



FACT SHEET

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FINAL RULE FOR ESTABLISHMENT OF THE BASIC HEALTH PROGRAM AND 2015 PAYMENT NOTICE

Today, the Centers for Medicare & Medicaid Services (CMS) issued the final rules establishing the standards for the Basic Health Program. The program provides states with the option to establish a health benefits coverage program for lower-income individuals as an alternative to Marketplace coverage under the Affordable Care Act. This program, which is voluntarily for states, enables them to create a program for individuals with incomes that are too high to qualify for Medicaid under the Medicaid expansion in the Affordable Care Act, but are in the lowest income bracket of individuals who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. These final rules set forth a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, state administration and federal oversight, and funding methodology. States can implement the Basic Health Program starting in 2015.

CMS also published the 2015 payment notice providing states the final funding methodology for the Basic Health Program and information about the 2015 payment rates.

Overview

Section 1331 of the Affordable Care Act provides states with a new coverage option, the Basic Health Program, for individuals who are citizens or lawfully present non-citizens, who do not qualify for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage and generally have income between 133 percent and 200 percent of the federal poverty level (FPL).

Benefits will include at least the ten essential health benefits specified in the Affordable Care Act; states can add benefits at their option. The monthly premium and cost sharing charged to eligible individuals will not exceed what an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace, including cost-

sharing reductions and advance premium tax credits; a state can lower premiums and other out of pocket costs at their option. A state that operates a Basic Health Program will receive federal funding equal to 95 percent of the amount of the premium tax credit and the cost sharing reductions that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the Marketplace.

Wherever possible, the final rule aligns Basic Health Program rules with existing rules governing coverage through the Marketplace, Medicaid, or CHIP. This will simplify administration for states and promote coordination between the Basic Health Program and other insurance affordability programs.

The final rule establishes: (1) the procedures for certification of a state-submitted Basic Health Program Blueprint, and standards for state administration of the Basic Health Program consistent with that Blueprint; (2) eligibility and enrollment requirements for standard health plan coverage offered through the Basic Health Program; (3) the benefits covered by standard health plans as well as requirements of the plans; (4) federal funding of certified state Basic Health Programs; (5) the purposes for which states can use such federal funding; (6) the parameters for enrollee financial participation; and (7) federal oversight of Basic Health Program funds.

The companion 2015 payment notice provides the methodology and data sources necessary to determine federal payment amounts made to states that elect to establish a Basic Health Program (BHP) for the 2015 operational year. The methodology in this payment notice is for CY 2015, and we anticipate updating the funding methodology annually with subsequent payment notices as we gain more experience with the Marketplace.

The final rule and final 2015 payment notice are intended to enable states to implement programs effective on or after January 1, 2015.

Key Provisions of the Final Rule

State establishment of a Basic Health Program. The regulation establishes the “Basic Health Program Blueprint” as the vehicle by which states will seek Secretarial certification to implement a Basic Health Program, consistent with the process for State-based Marketplaces. The regulation establishes fundamental elements of a Basic Health Program consistent with the statute, including statewide operation, and enrollment of all eligible individuals and prohibition on enrollment caps and waiting lists. The rule provides some flexibility around enrollment for states implementing in the first year.

Eligibility and Enrollment. The regulation lays out the eligibility criteria tying most standards to those used to determine eligibility for advance premium tax credits and cost sharing reductions. Additionally, it provides a state option to use the annual open enrollment model as in the Marketplace or the continuous enrollment model as in Medicaid and most CHIP programs. It

also provides a state option to use 12 month continuous eligibility. States are required to use the single streamlined application, to ensure coordination among other insurance affordability programs and to have government agencies determine eligibility.

Standard Health Plan. The regulation codifies the statutory provision requiring standard health plans and outlines the competitive contracting process and other contracting requirements. It defines the types of entities that can contract with the state to provide a standard health plan to Basic Health Program enrollees and ensures a choice of at least two standard health plan offerors while offering flexibility where choice is not feasible such as in rural areas. The rule defines the minimum benefit standard (the essential health benefits) and makes provisions for additional benefits at state option.

Enrollee Financial Responsibilities. Consistent with the statute, the rule provides that monthly premiums may not exceed the monthly premium the individual would have paid had he/she enrolled in the second lowest cost Marketplace silver plan. It establishes cost-sharing standards consistent with the Marketplace's, including protections for American Indian/Alaskan Natives and the prohibition of cost sharing for preventive health services.

Financing of Basic Health Program. The final rule establishes state Basic Health Program trust funds for receipt of federal deposits, sets the parameters on the permitted uses of funding, and establishes the process through which HHS will annually develop and finalize the Basic Health Program funding methodology and state payment amounts.

Oversight. The rule promotes program integrity and establishes standards for both state and federal oversight of the Basic Health Program. Standards are set for voluntary program termination by the state as well as Secretarial termination of Basic Health Program certification.

Key Provisions of the Final Payment Notice

Funding formula. The final 2015 payment notice describes the formula that will be used to determine the federal 2015 BHP payment rates, the final values for each of the factors relied on, and the data sources and methodologies used to develop the factors included in the formula. The payment methodology includes factors used to calculate the value of PTC and CSR for persons enrolled through the Marketplace, as well as several factors specific to the BHP payment (including those to estimate the impacts of tobacco rating factors, income reconciliation, and differences in the health status of BHP enrollees relative to persons enrolled through the Marketplace).

Use of 2014 or 2015 Marketplace Premiums. The final 2015 payment notice provides states with the option to use either 2014 premium data (trended forward) as the basis for the 2015 payment rate calculation, or actual 2015 premium data. (The actual 2015 data will serve as the "default" for calculation purposes unless a state elects otherwise). States must notify CMS by May 15, 2014 if they elect to use 2014 premium data as the basis for the payment calculation.

Risk Adjustment. The final 2015 payment notice establishes a process by which a state interested in a retrospective risk adjustment could propose a methodology that would reconcile its federal 2015 BHP payments to reflect the risk profile of its BHP population relative to persons enrolled through the Marketplace. This methodology is subject to approval by CMS and the Chief Actuary of CMS. While the reconciliation process is optional for the states, the payment notice includes a general description of the process, including timeframes for proposing and finalizing the risk adjustment methodology.

National Data Used to Determine Factors in the Methodology. CMS will use national data for other factors in the funding methodology. As we gain more experience in the Marketplace and as more data become available, future payment methodologies and factors used in the methodology may be revised, as appropriate. Any future adjustments will be announced in future years' payment notices and the public will have an opportunity to comment on the changes.

This final rule and final payment notice can be found at <http://www.ofr.gov/inspection.aspx>.