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MIND THE GAP: BASIC HEALTH ALONG THE ACA'S COVERAGE CONTINUUM

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I. INTRODUCTION

It will not be easy to implement the Affordable Care Act's (ACA's)¹ insurance access provisions, and implementation will not be a one-time event. The ACA's delayed Basic Health Program (BHP)² underscores both of these points. This insurance affordability program was intended to be available as a state option in January 2014, in explicit coordination with an expanded Medicaid and the new insurance exchange Marketplaces.³ The BHP is designed to be a separate program that operates as a bridge between the two, with the goals of reducing insurance costs and increasing care continuity for low-income people who are ineligible for Medicaid and who would otherwise qualify for subsidized private insurance coverage through the Marketplace.⁴

Because of federal regulatory delay, the program cannot start before 2015.⁵ For states considering the BHP, this delay complicates what was already a

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 26 and 42 U.S.C.).

2. See Patient Protection and Affordable Care Act § 1331, 42 U.S.C. § 18051 (Supp. V 2012) (explaining basic health program option).

3. See Basic Health Program, 78 Fed. Reg. 186,59122, 186,59127 (proposed Sept. 25, 2013) (to be codified at 45 C.F.R. pt. 600) (discussing BHP coordination with the Marketplace and Medicaid). In the ACA the sites for purchasing individual private insurance plans are referred to as "Exchanges," but the federal government's information website and other popular sources now term them "Marketplaces." See *Health Insurance Marketplace for Individuals*, HEALTHCARE.GOV, <https://www.healthcare.gov/marketplace/individual> (last visited Oct. 14, 2013) (displaying the federal government website's use of the term "Marketplace").

4. 42 U.S.C. § 18051(a)(1)–(2) (Supp. V 2012). See also Basic Health Program, 78 Fed. Reg. at 186,59123 (discussing the purpose of establishing a BHP).

5. See *Questions and Answers: Medicaid and the Affordable Care Act*, MEDICAID.GOV, (Feb. 2013), <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable->

complicated calculus, one with significant unknowns and moving parts. States with related pre-existing programs will be challenged to maintain aspects of their infrastructure while they consider the pros and cons of incorporating a delayed BHP, or related, still evolving options.⁶ One upside of the delay is that states will have preliminary data on the coverage status of those who would be served by the program and also on the functioning of their Marketplaces,⁷ and expanded Medicaid.⁸ States will have initial indications about whether and how the ACA's coverage incentives are working.⁹

A state's decision whether to adopt the BHP will involve consideration of its impacts on low-income residents, on the state Marketplace, and on the state budget.¹⁰ These considerations do not involve merely technical or financial issues.¹¹ They raise fundamental health care access issues that animated the BHP's adoption—both as part of the ACA and in its historical form.¹²

In this article, I first describe the origins of the BHP in a state program with parallels to the current federal reform effort.¹³ I then turn to the specifics of the

care-act-implementation/downloads/aca-faq-bhp.pdf (announcing that BHP regulations would be delayed); *see also* Basic Health Program, 78 Fed. Reg. 59,122, 59,123 (proposed Sept. 25, 2013) (to be codified at 45 C.F.R. pt. 600) (specifying that states will have the option to establish a BHP beginning Jan. 1, 2015).

6. *See infra* Part IV.

7. *See* 42 U.S.C. § 18022(G) (Supp. V 2011) (explaining that there will be a periodic review of the benefits offered by a state's Marketplace). *See Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies*, STATE REFORUM, https://www.statereform.org/system/files/508cms-10440_supporting_statement_part_a.pdf (last visited Nov. 30, 2013) (discussing the collection of data to determine coverage status and enroll individuals in appropriate coverage programs). *See* Amanda Cassidy, *Health Policy Brief: Basic Health Program*, HEALTH AFF. 1 (Nov. 15, 2012), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_80.pdf (discussing the establishment of a BHP as an additional means of expanding coverage after extending Medicaid and private health insurance to qualified individuals).

8. *See* STATE REFORUM, *supra* note 7 (stating that data must be collected to determine how individuals can apply for the ACA and which program is most appropriate); *see also* Cassidy, *supra* note 7 (stating Medicaid is set to expand in January 2014).

