3701 Wilshire Boulevard
Suite 750
Los Angeles, CA 90010
Ph. (310) 204-6010
Fax (213) 368-0774
nhelp@healthlaw.org

Issue Brief

The Basic Health Option under Health Reform: Recommendations for California

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Overview

The Patient Protection and Affordable Care Act (ACA) gives states the option to establish a Basic Health program that provides health coverage for certain low-income residents instead of covering them in a Health Insurance Exchange. This Issue Brief discusses how low-income Californians can benefit from a Basic Health program, and recommends integrating the Basic Health program in California as closely with Medi-Cal as possible.

Background

Section 1331 of the ACA gives states the option to establish a Basic Health program.[1] This option permits states to offer one or more "Basic Health" insurance plans to individuals with incomes between 133% and 200% FPL[2] instead of offering them coverage through a Health Insurance Exchange.[3] Plans must provide at least the essential health benefits, and may only charge premiums and cost-sharing within certain limits. Plans may be offered by licensed HMOs, licensed health insurers, or some other network of health providers formed for this purpose. States electing to offer coverage through the Basic Health option will receive 95 percent of the federal funds that would have been spent on tax credits and cost-sharing subsidies for Basic Health enrollees if they had been covered through the Exchange.

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[1] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). This provision was introduced by Senator Cantwell of Washington, a state with a similar, successful program.

[2] States may also offer Basic Health to certain immigrants with income below 133% FPL who are not eligible for Medicaid. *See* ACA § 1331(e)(1)(B).

[3] For a more thorough summary of the federal law governing the Basic Health option, see Janet Varon, the National Health Law Program, *The Basic Health Option: Considerations for States Implementing Federal Health Reform* (2010). *See also* Stan Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States* (2011).

Discussion

The Basic Health presents an important opportunity for California because, if implemented carefully, it could help the state provide affordable, seamless coverage to low-income people.[4] A well-designed Basic Health program in California could reduce the number of uninsured residents by making coverage more affordable for lower income people and reducing the administrative burden and interruption in care associated with having to change plans.[5] As California decides whether and how to implement the Basic Health option,[6] it is important that the Basic Health option be implemented in a manner that will protect the needs of low-income consumers.

- **California's Basic Health program should be integrated with Medi-Cal.**

A successful Basic Health program in California should be completely integrated with Medi-Cal, such that Basic Health and Medi-Cal would operate as one program.[7] As such, Basic Health would use the same benefits package, delivery systems, and cost-sharing as Medi-Cal. It would look just like Medi-Cal on the "front-end." A Basic Health enrollee would get a card that says "Medi-Cal," would use the same providers as other Medi-Cal enrollees, and access the same plans. On the back end, the state would separately track Basic Health enrollees, in order to ensure that their expenses are paid

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[4] Although federal guidance regarding implementation of the Option has not yet been issued as of the date of this paper, HHS has promulgated a "Request for Information Regarding State Flexibility to Establish a Basic Health Program Under the Affordable Care Act." 76 Fed. Reg. 56767 (Sep. 14, 2011). California has pending legislation to implement a Basic Health program in California, but the bill will not be taken up again until 2012. *See* S.B. 703, 2011-2012 Reg. Sess. (Ca. 2011).

[5] *See, e.g.,* Stan Dorn *et al.*, *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households* (2011); *cf.* Gerry Fairbrother & Joseph Schuchler, *Stability and Churning in Medi-Cal and Healthy Families* (2008).

[6] As mentioned in footnote 4, *supra*, California Senator Ed Hernandez, O.D., introduced legislation to implement the Basic Health option in the 2011-2012 legislative session. The California HealthCare Foundation commissioned two studies to analyze the financial feasibility of implementing Basic Health in California and the impact of implementing Basic Health on the Exchange pool in California. *Compare* Mercer, *State of California Financial Feasibility of a Basic Health Program* (2011) (concluding that Basic Health is financially feasible in California and will not adversely impact the Exchange), *with* Rick Curtis & Ed Neuschler, Institute for Health Policy Solutions, *Income Volatility Creates Uncertainty about the State Fiscal Impact of a Basic Health Program (BHP) in California* (2011) (concluding that Basic Health is likely not financially feasible for California, and could hurt the Exchange's risk pool). *Cf.* Stan Dorn *et al., Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States* 11 tbl. 5 (2011), http://www.urban.org/uploadedpdf/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households.pdf (national study concluding that Basic Health is financially feasible for California). Although we find the analysis that concludes that Basic Health is feasible in California compelling, we do not address the financing issues in this issue brief.

