State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
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Coverage Alternatives for Low and Modest Income Consumers

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The Patient Protection and Affordable Care Act (ACA) describes a continuum of subsidized coverage for individuals with incomes below 400 percent of the Federal Poverty Level (FPL): Medicaid, the Children's Health Insurance Program (CHIP), Basic Health Program (state option) and advanced premium tax credits (APTCs)/cost-sharing reductions (CSRs) — collectively, insurance affordability programs (IAPs). To ensure a seamless system of coverage, the ACA requires a single streamlined application for all IAPs and a coordinated process for IAP eligibility and enrollment. States are looking beyond the eligibility and enrollment process and are exploring different mechanisms to address the cost-sharing cliff in the Exchange and also to promote continuity of coverage and care as consumers transition across IAPs.

The ACA gives states the option to create a Basic Health Program (BHP), a state-run, subsidized coverage vehicle for individuals with incomes below 200 percent FPL who are eligible for a Qualified Health Plan (QHP) and federal tax subsidies.[1] Some states, particularly those that have already expanded their Medicaid programs above 138 percent FPL, have expressed interest in pursuing a BHP in order to reduce premiums and cost-sharing that lower income families would otherwise have to pay for QHP coverage. In sub-regulatory guidance issued on February 6, 2013, the Centers for Medicare and Medicaid Services (CMS) indicated that it will issue BHP proposed rules for comment in 2013 and final guidance in 2014.[2] Based on this timeline, BHP implementation in interested states cannot occur before the 2015 coverage year.

States have begun to explore coverage models in addition to or as alternatives to the BHP that address either or both affordability in the Exchange and continuity of health plans and providers across IAPs. CMS has expressed willingness to work with states to develop strategies to facilitate coverage continuity and reduce cost-sharing.[3] The following chart, developed by Manatt Health Solutions, provides a side-by-side analysis of coverage alternatives under state and federal consideration including: the Basic Health Program; the Bridge Plan; QHP Premium and Cost-Sharing Support; maintaining existing Medicaid expansions above 133 percent FPL; and Premium Assistance. These options are compared against subsidized QHP coverage available under the ACA.

[1] Patient Protection and Affordable Care Act, P.L. 111-48, Section 1331.

[2] Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Frequently Asked Questions: Medicaid and the Affordable Care Act," February 6, 2013.

[3] Id. at 2; Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid." December 10, 2012.

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

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	Basic Health Program (BHP)	Bridge Plan	QHP Premium & Cost-Sharing Support	Maintain Existing Expansion	Premium Assistance	Subsidized QHP (Standard ACA)
Description	Section 1331 of the Patient Protection and Affordable Care Act (ACA) gives states the option to create a state-run, subsidized coverage vehicle for individuals with incomes below 200% FPL who are eligible for a Qualified Health Plan (QHP) with tax subsidies.[4] The state receives 95% of the value of the advance premium tax credits (APTCs) and cost-sharing reductions (CSRs) for each individual that enrolls in the BHP. By leveraging state purchasing and (presumably) lower than commercial level provider reimbursement, it is anticipated that states will be able to purchase coverage at rates lower than QHPs would otherwise charge, thereby reducing the premiums and cost-sharing of eligible enrollees. In a February 6, 2013 FAQ, the federal government indicated that it will not issue BHP guidance until late 2013, and the program will not be implemented in states until 2015.[5]	The idea for the Bridge Plan was developed by the State of Tennessee. Bridge Plans are QHPs offered by Medicaid Managed Care (MMC) organizations. Enrollment is limited to consumers transitioning from MMC coverage to Exchange coverage or family members of consumers enrolled in or transitioning from MMC coverage. In a December 10, 2012 FAQ, CMS issued guidance allowing a State-Based Exchange to certify a Medicaid Bridge Plan as a Qualified Health Plan.[6]	Some states are considering offering subsidies to "wrap around" Exchange coverage, thereby reducing the premiums and cost-sharing obligations of low and modest income individuals purchasing coverage through the Exchange. States could use state-only dollars to wrap. States interested in using federal Medicaid dollars to fund a premium or cost-sharing wrap should contact CMS. States ability to use federal Medicaid funding may depend on whether they had previously expanded coverage under a waiver and have waiver savings.	Some states are contemplating maintaining their existing Medicaid coverage of expansion populations until BHP guidance is available and they are able to implement a BHP or pursue an alternative model.	The January 22, 2013 proposed regulations authorize states to use federal and state Medicaid or CHIP funds to purchase QHP coverage for otherwise Medicaid/ CHIP eligible individuals. Some states are considering using premium assistance to buy QHP coverage for pregnant women with incomes above 138% FPL and below the state's eligibility level for pregnant women; other states are looking at premium assistance to buy Medicaid or CHIP eligible children into the QHP in which their parents are enrolled; and, still others are looking at it for subgroups of their new adults population. All Medicaid rules continue to apply and among other things, the state must provide a cost-sharing and benefit wrap to the extent the QHP covers fewer benefits or imposes greater cost-sharing than is contemplated under federal Medicaid rules. The state must also demonstrate that the cost of premium assistance is comparable to the cost of purchasing Medicaid coverage directly.	As defined in the ACA, individuals with incomes between 100% and 400% FPL are eligible to purchase health insurance coverage through Exchanges with federal subsidies in the form of APTCs and CSRs.
Participating Issuers	Medicaid Managed Care (MMC) plans	MMC plans certified as QHP issuers	QHP issuers	MMC plans (or Fee For Service Medicaid)	QHP issuers	QHP issuers

[4] Patient Protection and Affordable Care Act, P.L. 111-48, Section 1331.