9. *See* Patient Protection and Affordable Care Act § 1302 (codified as amended at 42 U.S.C. § 18022 (Supp. V 2012)) (establishing a periodic review of the benefits offered by a state's marketplace).

10. *See* Deborah Bachrach et al., *Focus on Health Reform—The Role of the Basic Health Program in the Coverage Continuum: Opportunities, Risks, and Considerations for States*, KAISER FAMILY FOUND. 3, 3 (Mar. 2012), http://www.statecoverage.org/files/KFF-Role_of_BHP_in_Coverage_Continuum-Manatt_3.2012.pdf (discussing the advantages and risks states should consider when deciding whether or not to implement a BHP).

11. *See id.* at 5–8 (discussing the considerations of establishing a BHP).

12. *See* John A. Graves et al., *Balancing Coverage Affordability and Continuity under a Basic Health Program Option*, NEW ENG. J. MED. e44(1), e44(1) (2011), *available at* <http://www.nejm.org/doi/pdf/10.1056/NEJMp1111863> (discussing the ACA's concern for continuity of coverage and the option to adopt a BHP to address disruptions in coverage).

13. *See infra* Part II.

ACA's provision and its context within the law's insurance affordability programs.¹⁴ Finally, I consider possible questions that the program raises for policymakers going forward.¹⁵ Can BHP coverage be designed to be increase affordability and promote care continuity better than Marketplace coverage? Would the existence of the BHP enhance or undermine the state's Marketplace?¹⁶ How would the federal funding compare to the state's costs for the program?¹⁷ Ultimately, whether a state adopts the BHP or not, it ought to mind the gap between Medicaid and the Marketplace.¹⁸ When transitioning between the Medicaid and Marketplace insurance platforms, people can stumble. In this transition, central ACA goals of affordability and continuity will be tested.¹⁹

II. THE BASIC HEALTH PROGRAM'S PAST—ITS ROOTS IN COMPREHENSIVE REFORM

The BHP was added to the ACA in Washington, D.C., but its roots lie in the other Washington.²⁰ Beginning in the mid-1980s, the Washington State legislature undertook a concerted effort to reduce the number of uninsured Washingtonians, then estimated at about 12% of the state's population.²¹ Washington Basic Health began as a pilot project in 1988 to offer state-subsidized private health insurance to 4,000 low-income residents of the state's two most populous counties.²²

The legislature reauthorized and expanded the project, and then included it as a centerpiece of the state's sweeping attempt at "ambitious, comprehensive health reform[] in the early 1990s."²³ Washington State's 1993 Health Services Act (HSA)²⁴ aimed at universal coverage, using mechanisms similar to those adopted

14. *See infra* Part III.

15. *See infra* Part IV.

16. *See infra* Part IV.

17. *See infra* Part IV.

18. *See infra* Part IV.

19. *See infra* Parts III–IV; *see also* Graves et al., *supra* note 12, at e44(3) (discussing the ACA's goal of "ensuring access to stable and affordable coverage.").

20. *See History of Basic Health*, WASH. STATE HEALTH CARE AUTH., <http://www.basicealth.hca.wa.gov/about.html> (last visited Oct. 14, 2013) (discussing the origin of Basic Health in Washington state).

21. *Id.*

22. *See id.* (discussing Washington Basic Health as a pilot program, as well as the state's establishment of a high-risk pool in efforts to reduce the number of uninsured Washingtonians); Health Care Access Act of 1987, ch. 5, 1987 Wash. Sess. Laws 2502 (discussing the establishment of basic health care services for Washingtonians).

23. *See* Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. HEALTH POL., POL'Y & L. 133, 133-37 (2000). *See generally* Washington Health Services Act of 1993, ch. 492, 1993 Wash. Sess. Laws 2070, 2073, *repealed by* Act of May 8, 1995, ch. 265, 1995 Wash. Sess. Laws 973 (revealing the history of the health care reform act in Washington).