[7] While complete integration may not be feasible, in order to maximize seamlessness and simplicity between the programs, California should integrate as many features of Basic Health and Medi-Cal as possible to keep the programs closely aligned.

for out of the Basic Health trust fund, as opposed to the federal matching system used for other Medi-Cal enrollees.

Integrating Basic Health with Medi-Cal is critical because the two programs will essentially serve the same population. Indeed, many Basic Health enrollees currently rely on Medi-Cal, or Medi-Cal-like programs to provide some or all of their care. Some potential Basic Health enrollees are already receive Medi-Cal funded limited-scope health care services through, for example, the Breast and Cervical Cancer Treatment Program (BCCTP), the Family Planning, Access, Care and Treatment (Family PACT) program, or the Tuberculosis Program. Other potential Basic Health enrollees receive health care services through California's Low Income Health Programs (LIHPs), an 1115 waiver program that offers adults ineligible for Medi-Cal a full range of benefits that is less comprehensive than the benefits package offered in Medi-Cal. Integrating Basic Health with Medi-Cal will allow California to continue serving this population as seamlessly as possible, without major shifts in cost-sharing or provider networks.

Moreover, going forward, enrollees are likely to move between Medi-Cal and Basic Health frequently. A recent study indicates that, nationally, about half of individuals and families with income below 200% FPL will experience changes that shift their eligibility between Medicaid[8] and Basic Health in a year.[9] These changes in program eligibility are called "churning."[10] If the programs are not integrated, churning between Medi-Cal and Basic Health may lead to a variety of problems for low-income Californians. First and foremost, churning can cause people to go without needed health care services for a variety of reasons, for example because the cost becomes too expensive, a service is no longer covered, or a trusted provider is not included in their new plan's network. In addition, churning may cause families to be enrolled in different plans, making care coordination difficult. Finally, people may become confused when forced to navigate completely different systems for obtaining coverage when their life circumstances change. Thus, integrating the Basic Health option with Medi-Cal is critical to minimizing breaks in coverage and gaps in care and to increasing the potential for low-income health care consumers to experience seamless and simplified coverage.

Even if Basic Health is not integrated with Medi-Cal, it could offer some real benefits to consumers in the form of reduced cost-sharing and a more robust benefits package than what they would be able to purchase in the Exchange. A well-designed Basic Health program should also facilitate families obtaining coverage through a single health plan, making care more accessible, seamless, and affordable for them. But if establishing a Basic Health program forces people to move between three separate health coverage programs—Medi-Cal, Basic Health and the Exchange—those gains may be outweighed by the additional administrative burden people will encounter if circumstances change and make it much more difficult for people to receive care

[8] Medicaid is the federal name of the program that is known as "Medi-Cal" in California.
[9] *See* Benjamin D. Sommers, and Sara Rosenbaum, *Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges* 30 Health Aff. 228 (2011).
[10] *See id.* at 230.

continuously from their providers.[11] In addition, integrating Basic Health with Medi-Cal offers California the opportunity to ensure that Medi-Cal participation remains attractive to providers by enticing them with slightly higher payment rates in Basic Health. Thus, a properly designed Basic Health program should offer the same cost-sharing and benefits as Medi-Cal and seamlessly facilitate enrollees' staying with their providers and plans as their circumstances shift them between Medi-Cal and the Basic Health program. A poorly designed Basic Health program will only increase the amount of churning by creating two points of discontinuity instead of one.

- **The Basic Health program Should Be Governed and Managed by the Department of Health Care Services**

To administer a Basic Health program that is seamless with Medi-Cal, the Department of Health Care Services (DHCS) should administer Basic Health in California.[12] Basic Health should appear as integrated with existing programs as possible on the "front end" so that consumers experience Basic Health as a program that works seamlessly with existing programs, including Medi-Cal and Healthy Families. At the same time, the Basic Health program's "back end" should build off of Medi-Cal's existing eligibility and enrollment infrastructure to reduce churning by facilitating seamless transitions between when enrollees' circumstances change. Similar to the existing "state-only" Medi-Cal program, a consumer who enrolls in the new Basic Health need not be aware that she is enrolled in a differently-funded program other than traditional Medi-Cal. The consumer simply receives a health insurance card, enrolls in a health plan, and accesses covered services as if she were in Medi-Cal. DHCS or county staff would keep track of these enrollees separately since their services are financed differently, and ensure that enrollees change "codes" when their circumstances warrant a move between programs, without any need for additional information or documentation from the consumer. DHCS should build the "back end" to be robust enough to help facilitate seamless

[11] There is no research currently available that precisely estimates how many individuals and families might churn between Basic Health and the Exchange if Basic Health is implemented, but existing research suggests that the figure will not be insignificant.

