

Washington State Proposal

for a

Federal Basic Health Option

June 18, 2012

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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 context¹;
- 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 HB2319ⁱⁱ, 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^v, 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 2 nd lowest cost silver plan
150-200% FPL	Based on 80% actuarial value of Exchange gold plan	Based on 87% actuarial value of Exchange 2 nd 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

<p>Coinsurance, deductibles and annual out-of-pocket maximum:</p> <ul style="list-style-type: none"> • 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. <p>Additional copayments are not subject to the deductible:</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Preventive care • Maternity care (provided through Medicaid) • Oxygen 	<ul style="list-style-type: none"> • \$10 – office visits, hospital outpatient visits • \$100 per hospital admission (up to \$500 annual maximum) • Pharmacy: <ul style="list-style-type: none"> – tier 1 \$3 (e.g., generic in formulary) – tier 2 \$7 (e.g., generic alternative) – tier 3 50% drug cost (formulary brand name) 	<ul style="list-style-type: none"> • No deductibles or coinsurance
2004-2009	Same	<ul style="list-style-type: none"> • \$15 – office visits, hospital outpatient visits • \$100 per non-emergency hospital visit (i.e., no admission) • Pharmacy - previous tiers 1-2 combined <ul style="list-style-type: none"> – tier 1 \$10 (e.g., generics) – tier 2 50% drug cost (formulary brand name) 	<ul style="list-style-type: none"> • \$150 deductible introduced Once deductible met: <ul style="list-style-type: none"> • 20% coinsurance – hospital inpatient, ambulance, chiropractic/PT, CD, organ transplants • \$1,500 Annual OOP maximum
2010-current	Same	Same	<ul style="list-style-type: none"> • \$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 Health 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
<p>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.</p>	<p>BHPO Premium Contributions – p12 BHPO Cost Sharing Reductions – p10</p>
<p>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.</p>	<p>Eligibility – p5 Flexible Benefits Design – p9</p>
<p>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.</p>	<p>Delivery System Contracting – p8</p>
<p>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.</p>	<p>Delivery System Contracting – p8</p>
<p>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.</p>	<p>Flexible Benefit Design – p9</p>

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

31 PART VI

32 THE BASIC HEALTH OPTION

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

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

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

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

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

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

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

24 (a) Actively consult with the board of the Washington health
25 benefit exchange, the office of the insurance commissioner, consumer
26 advocates, provider organizations, carriers, and other interested
27 organizations;

28 (b) Consider any available objective analysis specific to
29 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.

The Honorable Kathleen Sebelius
February 6, 2012
Page 2

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

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)

	A	B	C	D	E	F	G	H
Age Range	0-65 % FPL	65-100 % FPL	100-125 % FPL	125-140 % FPL	140-155 % FPL	155-170 % FPL	170-185 % FPL	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 <i>Median Income</i> ^{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
<p>1. Tribal Membership Card with picture from a federally recognized tribe. state recognized tribe or the Bureau of Indian Affairs (BIA)</p> <p>2. Tribal Sponsorship Agreement with the Health Care Authority for participation in the Basic Health program*</p>	<p>1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND</p> <p>a. A US American Indian/Alaska Native tribal membership card or tribal enrollment letter, without picture OR</p> <p>b. A certificate of tribal membership / affiliation, OR</p> <p>c. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood, OR</p> <p>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. **</p> <p>2. Indian and Northern Affairs Canada (INAC) Card; AND Documentation of 50% Native blood, such as:</p> <p>a. A Certificate of Indian blood issued by the Bureau of Indian Affairs OR</p> <p>b. A document issued by a federal or state recognized tribe verifying 50% Native blood***</p>	<p>1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND</p> <p>a. Documentation showing native descent, such as a birth certificate or relative tribal ID cards; OR</p> <p>b. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood.</p> <p>2. Current state driver's license or state identity card for a non-native mother carrying the child of an eligible native****; AND</p> <p>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</p> <p>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).</p>

* 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