24. Washington Health Services Act of 1993, ch. 492, 1993 Wash. Sess. Laws 2070, *repealed by* Act of May 8, 1995, ch. 265, 1995 Wash. Sess. Laws 973.

nearly two decades later in the ACA.²⁵ Washington's HSA required most state residents to have health insurance, and most employers to provide it.²⁶ The HSA included a phase-in of pure community rating on the individual market, ultimately with no price variability for age, pre-existing condition or other factors.²⁷

Washington Basic Health, which became permanent under the HSA,²⁸ was a significant piece of this attempt at universal coverage.²⁹ Washington Basic Health was to the state HSA somewhat as the health insurance Marketplaces are to the federal ACA.³⁰ Individuals and families without access to employer-sponsored insurance, Medicare, or Medicaid, could turn to Washington Basic Health, a marketplace of comparable private insurance plans offering at least the statutorily required set of benefits, with sliding-scale state subsidies for those with incomes below 200% of the Federal Poverty Level (FPL).³¹ Those with incomes above 200% FPL were statutorily eligible to buy insurance on this marketplace, but without state subsidies.³²

25. Compare *id.* §§ 101–102 (discussing the essential services that will be offered to Washingtonians that enroll in certified health plans), with Patient Protection and Affordable Care Act § 1302, 42 U.S.C. § 18022 (Supp. V 2012) (discussing the essential health benefits that will be offered to individuals enrolling in health plans).

26. See Washington Health Services Act of 1993, ch. 492, §§ 463–464, 1993 Wash. Sess. Laws 2070, *repealed by* Act of May 8, 1995, ch. 265, 1995 Wash. Sess. Laws 973 (discussing state resident and employer participation in Washington's HSA). Because Washington is one of the few states without an income tax, the legislature could not rely on a tax penalty to enforce the individual mandate, unlike the federal government in the ACA. See *Income Tax*, DEP'T OF REVENUE WASH. STATE, <http://dor.wa.gov/content/findtaxesandrates/incometax/> (last visited Nov. 19, 2013) (explaining that “Washington State does not have a personal or corporate income tax.”). See *What's the Penalty for Not Having Health Insurance?*, EHEALTH (June 26, 2013), <https://www.ehealthinsurance.com/affordable-care-act/faqs/how-much-are-the-tax-penalties-for-not-having-health-insurance-and-when-do-they-apply> (discussing the ACA tax penalty and how it is implemented). What was to be done about employers who were required to provide insurance and did not or individuals who were required to have insurance and did not? The newly created Washington Health Services Commission was to report back on the “reasons why individuals are not enrolled . . . and [make] recommendations regarding enforcement of this requirement.” Washington Health Services Act of 1993, ch. 492, § 463, 1993 Wash. Sess. Laws 2070, *repealed by* Act of May 8, 1995, ch. 265, 1995 Wash. Sess. Laws 973.

27. See Washington Health Services Act of 1993, ch. 492, § 453, 1993 Wash. Sess. Laws 2070, *repealed by* Act of May 8, 1995, ch. 265, 1995 Wash. Sess. Laws 973 (discussing the HSA's uniform and supplemental benefits package based on community rating).

28. See *id.* at 2075 (discussing the legislative findings on the importance of a Washington Basic Health).

29. See *id.*

30. See *supra* note 25 and accompanying text.

31. Washington Health Services Act of 1993, ch. 492, § 208, 1993 Wash. Sess. Laws 2070, *repealed by* Act of May 8, 1995, ch. 265, 1995 Wash. Sess. Laws 973.

32. See *id.* (discussing the enrollment of subsidized and unsubsidized individuals). In the recent decade, however, unsubsidized coverage under the program has been mostly unavailable as insurance companies declined to participate in that portion of the market. See *History of Basic Health*, *supra* note 20 (discussing a decline in unsubsidized coverage as a result of rising costs).

Before this comprehensive health reform statute went into effect, however, the legislature gutted it.³³ The legislature first repealed the contentious mandates (to individuals and employers)³⁴ and then, as insurers abandoned the individual market, limited key consumer protections (including that people not be denied a policy or charged more based on pre-existing conditions).³⁵ Changing political circumstances influenced this quick turnabout. Republicans gained control in the state House and came within one seat in the Senate,³⁶ while raising objections to what they saw as government overreaching in the health care arena.³⁷ In addition, the federal government seemed unlikely to grant an ERISA waiver,³⁸ which was probably necessary to enforce the employer mandates.³⁹ Furthermore, the Clinton health plan,⁴⁰ which had been under serious consideration in 1993, was effectively dead when Washington's newly realigned legislature opened its session.⁴¹

Washington Basic Health, however, remained. Several other states adopted similar programs to cover low-income residents not eligible for Medicaid.⁴²

33. See *infra* notes 34–39 and accompanying text (tracing the evolution of Basic Health, which was adopted under the ACA).