[12] The legislation that would establish Basic Health in California appoints the Managed Risk Medical Insurance Board (MRMIB), the agency that administers California's CHIP Program, to administer Basic Health. Because MRMIB is not the Medicaid agency, it is not the preferred agency to run Basic Health, as its infrastructure and processes are completely separate from Medi-Cal. Housing the program in DHCS instead would allow for great efficiencies and integration between Basic Health and Medi-Cal, given the large numbers of enrollees who will move between the two programs. Moreover, California Governor Jerry Brown proposed in 2011 to move current CHIP enrollees (the Healthy Families Program) into Medi-Cal and eliminate MRMIB's responsibility for California's CHIP program. While this proposal has not moved forward, merging Healthy Families into Medi-Cal would improve alignment and reduce the effects of churning between those two programs for many of the same reasons described herein. If Healthy Families Program is successfully combined with Medi-Cal, there is even less reason to house Basic Health with MRMIB. Instead, the state's Medicaid agency is the appropriate authority to administer all three programs. Not only will administering Basic Health through the Medicaid agency ameliorate churning between Basic Health and Medi-Cal, but it would facilitate more families being covered in the same plan.

transitions when consumers become eligible for the Exchange (i.e., when their income exceeds 200% FPL). While some enrollees may feel disinclined to participate in a "welfare" program, any potential stigma to enrollees could be eliminated by re-branding Medi-Cal.[13]

If the state chooses another agency to administer Basic Health, the efficiencies that could come from shared IT infrastructure and eligibility, enrollment, retention and due process procedures, could be lost. Therefore, the Exchange is not the preferred choice to administer Basic Health Programs in California. Specifically, the Exchange lacks a proven track record in serving low-income populations, but will serve a broader range of middle-income individuals. Exchange plans will look more like commercial plans than Medicaid or Healthy Families,[14] and the Exchange may not be familiar with the kinds of cost-sharing and benefits structures that low-income people need. The IT infrastructure, personnel and notices in the Exchange will not be well-suited to needs of a public health coverage program like Basic Health. Finally, given that the Exchange will not administer Medi-Cal or CHIP, the Exchange will not be able to as effectively facilitate transitions among those programs and Basic Health. For these reasons, DHCS is a better choice to administer Basic Health than is the Exchange.

- **Basic Health eligibility should extend to low-income adults ineligible for Medi-Cal.**

The ACA gives states a fair amount of discretion to define eligibility for Basic Health and develop enrollment and retention procedures for the program.[15] The ACA establishes four criteria for determining Basic Health eligibility: age, income, immigration status, and availability of other coverage. Only individuals who are younger than 65 may be eligible for Basic Health.[16] An individual must not be eligible for minimum essential coverage (including Medicaid and "affordable"[17] employer-sponsored coverage).[18] In terms of immigration status, all lawfully present aliens, citizens and nationals are eligible.[19] As to income, only those with Modified Adjusted Gross Income (MAGI) at or below 200% FPL

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[13] For example, several Low Income Health Programs have used new names and logos to differentiate themselves from prior or existing safety net programs. *See, e.g.,* Press Release, Alameda County Health Care, Alameda County launches HealthPAC Program for the Uninsured (July 1, 2011), http://achealthcare.org/2011/07/july-1-2011alameda-county-launches-healthpac-program-for-the-uninsured; CMSP, What's New?, http://www.cmspcounties.org/news/whats_new.html (last accessed October 29, 2011). A Basic Health Program in California could similarly use a different name and logo to differentiate itself from Medi-Cal.

[14] Healthy Families is California's Children's Health Insurance Program (CHIP).

[15] Forthcoming regulations may provide further guidance on these issues.

[16] ACA § 1331(e)(1)(D).

[17] Affordable coverage in this context is defined as coverage where the individual's annual required contribution does not exceed 8% of the individual's household income. IRC § 5000A(e)(2).

[18] ACA § 1331(e)(1)(A), (C).