[5] Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Frequently Asked Questions: Medicaid and the Affordable Care Act," February 6, 2013. http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/ACA-FAQ-BHP.pdf

[6] Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid." December 10, 2012. http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

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Funding	The state receives federal funding equal to 95% of the amount each BHP enrollee would have received through APTC/CSRs had they obtained coverage through the Exchange.[7] Per enrollee amount is subject to year-end reconciliation and the state (not the enrollee) is at risk for over payment. Some limited consumer premium and cost-sharing are likely.	Federal APTC/CSR funding; minimal consumer cost sharing	Federal APTC/CSR funding plus state-only or federal Medicaid funding to wrap premium and cost-sharing obligations of enrollees	State and federal Medicaid dollars with the state's standard federal match	State and federal Medicaid dollars. Enhanced match rate for "newly eligible" beneficiaries.	Federal APTC/CSR funding plus consumer premiums and cost-sharing
Eligibility Criteria	Individuals with incomes below 200% FPL who are not eligible for Medicaid and are eligible for QHP coverage	Individuals who are APTC eligible and transitioning from MMC, and family members of MMC enrolled or transitioning with income eligibility levels set by the state	Individuals who are APTC eligible likely with income eligibility limits set by the state	Individuals under age 65; not eligible for and enrolled in mandatory or optional Medicaid category; and have a household income above 138% FPL and below income standard established by the state[8]	Medicaid or CHIP eligible individuals	Individuals who are APTC/CSR eligible with incomes up to 400% FPL
Product Type	Basic Health Plan	QHP	QHP	Medicaid	QHP	QHP
Benefit Package	Essential Health Benefits (EHB)	EHB[9]	EHB	Medicaid standard or other benefit design approved in state plan or waiver	EHB plus Medicaid benefit wrap to meet Medicaid coverage requirements	EHB
Rate Development	Unclear. Likely risk adjusted rates set by Exchange or state.	Unclear. Likely risk adjusted rates set by Exchange, state or plan.	Rate filing and prior approval	Medicaid FFS or MMC rate methodology apply	Rate filing and prior approval	Rate filing and prior approval
Provider Network	Medicaid network	Medicaid network	QHP network	Medicaid network	QHP network	QHP network
Consumer Continuity	Facilitates continuity of plans and providers for low-income individuals who experience income fluctuations up to 200% FPL. Promotes plan continuity for families with members eligible for different insurance products and subsidies ("mixed families").	Facilitates continuity of plans and providers for some low-income individuals who experience income fluctuations up to income level set by state. Promotes plan continuity for families with members eligible for different insurance products and subsidies ("mixed families").	No Impact	Facilitates continuity up to expanded Medicaid eligibility level.	Assures continuity of plans and providers as the same plans and provider networks will be available as individuals experience income fluctuations. Also permits pregnant women previously enrolled in a QHP to stay in the QHP while taking advantage of Medicaid's cost sharing and benefit rules.	No impact

[7] Supra note 1 at § 1331(d)(3).

[8] Social Security Act § 1902(a)(1)(A)(ii)(XX); 42 CFR § 435.218.

[9] Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid." December 10, 2012. http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

	Basic Health Program (BHP)	Bridge Plan	QHP Premium & Cost-Sharing Support	Maintain Existing Expansion	Premium Assistance	Subsidized QHP (Standard ACA)
Consumer Affordability	Mitigates cost-sharing "cliff" by offering consumers with incomes up to 200% FPL more affordable coverage than subsidized QHPs.	Mitigates cost-sharing "cliff" for eligible consumers transitioning from Medicaid and their families by offering more affordable coverage than if they transitioned to subsidized QHP coverage.	Mitigates cost-sharing "cliff" by offering low-income consumers more affordable coverage than if they received standard subsidized QHP coverage.	Mitigates cost-sharing "cliff" by offering consumers with incomes above 138% FPL up to the expanded eligibility level more affordable coverage than available through subsidized QHPs.	Does not address QHP cost-sharing cliff for consumers with incomes above 138% FPL.	Consumers will experience an affordability "cliff" as they transition from Medicaid to a QHP.
State Fiscal Impact	Unclear/potential state funding obligation if cost of program exceeds federal funding.	No state funding obligation	Requires some state funding. States interested in using federal Medicaid funding should reach out and discuss with CMS.	State foregoes federal tax credit dollars by continuing state Medicaid funding for individuals who would otherwise be eligible to purchase coverage in the Exchange with federal funding.	Premium assistance may be somewhat more costly to state than directly under the state plan or waiver. However, states may find the costs comparable as other factors are considered (e.g. reduced churning, reduced cross subsidization and required increase in Medicaid rates to assure sufficient access).	No state funding obligation
Provider Reimbursement Impact	Expected to be higher than Medicaid rates but lower than commercial rates.	Unclear, but likely to be either Medicaid rates or enhanced Medicaid rates, but below commercial rates.	Commercial rates	Medicaid rates	Commercial rates	Commercial rates
Exchange Assessments	Do not apply	Apply	Apply	Do not apply	Apply	Apply
Federal Authority	ACA	ACA	ACA, Social Security Law, IRS	State Plan Amendment or Waiver	ACA, Social Security Law	ACA
Issues/ Considerations	Federal guidance will not be finalized until 2014 and program may not be implemented until 2015.	Only addresses affordability and continuity for consumers transitioning from Medicaid and their families.	CMS may not approve use of federal Medicaid funding. One issue will be whether the state is able to demonstrate budget neutrality. Does not mitigate plan, benefit, provider continuity.	Leaves federal funding "on the table" for consumers otherwise eligible for tax subsidies. May ease transition burden on consumers and administrative burden on state associated with implementing different coverage models in 2014 and 2015.	Does not address issue of affordability of coverage; does address issues of continuity of coverage and care. May be operationally complicated.	Does not mitigate concerns related to continuity, affordability, harm to existing Medicaid expansion populations.