34. Act of May 8, 1995, ch. 265, 1995 Wash. Sess. Laws 973. See *History of Basic Health*, *supra* note 20 (noting that HB 1046 repealed much of the HSA, “eliminating the minimum benefits package and the employer/individual mandate”). See also Kirk, *supra* note 23, at 137–38 (stating that “[i]n addition to removing the employer provisions that ran afoul of ERISA, the repeal had important implications for the individual market”).

35. See Act of March 23, 2000, ch. 79, 2000 Wash. Sess. Laws 413, 425 (regarding eligibility for pool coverage for those who have been denied coverage, have had restrictive riders added to their policy, or have up-rated premiums based on pre-existing conditions).

36. Kirk, *supra* note 23, at 137.

37. See Robert Cihak, et al., *The Rise and Repeal of the Washington State Health Plan: Lessons For America's State Legislators*, Heritage Found. (June 11, 1997), <http://www.heritage.org/research/reports/1997/06/bg1121nbsp-the-rise-and-repeal-of-the-washington> (describing the “attempt to implement the Washington State plan produced a citizens' revolt and led to a Republican takeover of the legislature” which “repealed the reform package”).

38. See Kirk, *supra* note 23, at 137 (explaining that “Washington's ERISA waiver prospects at the national level” appeared to diminish as of the fall of 1994).

39. See Kirk, *supra* note 23, at 138 (explaining that when the legislature passed legislation repealing parts of the HSA, it also removed “the employer provisions that ran afoul of ERISA”). The Employee Retirement Income Security Act (ERISA) is a complicated federal statute that, among many other things, “supersede[s] any and all state laws insofar as they may now or hereafter relate to any employee benefit plan” ERISA § 514, 29 U.S.C. § 1144(a) (2006); *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 197–98 (4th Cir. 2007) (holding that ERISA pre-empts Maryland employer-coverage requirement). See also *Golden Gate Restaurant Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639, 661 (9th Cir. 2008), *reh'g denied*, 546 F.3d 639 (2008), *cert. denied*, 130 S.Ct. 3497 (2010) (holding that ERISA does not pre-empt San Francisco employer-coverage requirement).

40. See Kirk, *supra* note 23, at 137–38 (describing a coalition of business groups that ran advertisements comparing Clinton's “failed” health plan to the HSA).

41. See *id.* at 137–38 (noting that the “Clinton plan” did not pass).

42. See Bachrach et al., *supra* note 10, at 16 (discussing pre-ACA state-funded programs for coverage of low-income adults); see also Cassidy, *supra* note 7, at 3 (stating that, post-ACA, Massachusetts and California passed initial legislation enabling a BHP, and “[s]even other states have passed legislation requiring an analysis of the prospect”).

MinnesotaCare, for example, is a prominent example, which provided subsidized insurance to about 130,000 of that state's working poor in 2012.⁴³ At its height in 2002, Washington Basic Health insured more than 135,000 individuals.⁴⁴ Under Washington Basic Health, private insurers bid to provide coverage; in 2012, all coverage was provided through managed care entities that also served the Medicaid population.⁴⁵ Coverage specifics have changed over time. In recent years, as the program's funding was cut, Washington Basic Health recipients have seen higher out-of-pocket costs in the forms of deductibles, co-pays, and co-insurance.⁴⁶

State budget constraints significantly limited the number of enrollees. In 2012, 35,000 individuals had Washington Basic Health coverage, and 166,000 more were on a waitlist.⁴⁷ This is a fraction—though not an insignificant fraction—of the one million state residents without any insurance in 2012.⁴⁸ The percentage of residents without health insurance at that point was a bit higher than when the state piloted Washington Basic Health decades before.⁴⁹ Leading up to 2014, Washington Basic Health and other similar state programs received federal funds under a Medicaid transitional bridge waiver,⁵⁰ an explicit recognition that many of those in the program would be eligible for Medicaid in 2014.