[19] ACA § 1331(e)(1)(A)-(B).

may be eligible for Basic Health.[20] Individuals eligible for a Basic Health option must enroll in the Basic Health program and may not enroll in the Exchange (although they would be eligible to purchase coverage through the Exchange with subsidies had the state not established a Basic Health program).[21]

At a minimum, a Basic Health program in California should include lawfully present immigrants, citizens and nationals not eligible for Medi-Cal or other minimum essential coverage, aged 19 to 64,[22] with income below 200% FPL. As such, the Basic Health eligibility pool would be largely composed of those "childless adults" and parents with income between 133% and 200% FPL who are not currently eligible for full-scope Medi-Cal. To the extent that some Basic Health enrollees might also be eligible for additional benefits or reduced cost-sharing through a limited-scope Medi-Cal program (for example, Medi-Cal for pregnancy related services or BCCTP), the state should permit these individuals to enroll in both programs in order to obtain the full range of services they need with the lowest cost-sharing possible.

- **Basic Health should offer the same benefits as Medi-Cal.**

The ACA requires Basic Health programs to offer "at least the essential health benefits" that qualified health plans in the Exchange will offer.[23] As defined by the ACA, essential health benefits include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services (including chronic disease management); and pediatric services, including oral and vision care.[24] For the most part, the essential health benefits will not be as generous as the package of benefits offered to Medi-Cal beneficiaries in a "full-scope" Medi-Cal program.[25]

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[20] ACA § 1331(e)(1)(B).
[21] ACA § 1331(e)(2).
[22] Technically, Basic Health must be available to anyone who meets the eligibility requirements and is under age 65. It is assumed in this paper that all children aged 18 and under will be eligible for either Medi-Cal or Healthy Families through programs that are protected by the Maintenance of Effort requirements in the ACA until 2019. Once these programs are no longer mandatory for states after 2019, some children could become eligible for Basic Health, too.
[23] ACA § 1331(a)(2)(B).
[24] ACA § 1302(b)(1). Additional regulatory guidance further defining "essential health benefits" is forthcoming, and expected in late 2011.
[25] While further guidance on the exact scope of the "essential health benefits" is forthcoming, so far HHS has not indicated that the it intends to add significantly to the scope of benefits required by the the ACA itself. The ACA, permits states to offer "benchmark coverage" to the new Medicaid expansion adult group, which many individuals will qualify for when their income is too low to qualify for Basic Health. *See* ACA § 2001(a)(2), 42 U.S.C. 1396a(k)(1). While such benchmark coverage may be less generous than the coverage currently offered to full-scope Medi-Cal enrollees, California should opt to offer the same scope of benefits to those newly eligible for Medi-Cal as it offers to other existing Medi-Cal enrollees.

A robust benefits package is crucial to making Basic Health work for low-income people. As described, above, high levels of income volatility could result in millions of people moving between Medi-Cal and Basic Health each year. If each move creates a change in the services covered, coverage disruptions will ensue. As a result, consumers might lose access to needed services, perhaps even in the middle of a course of treatment. Studies show that disruptions in coverage often lead to individuals' going without needed services, which in turn causes their health status to decline.[26] Ensuring that Basic Health programs cover more benefits that qualified health plans is especially vital given that many vulnerable populations will access their health care through Basic Health. Research indicates that many individuals who access Basic Health will have multiple chronic conditions, disabilities, and/or mental illness.[27] Therefore, the benefits offered in Basic Health should be expansive enough to enable people to function independently in the community, both physically and mentally.

To implement the Basic Health option in California in a manner that ensures continuity of care and coverage, as well as full integration with Medi-Cal, the state should offer services above and beyond the required essential health benefits package and mirror those required in the existing Medicaid program. The ACA expressly sanctions states' using funds designated for the Basic Health option to provide "additional benefits" beyond essential health benefits.[28] States are charged with negotiating for additional benefits from plans.[29] Further, states that implement Basic Health programs options are mandated to "seek to coordinate the administration of, and the provision of benefits under" its Basic Health program, Medicaid, Healthy Families, and other State health programs "to improve continuity of care."[30] Thus, aligning the Basic Health program benefits package to Medi-Cal's benefits package squarely fits within the statutory vision of a Basic Health plan.

- **Basic Health should impose the same cost-sharing limits as Medi-Cal.**

The ACA ensures that Basic Health enrollees may not be charged higher premiums in Basic Health than they would otherwise pay in the Exchange, accounting for the subsidies they would receive there. [31] In addition, cost-sharing in Basic Health is limited. For those with income below 150% FPL, cost-sharing may not exceed 10% of the total cost of care; for those with income between 150 and 200% FPL, cost-sharing

