**

Estimated Costs by Object:

Objects		FY14	FY15	FY16	FY17	FY18	FY19
A	Salaries & Wages	-	1,782,000	4,308,000	5,100,000	5,849,000	6,597,000
B	Employee Benefits	-	619,000	1,583,000	1,894,000	2,189,000	2,482,000
E	Goods and Services	-	7,838,000	6,757,000	6,398,000	7,605,000	8,811,000
G	Travel	-	7,000	19,000	23,000	26,000	30,000
J	Capital Outlays	-	432,000	264,000	144,000	136,000	136,000
N	Grants, Benefits Services	-	-	-	-	-	-
Total		**-**	**10,678,000**	**12,931,000**	**13,559,000**	**15,805,000**	**18,056,000**

Estimated Costs by Fund:

Expenditures		FY14	FY15	FY16	FY17	FY18	FY19
001	GF-State	-	10,678,000	12,931,000	13,559,000	15,805,000	18,056,000
Total		**-**	**10,678,000**	**12,931,000**	**13,559,000**	**15,805,000**	**18,056,000**
Biennial Total			**10,678,000**		**26,490,000**		**33,861,000**

Part IV: Capital Budget Impact

None.

Part V: New Rule Making Required

Yes, rulemaking would be required to support the operations of a new coverage program.

Individual State Agency Fiscal Note

Bill Number: 2594 HB	Title: Federal basic health program	Agency: 300-Dept of Social and Health Services

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

Non-zero but indeterminate cost. Please see discussion.

Estimated Expenditures from:

Non-zero but indeterminate cost. Please see discussion.

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Legislative Contact:	Erik Cornellier	Phone: 360-786-7116	Date: 02/06/2014
Agency Preparation:	Wendy Polzin	Phone: 360-902-8067	Date: 02/20/2014
Agency Approval:	Mickie Coates	Phone: 360-902-8077	Date: 02/20/2014
OFM Review:	Danielle Cruver	Phone: (360) 902-0575	Date: 02/20/2014

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Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

The Federal Patient Protection and Affordable Care Act provides states the option to establish a blueprint for a federal basic health program for individuals with incomes up to 200 percent of the federal poverty level who are not eligible for Medicaid. The Health Care Authority (HCA) is tasked with developing a blueprint for a Federal Basic Health Option (FBHO). HCA must consult with the Washington Health Benefit Exchange (HBE), the Department of Social and Health Services (DSHS) and other impacted programs to implement and operate the FBHO.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

The proposed legislation has the potential to impact federal funding awarded for work on the Eligibility Services (ES) program.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

HCA assumes the requirements of this proposed legislation would have significant impact on DSHS systems. The following are areas of potential impact to DSHS systems:
-Eligibility and enrollment rules and related functionality
-Automated system-generated correspondence and consumer materials
-Plan definition, selection, and management functionality
-Financial management, payment processing rules, and interfaces with state and federal financial systems
-Alignment with current systems change requests and schedule

This proposed legislation and the requirements within it would drive significant Information Technology (IT) workload in the Economic Services Administration (ESA). It would require reprogramming of existing systems within the DSHS, including the Automated Client Eligibility System (ACES), the ES, and other systems. ACES is written in the COBOL programming language. Implementing the as yet undetermined changes that would be required under this bill would impact and delay other planned changes to ACES. ESA is not able to hire additional programmers to perform this work because COBOL is an older programming language that is no longer widely used or taught. In addition, reprogramming code can only be done in limited sections, requiring that only one particular section of code may be worked on at one time. This limitation would not be alleviated with additional staff.

The proposed legislation directs that coverage under the FBHO must begin on January 1, 2016. To reach this target ESA estimates the total project period will last approximately 16 months. ESA expects they would begin work on the project in August or September 2014, and that it would be under development continuously through October 2015 when the new code would be installed in preparation for January 2016 implementation.

In order to meet the January 2016 implementation specified in the proposed legislation, ESA estimates it could require a minimum of 11,000 hours of work by IT staff and contractors, depending on specific design requirements. This will cause significant delays to other high priority projects, specifically changes requested by HCA and the HBE throughout the year, including changes during the open enrollment period in 2015. In addition, ESA currently does not have federal approval to use enhanced matching funds used for ES on the work required by this proposed legislation. Shifting work from ES could jeopardize federal funds. Due to the limited ability to reprogram ACES, the uncertain nature of changes, and the delay to other IT priorities, this proposed legislation is expected to have an unquantifiable impact on ESA systems and other Affordable Care Act related priorities.

Part III: Expenditure Detail

Part IV: Capital Budget Impact

NONE

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

New or amended rules may be required under this legislation.