43. See *MinnesotaCare*, MINN. DEP'T. OF HUMAN SERVS., http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=id_006255 (last visited June 25, 2013) (stating that “[t]he program served an average of 129,000 people each month in state fiscal year 2012.”).

44. *Washington State Proposal for a Federal Basic Health Option*, WASH. STATE HEALTH CARE AUTH. 1, 2 (2012), available at www.hca.wa.gov/hcr/me/documents/WA_State_BHPO_Proposal_2012_06.pdf [hereinafter *HCA Proposal*]; see also *More Washingtonians wait-listed for Basic Health as employers cut coverage*, ECONOMIC OPPORTUNITY INSTITUTE (Feb. 23, 2012), <http://www.eonline.org/blog/more-washingtonians-wait-listed-for-basic-health-as-employers-cut-coverage/> (stating that enrollment for Washington's Basic Health was at “a high of 135,000 in 2002.”).

45. *HCA Proposal*, *supra* note 44, at 8 (describing how contracts were awarded to five managed care organizations to offer coverage to enrollees of Medicaid and Washington Basic Health whose coverage started on July 2012).

46. See *History of Basic Health*, *supra* note 20 (explaining that the average co-insurance and co-pays for enrollees increased from the 2009 average of \$34 per month to \$60 per month in 2010, and that the annual deductible increased from \$150 to \$250 in 2010).

47. See *HCA Proposal*, *supra* note 44, at 2 (explaining the waitlist as a result of an enrollment freeze caused by budget cuts).

48. Mike Kreidler, *State of the Uninsured Health Coverage in Washington State Costs, Trends and Projections 2008 to 2014*, WASH. STATE OFFICE OF THE INS. COMM'R 1, 1 (Dec. 13, 2011), <http://www.insurance.wa.gov/about-oic/commissioner-reports/documents/2011-uninsured-report.pdf> (stating that “[r]oughly 1 million Washingtonians—14.5 percent—now have no health insurance” going into 2012).

49. *Compare History of Basic Health*, *supra* note 20 (estimating that 12% to 14% of Washington residents were uninsured in 1986 when Washington Basic Health was piloted) *with Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUND. (2013), <http://kff.org/other/state-indicator/total-population/> (estimating the current percentage of uninsured Washington residents at 14%).

50. See *History of Basic Health*, *supra* note 20 (explaining that the waiver provided an estimated \$7.7 million per month in federal funds in 2011, covering about 40% of the cost of

III. THE BASIC HEALTH PROGRAM'S PRESENT—AN ACA PROVISION WITH KEY UNKNOWNNS

Citing her state's experience, United States Senator Maria Cantwell of Washington successfully offered the BHP option as an amendment to legislation that became the ACA.⁵¹ Within the ACA, the BHP is located at 42 U.S.C. § 18051.⁵² Section 18051 falls, actually and symbolically, between the ACA provisions for the new Marketplaces⁵³ and expanded Medicaid.⁵⁴ The BHP is indelibly intertwined with these two key access provisions.

As drafted, the ACA presumed that in January 2014 all states would expand their Medicaid populations, but the Supreme Court's June 2012 decision makes this a state option.⁵⁵ In states that take this option—the “expansion states”—Medicaid programs would be expanded to cover all citizens and immigrants with five years' legal residency who are under age sixty-five and have incomes under 138% FPL.⁵⁶ Because Medicaid otherwise targets categories of low-income people (primarily those over sixty-five or with qualifying disabilities, children, and pregnant women) this expansion effectively means Medicaid eligibility for many more low-income working adults, who would not otherwise be eligible no matter how low their

Washington Basic Health and Disability Lifeline, a separate state program for uninsured people with qualifying disabilities).

51. See Press Release, Senator Maria Cantwell, Health Care Reform Bill Includes Major Cantwell Initiatives to Control Costs, Improve Quality of Care (Oct. 13, 2009), *available at* <http://www.cantwell.senate.gov/news/record.cfm?id=318903> (stating that “the [Senate Finance] Committee approved a Cantwell amendment that would establish a nation-wide version of Washington state's Basic Health system”).