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[26] *See, e.g.,* Gold *et al. Insurance continuity and receipt of diabetes preventive care in a network of Federally Qualified Health Centers,* 47 MED CARE 431 (2009); Gleason *et al., Enhancing Health Care Transition for Youth and Young Adults Living with Chronic Medical Conditions and Disabilities* (2009), at http://www.physicianparent.org/siteimages/PPCpaper_web.pdf.
[27] *See, e.g.,* Brown *et al., The State of Health Insurance in California* (2009), at http://www.healthpolicy.ucla.edu/pubs/files/SHIC_RT_82009.pdf; An and Sturm, *Self-Reported Unmet Need for Mental Health Care After California's Parity Legislation,* 61 PSYCHIATRIC SERV. 861 (2010).
[28] ACA § 1331(d)(2).
[29] ACA §§ 1331(c)(1).
[30] ACA § 1331(c)(4).
[31] ACA § 1331(a)(2)(A)(i).

may not exceed 20% of costs.[32] As such, the ACA would allow much higher cost-sharing in Basic Health than is currently permitted in traditional Medi-Cal.[33] Nevertheless, the ACA not only permits, but encourages states to limit cost-sharing in Basic Health. States must negotiate with plans in the contracting process to determine premiums and cost-sharing for Basic Health.[34] One of the main permitted uses for funds designated for Basic Health is reducing premiums or cost-sharing.[35]

Ensuring that Basic Health is affordable is critically important because Basic Health enrollees will be extremely low-income and are unlikely to find even modest premiums or copayments affordable. For example, the Insight Center for Community Economic Development estimates that a single adult in San Joaquin County needs $1,861 per month (about 205% FPL) to make ends meet.[36] For other parts of the state where the cost of living is higher, the amount needed is even higher.[37] The California Budget Project estimated last year that, statewide, a single adult needed $2,537 per month (281% of the 2010 FPL) to get by.[38] At 200% FPL and below, most Californians are struggling just to meet their basic, subsistence level needs, and have little, if any, disposable income left to contribute toward the cost of health care services.

Thus charging low or no premiums and/or copayments is essential to a Basic Health program's success. First, lower premiums in Basic Health compared to the Exchange will reduce the number of uninsured in California because more people will enroll. In

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[32] The Senate bill (H.R. 3590, The Patient Protection and Affordable Care Act) signed into law on March 23, 2010, capped cost-sharing in the exchange at 10 percent for people with incomes between 100 and 150% FPL, which is also the level of cost-sharing for the platinum plan, and 20% for people with incomes between 150 and 200 percent of poverty, which is also the level of the gold plan. The reconciliation bill (H.R. 4872) signed into law on March 30, 2010, increased cost-sharing subsidies for people in those income ranges from 90 percent to 94 percent (so an enrollee is responsible for only 6% as opposed to 10%) and from 80 percent to 87 percent (so an enrollee is responsible for 13% as opposed to 20%). Presumably the cost-sharing limits in the reconciliation bill will apply to the standard plans offered through state Basic Health Programs, but further guidance will clarify this issue.

[33] In "medically needy" Medi-Cal programs, enrollees pay a share-of-cost to access services, based on the amount of their income that exceeds a set "maintenance need level." Thus higher income enrollees in "medically needy" programs may pay more than 10 or even 20% of their incomes to access services.

[34] ACA § 1331(c)(1).

[35] ACA § 1331(d)(2).

[36] Insight Center for Community Economic Development, *The Self-Sufficiency Standard for San Joaquin County, CA 2011* (2011), http://www.insightcced.org/uploads/cfes/2011/San%20Joaquin.pdf.

[37] For example, in Los Angeles County, a single adult is estimated to need $2,541 per month (280% FPL) to achieve economic self-sufficiency, and in San Francisco, a single adult is estimated to need $2,524 per month (278% FPL). Insight Center for Community Economic Development, Self-Sufficiency Standard for California & Self-Sufficiency Calculator, http://www.insightcced.org/index.php?page=calculator.

[38] California Budget Project, *Making Ends Meet: How Much Does It Cost to Raise a Family in California?* 4 (2010), *available at* http://www.cbp.org/pdfs/2010/100624_Making_Ends_Meet.pdf.

general, the lower the cost of purchasing health insurance coverage, the more likely low-income people are to enroll in it.[39] When premiums are higher, people are more likely to become uninsured and go without care they need.[40] Second, lower copayments in Basic Health will improve health outcomes for enrollees. People are more likely to receive preventative services and comply with medical advice when copayments are lower.[41] But they are more likely to go without needed services[42] and use costly emergency and inpatient services[43] when copayments are higher. Currently, Medi-Cal beneficiaries pay only nominal copayments for most services, and many services are free.[44] If Basic Health imposes higher cost-sharing than Medi-Cal, the result is likely to be decreased enrollment in Basic Health, and more sick people returning to Medi-Cal after periods of uninsurance when their incomes fluctuate. In order to make the Basic Health program work effectively for California consumers, California should place much more stringent limits on cost-sharing by aligning cost-sharing in Basic Health with Medi-Cal cost-sharing limits.