52. Patient Protection and Affordable Care Act, 42 U.S.C. § 18051 (Supp. V 2012).

53. See *id.* § 18051(a)(1) (offering through Basic Health at least the “essential health benefits” in 18022(b) “in lieu of offering such individuals coverage through an Exchange”); see also *id.* § 18031(a)(1) (establishing the Marketplaces).

54. See 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (Supp. V 2012) (expanding Medicaid to individuals under sixty-five years old who are not pregnant, but whose incomes do not exceed 133% of the poverty line).

55. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012) (holding that Medicaid expansion “is unconstitutional when applied to withdraw existing Medicaid funds from States that decline to comply with the expansion”); see also Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. Rev. 1, 87 (2013) (criticizing the Medicaid ruling for “missteps” that resulted from “factual inaccuracies promulgated by the Court”).

56. 42 U.S.C. § 1396a(a)(10)(A) (Supp. V 2012); see also Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. § 1613(a) (2008) (stating “an alien who is a qualified alien . . . is not eligible for any Federal means-tested public benefit for a period of 5 years beginning on the date of the alien's entry into the United States with a status within the meaning of the term ‘qualified alien’”). The ACA expansion threshold is 133% FPL, but the statute specifies that 5% of an individual's income is to be disregarded, effectively raising it to 138% FPL. See 42 U.S.C. § 1396a(e)(14)(I) (Supp. V 2012).

income.⁵⁷ Just how many more depends significantly on how many states, and which states, expand their programs.

The Marketplaces are the other primary means that the ACA aims to significantly increase the number of people with health insurance coverage.⁵⁸ The Marketplaces will offer private insurance plans—known as “qualified health plans” (QHPs)—that provide at least the “essential health benefits,” and meet other criteria.⁵⁹ Plans will be offered at four “metal levels”—bronze, silver, gold and platinum—with progressively higher actuarial values such that bronze plans would have the lowest premiums but correspondingly higher expected out-of-pocket costs (up to the standard out-of-pocket limit).⁶⁰

A crucial aspect of these Marketplaces (and a large part of the cost to the federal government) is their function as a vehicle for federal advance premium tax credits to support insurance purchase.⁶¹ These tax credits are effectively subsidies that are available to citizens and people with at least five years’ legal residency in the United States who are not eligible for Medicaid, do not have adequate, affordable employer-sponsored insurance, and have incomes that are between 100%⁶² and 400% FPL.⁶³ These sliding scale subsidies are pegged to the premium

57. See 42 U.S.C. § 1396d(a)(10)(A) (granting “medical assistance” in the form of payment of part or all of the costs for medical care and services for those over sixty-five or with qualifying disabilities, children, and pregnant women); see also *Medicaid and the Uninsured*, KAISER FAMILY FOUND. 1, 1 (Mar. 2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/7993-03.pdf> (stating that prior to the ACA, state Medicaid programs could only cover non-disabled adults without dependent children by obtaining a waiver or through the state’s own funding because federal Medicaid matching funds were not available to states covering that population of adults).

58. See *Explaining Health Care Reform: Questions About Health Insurance Exchanges*, KAISER FAMILY FOUND. (Apr. 2010), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7908-02.pdf> (explaining that the purpose of the Marketplaces is to make the purchase of health insurance easier and more affordable for individuals and small businesses that do not have access to employer or public health coverage).

59. See 42 U.S.C. § 18021(a)(1) (defining “qualified health plan”); *id.* § 18022(b) (listing the minimum benefits, general categories, items, and services covered under the “essential health benefits package”).

60. See 42 U.S.C. § 18022(d) (setting out the bronze, silver, gold and platinum levels of coverage with the percentage of actuarial values).

61. See I.R.C. § 36B(a) (Supp. V 2012) (stating that “there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year”).

62. See Dylan Scott, *The Story Behind the Biggest Mistake in Obamacare*, GOVERNING FEDWATCH (Feb. 19, 2013), <http://www.governing.com/blogs/fedwatch/gov-obamacare-mistake.html> (arguing that the fact that the subsidy eligibility begins at 100% FPL rather than at 138% FPL (the Medicaid expansion level) may simply be a drafting error). If it is a drafting error, it is one that would have been of limited consequence but for the Supreme Court’s decision. *Id.* Those who are Medicaid eligible are ineligible for subsidies; thus the subsidies effectively begin at 138% FPL in expansion states. *Id.* That subsidies begin instead at 100% FPL in non-expansion states has at least a couple of consequences. One is that federal costs for subsidies might be higher (though offset by reduced federal Medicaid costs). Another is the possibility of a Medicaid

price of the second least expensive silver plan.⁶⁴ Cost-sharing subsidies (to reduce the financial burden of deductibles, co-pays, and co-insurance) are also available to purchasers with incomes between 100% and 250% FPL.⁶⁵ Subsidies are not available to those with incomes below 100% FPL.⁶⁶ In a non-expansion state, then, many low-income, non-disabled, non-pregnant adult citizens will be ineligible for Medicaid and also ineligible for subsidized private insurance.⁶⁷

The BHP would operate as a separate state-run program between the subsidized Marketplace and expanded Medicaid.⁶⁸ It is intended to be another of the “insurance affordability programs,” in common with these two and the Child Health Insurance Program.⁶⁹

“premium assistance” or “private option” arrangement as discussed *infra* text accompanying note 71. *Id.*

63. *See id.* (stating that those with an income between 100–400% of the FPL qualify for federal tax subsidies under this law).

64. *See* I.R.C. § 36B(b)(2) (explaining that premium assistance may be the excess of “the adjusted monthly premium for such month for the applicable second lowest cost silver plan”).

65. *See* Patient Protection and Affordable Care Act, 42 U.S.C. § 18071(c)(2) (Supp. V 2012) (stating the income levels for reduced cost sharing under the plan).

66. *See id.* at § 18071(c)(1)(A) (listing all income levels that qualify for cost sharing subsidies, which are all above the 100% FPL).

67. *See The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAMILY FOUND. 1, 7 (Oct. 2012), available at [http://theadvocate.com/csp/mediapool/sites/dt.common.streams.StreamServer.cls?STREAMOID=bK8_JxfGnfcXzTSDxu0\\$JZM5tm0Zxrvol3sywaAHBAkhdffID9VMoMYJ7v66u_FE0\\$uXvBjavslIACLNr6VhLEUIm2tympBeeq1Fwi7sligrCfKm_F3DhYfWov3omce\\$8CAqP1xDAFoSAgEcS6kSQ--&CONTENTTYPE=application/pdf&CONTENTDISPOSITION=Kaiser%20Commission%20Coverage%20Gap%20October%202013.pdf](http://theadvocate.com/csp/mediapool/sites/dt.common.streams.StreamServer.cls?STREAMOID=bK8_JxfGnfcXzTSDxu0$JZM5tm0Zxrvol3sywaAHBAkhdffID9VMoMYJ7v66u_FE0$uXvBjavslIACLNr6VhLEUIm2tympBeeq1Fwi7sligrCfKm_F3DhYfWov3omce$8CAqP1xDAFoSAgEcS6kSQ--&CONTENTTYPE=application/pdf&CONTENTDISPOSITION=Kaiser%20Commission%20Coverage%20Gap%20October%202013.pdf) [hereinafter *The Coverage Gap*] (stating that many states opting out of Medicaid expansion leave millions of low-income adults uninsured because they “will remain outside the reach of the ACA,” do not have employer-sponsored coverage, are not eligible for state-assisted coverage, and even those eligible to purchase coverage on the Marketplaces may be ineligible for the premium tax credits and cost-sharing subsidies”—thus the insurance premium costs for low-income people in the coverage gap are “likely prohibitively expensive”).

68. *See* 42 U.S.C. § 18051(a)(1)–(e)(1)(A) (stating that a BHP may be established to provide health benefits “to eligible individuals” in lieu of offering such individuals coverage through an Exchange,” and an eligible individual “is not eligible to enroll in the State’s [M]edicaid program”).