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[39] *See, e.g.,* Gery P. Guy, *The Effects of Cost Sharing on Access to Care Among Childless Adults,* 45 Health Serv. Res. 1720 (2010); Amy J. Davidoff *et al., Lessons Learned: Who Didn't Enroll In Medicare Drug Coverage In 2006, And Why?,* 29 Health Aff. 1255 (2010); Michael Chernew *et al., The Demand for Health Insurance Coverage by Low Income Workers: Can Reduced Premiums Achieve Full Coverage?*, 32 Health Serv Res. 453 (1997);

[40] *See, e.g.,* Stephen Zuckerman *et al., Missouri's 2005 Medicaid Cuts: How Did They Effect Enrollees and Providers?* 28 HEALTH AFF W335 (online ed. Feb. 2009), http://content.healthaffairs.org/content/early/2009/02/18/hlthaff.28.2.w335.full.pdf+html; Leighton Ku & Victoria Wachino, *The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings* (2005), *available at* http://www.cbpp.org/cms/?fa=view&id=321.

[41] *See, e.g.,* Amal Trivedi *et al, Effect of Cost Sharing on Screening Mammography in Medicare Health Plans,* 358 NEW ENG. J. MED. 375 (2008), *available at* http://www.nejm.org/doi/full/10.1056/NEJMsa070929#t=article; Michael *Chernew et al, Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care,* 23 J. GEN. INTERN MED. 1131, (2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517964/?tool=pubmed.

[42] *See, e.g.,* Daniel Hartung *et al., Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-Service Medicaid Population,* 46 MED. CARE 565, (2008), *available at* http://www.ncbi.nlm.nih.gov/pubmed/18520310;

[43] *See, e.g.,* Bill Wright, *et al., The Impact of Increased Cost Sharing on Medicaid Enrollees,* 24 HEALTH AFF. 1106 (July/August 2005), *available at* http://www.healthaffairs.org/RWJ/Wright.pdf; Neal T. Wallace *et al., How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan*, 43 HEALTH SERV. RES. 515 (2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442363/.

[44] Cal. Welf. & Inst. Code § 14134. In 2011, California submitted to CMS a proposal to increase the amount of those copayments dramatically. At this writing, that proposal is still pending CMS approval, and CMS has denied a similar proposal by the state of Washington, indicating that California's proposal may not pass muster.

- **Basic Health should use the existing Medi-Cal delivery system as a foundation, but should also incorporate Primary Care Case Management models and use the networks established to serve LIHPs.**

The ACA requires that that Basic Health plans be operated using managed care plans or with "systems that offer as many of the attributes of managed care as are feasible in the local health care market."[45] States must use a competitive process to select plans, and are encouraged to offer a choice of plans.[46] States may only select plans that assure that 85 cents of every dollar collected in premiums pays for medical care and quality improvements (an 85% medical loss ratio).[47]

The Basic Health option in California should leverage California's existing relationships with managed care plans serving the Medi-Cal population to serve Basic Health enrollees, as well.[48] Basic Health plans are required to coordinate with Medicaid and Children's Health Insurance Program (CHIP) in order to maximize efficiency and continuity of care.[49] By using the same plans to serve Basic Health enrollees, California can maximize efficiency and continuity of care. Using the same plans with the same provider networks is especially important to ensuring continuity of care, since, as described above, Basic Health enrollees are likely to move between Medi-Cal and Basic Health as their income fluctuates. Using the same plans will also help to ensure that families can be covered under the same plan, allowing them to better coordinate care.

California will likely need to look beyond its existing pool of risk-based capitated managed care plans that serve Medi-Cal enrollees to meet the requirements of the Basic Health option. In many rural parts of the state, there are no managed care plans available to Medi-Cal beneficiaries. In addition, some populations are excluded from mandatory managed care. Therefore, California should consider establishing a Primary Care Case Management (PCCM) model to meet the needs of Basic Health and Medi-Cal enrollees. PCCM programs are based on the patient-centered medical home model. Many other states currently use PCCM models to deliver services to Medicaid beneficiaries. PCCM programs connect enrollees to primary care providers and then pay those providers a modest fee per month per beneficiary to provide enrollees with a range of care management activities. PCCMs frequently incorporate many of the plan features that the ACA requires states to negotiate for in Basic Health. These include care coordination, incentives for use of preventive services, and patient-centered decision-making.[50] Because PCCMs pay providers on a fee-for-service basis, they may

[45] ACA § 1331(c)(2)(C).
[46] ACA §§ 1331(c)(1), (3)(A).
[47] ACA § 1331(b)(3).
[48] As of this writing, further guidance is forthcoming about how states are to establish a competitive bidding process to select plans for participation in Basic Health programs pursuant to ACA § 1331(c)(1). Depending on how competitive bidding is to proceed, states may be able to require plans to participate in Medi-Cal in order to be considered for BHP.
[49] ACA § 1331(c)(4).
[50] ACA § 1331(c)(2).

be more readily accessible than risk-based capitated managed care plans in rural or sparsely populated areas.

In addition, California should draw upon its experience with networks serving the LIHP in its current 1115 Medicaid waiver to serve individuals covered by the Basic Health option. The networks that currently provide care to Californians in LIHPs should transition to serve new Medi-Cal and Basic Health enrollees in 2014. The LIHPs were established by an 1115 Waiver in California to allow counties to leverage federal Medicaid dollars to provide care to low-income childless adults in advance of full Medicaid expansion in 2014.[51] Counties may serve individuals with income up to 200%, though counties may opt to set eligibility limits at a lower level.[52] Implementation of the LIHPs began in ten counties in July, 2011. In these county-based programs, California is currently experimenting with plans that offer unique features particularly suited to the Basic Health population. Many of these features are those for which the ACA requires states to negotiate in Basic Health: care coordination, incentives for use of preventive services, patient-centered decision-making, consideration of differing health care needs and resource differences, and performance measures focusing on quality of care and improved outcomes.[53] California can build on its experience with these features in the LIHP plans to select the most successful features and plans for Basic Health in 2014.

In contracting with networks and plans for its Basic Health program, California should account for provider rates that assure that the networks available in Basic Health can serve enrollees' best interests. At least some analysts predict that California will be able to offer providers in Basic Health a 20-70% higher reimbursement rate than that currently offered in Medi-Cal.[54] California could use Basic Health's comparatively generous reimbursement rates to attract plans and networks to participate in both Basic Health and Medi-Cal, and to ensure that those plans and networks offer adequate capacity to meet the needs of Basic Health enrollees. At the same time, California should carefully evaluate the best allocation of funds among competing needs such as increasing provider rates, lowering premiums and/or cost-sharing, and increasing the benefits covered. California must strike the right balance to promote the best interests of enrollees.

- **Basic Health should integrate its notice and appeals process with Medi-Cal.**

The ACA is silent as to what due process should be offered to applicants to and enrollees in a Basic Health program.[55] It is critical that, at a minimum, constitutional guarantees of due process be protected – adequate and timely notice, a fair and

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[51] *See* Center for Medicare & Medicaid Services, Special Terms and Conditions of the California Bridge to Reform Demonstration Waiver, Waiver No. 11-W-00193/9 (Nov. 2010), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Publications/CaliforniaSTCs11-2-10.pdf.
[52] *Id.* ¶ 58.b.
[53] ACA § 1331(c)(2).
[54] *See, e.g.,* Mercer, *supra* note 6 at 20.
[55] Regulatory guidance on this question will be forthcoming as to the Exchange and, may apply to the Basic Health option as well.

independent hearing, etc.[56] The Basic Health program in California should offer the same due process protections as Medi-Cal. If the program is fully integrated with Medi-Cal, then individuals would have access to the same appeals system as Medi-Cal beneficiaries. Even if the programs are not integrated completely, the state should adopt a single, integrated appeal process for determining eligibility (whether Medi-Cal, Basic Health, or Exchange subsidies) and that process should meet the due process standards that apply to Medi-Cal fair hearings.

Completely integrating the Basic Health notice and appeals processes with those of Medi-Cal will also maximize efficiency and ensure a smooth process for all involved. Eligibility for Basic Health and Medi-Cal will be integrally linked—eligibility for one necessarily means ineligibility for the other. So by offering one, integrated notice and appeals system, consumers will be efficiently notified about program or eligibility changes, and can participate in a full hearing on all of the relevant issues, rather than having to navigate two separate systems if, for example, a disagreement arises as to whether a person should be enrolled in Medi-Cal / Basic Health or the Exchange.

One of the critical features of Medicaid due process is the right to a comprehensive Notice of Action. Whenever a determination of eligibility for coverage (e.g. Medi-Cal or Basic Health) is made, including coverage for subsidies in the Exchange, or a determination to terminate or modify coverage (e.g., determination that a consumer is eligible for a lower level of tax credit), the consumer must receive a plainly worded notice telling her of the decision, what the reasons were for any adverse determination, and explaining how to appeal a decision if she believes it is incorrect. The notice should include information about the program she is being determined eligible for, or the process undertaken to determine eligibility. There should be no termination from coverage without an assessment of eligibility for each of the programs (Medi-Cal, Basic Health and the Exchange) and until the individual is actually enrolled in the new health coverage. Decisions to terminate or modify Medi-Cal or Basic Health coverage should go through the current fair hearing appeals process before a neutral and independent arbiter, which must include the individual's right to maintain aid/coverage during an appeal. This way the protections and rules that exist in Medi-Cal would also extend to Basic Health.

- **Enrollment and Retention in Basic Health**

The ACA is silent as to when applicants may apply to and be enrolled in a Basic Health program, and as to the length of Basic Health coverage.[57] Though the ACA does require a single application and seamless eligibility determinations, enrollment will work very differently in the Exchange compared to Medi-Cal. In the Exchange, people will only be able to enroll in plans during one "open enrollment period" per year (unless they have certain changes in circumstances that create a need for enrollment outside of the open enrollment period). In general, if a person would have been eligible for coverage in the Exchange, but didn't apply during the open enrollment period, that person will not be

[56] *See, e.g., Goldberg v. Kelly,* 397 U.S. 254 (1970); *Matthews v. Elridge,* 424 U.S. 319 (1976).
[57] Regulatory guidance on this question may be forthcoming.

able to get coverage that year, and penalties may apply. By contrast, in Medi-Cal, a person can apply and begin coverage at any time, as long as she meets the eligibility requirements at the time of application.

The enrollment in the Basic Health option should follow the Medi-Cal model. Eligibility for Basic Health, like Medi-Cal, should account for whether a person is eligible at the time of application. Using the same enrollment procedures will not only help to integrate the Basic Health option with Medi-Cal, but will also minimize confusion and unnecessary gaps in coverage if people fail to apply during an "open enrollment period" for any reason.

Once people are enrolled in the Basic Health program, they should remain eligible for the year, and only subject to annual redeterminations, as in Medi-Cal.[58] Annual eligibility redeterminations would allow a person who enrolls in the Basic Health program to keep that coverage for one full year.[59] Because circumstances in lower income families change frequently, eligibility for a year would both minimize the associated administrative burden across programs and help to ensure continuity of coverage for consistency in service delivery.

If California's Basic Health program adopts annual redetermination of eligibility, the state will only have to check eligibility for the Basic Health once a year, and it could be aligned with the Medi-Cal redetermination time frame. Once a person is enrolled in health coverage, the state need only check for changes in age, coverage, income, household size, and county of residence. Other data would be unnecessary at annual renewal. For example, once someone has proven that he is a citizen, he should not be asked to verify citizenship again if he moves from one coverage program to another. When consumers apply for the Basic Health option they should be asked whether they want the state to automatically check for necessary information regarding eligibility and keep them on if eligible. Under this system, the state would first conduct an ex parte process for health coverage renewal, e.g. check of tax return, other public benefit programs, etc. for family size, address and income. If a consumer is still eligible for the Basic Health program, she would keep coverage for another year. If his coverage is renewed, the consumer should receive a notice laying out the information upon which the renewal is based and advising the consumer to contact the program if this information is incorrect.

Conclusion

California has the opportunity to implement a Basic Health program that is integrated with Medi-Cal to minimize breaks in coverage and gaps in care and to increase the

[58] In 2014, Medicaid programs that rely on Modified Adjusted Gross Income to determine eligibility are proposed to use continuous eligibility. *See* Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 76 Fed. Reg. 51148 (proposed Aug. 17, 2011) (to be codified at scattered sections of 42 C.F.R.).

[59] If Basic Health and Medi-Cal are not completely integrated, however, an enrollee should still be able to request a determination for Medi-Cal, if her income decreases.

potential for low-income consumers to experience seamless and simplified coverage. By closely integrating or aligning Basic Health with Medi-Cal, California can ensure that enrollees whose circumstances change continue to have affordable and comprehensive coverage and access to care as compared to the Exchange. Integrating Basic Health with Medi-Cal could help families obtain coverage through the same plans, making it easier for families to coordinate care. If California ultimately moves all of the children in Healthy Families program into Medi-Cal, even more families will be able to obtain coverage together under one program. California should take advantage of this historic opportunity to reduce the number of Californians who are uninsured by making care accessible, affordable, and comprehensive through the Basic Health option.