69. *See id.* § 18051 (Supp. V 2012) (giving states “flexibility to establish basic health programs for low-income individuals not eligible for [M]edicaid”). CHIP has for many years allowed states to cover with enhanced matching federal dollars children and some parents in households with incomes above traditional Medicaid limits. *See State Children’s Health Insurance Program (CHIP): Reauthorization History*, KAISER FAMILY FOUND. (Feb. 2009), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7743-02.pdf> (stating that CHIP was enacted in the Balanced Budget Act of 1997 to expand eligibility levels and simplify enrollment procedures). *See generally* CHIP Reauthorization Act of 2009, 42 U.S.C. §§ 1397ee(b)–ll (Supp. V 2012).

One of the BHP's goals is to address issues of affordability.⁷⁰ An "affordability cliff" will exist between Medicaid, which has few out-of-pocket costs, and the Marketplace, in which people just over the Medicaid cut-off will have higher cost-sharing and also may pay premiums that, after subsidies, can amount to as much as 3% of their income⁷¹—a relatively high amount for low-income individuals and families. This is a highly price-sensitive population with high rates of uninsurance.⁷² Low-income people, particularly healthy low-income people, might find even the subsidized rates too high, and thus decline coverage.⁷³

Another goal is to reduce churn and its impacts.⁷⁴ "Churn" is shorthand for continuity of care and administrative disruptions that arise when people transition back and forth between insurance platforms as their income or family composition changes.⁷⁵ Income fluctuations are common among those with low-wage jobs, and private insurance often comes with different physician and clinic networks than does Medicaid.⁷⁶

The BHP allows states to use federal funds to craft a separate, state-run program of private insurance for residents with incomes below 200% FPL who are ineligible for Medicaid and who would otherwise qualify for subsidized coverage through the Marketplace.⁷⁷ The state would contract with one or more managed care plans to offer BHP coverage.⁷⁸ The amount of federal funds provided to the

70. See Bachrach et al., *supra* note 10, at 17 (stating that the overall intent of the BHP is to be more affordable to consumers).

71. See Ann Hwang et al., *Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges*, 31 HEALTH AFF. 1314, 1314 (2012), available at <http://content.healthaffairs.org/content/31/6/1314.full.html> (explaining that "a high proportion of people with low incomes will experience frequent shifts in eligibility between Medicaid and state insurance exchanges"); see also *Subsidy Calculator Premium Assistance for Coverage in Exchanges*, KAISER FAMILY FOUND. (Oct. 2013), available at <http://kff.org/interactive/subsidy-calculator/#state=&zip=&income-type=dollars&income=33000&employer-coverage=0&people=4&alternate-plan-family=individual&adult-count=2&adults%5B0%5D%5Bage%5D=21&adults%5B0%5D%5Btobacco%5D=0&adults%5B1%5D%5Bage%5D=21&adults%5B1%5D%5Btobacco%5D=0&child-count=2&child-tobacco=0> (estimating that Marketplace premiums for those just over the 138% Medicaid cut-off can amount to up to 3.35% of their income).

72. See Hwang et al., *supra* note 71, at 1314–18 (stating that affordability of coverage to enrollees in the Marketplace may be affected by "a disrupted source of financial subsidy, [which] may lead to breaks in coverage" and when "recouping tax credit overpayments, [which] might occur if people receiving coverage through an exchange experience a rise in income during the course of the year, because they will then be required to repay any excess tax credits that they received").

73. *Id.*

74. See, e.g., Basic Health Program, 78 Fed. Reg. 59,122, 59,140 (proposed Sept. 25, 2013) (to be codified at 42 C.F.R. pt. 600) (discussing the issue of churn).

75. *Id.*

76. *Id.*

77. See Patient Protection and Affordable Care Act, 42 U.S.C. § 18051(e) (Supp. V 2012) (defining "eligible individual").

78. 42 U.S.C. § 18051(a)(1) (Supp. V 2012).

state for the BHP would be tied to subsidies the federal government would have spent on the covered population had it remained in the Marketplace.⁷⁹

Thus, the amount of funding for the program is quite linked to the premiums and cost sharing associated with plans on the Marketplaces. States that choose this option are to receive 95% of what the federal government would have spent on premium subsidies,⁸⁰ and 95% or 100% (the ACA is not entirely clear) of what the federal government would have spent on cost-sharing subsidies.⁸¹ There are significant financial calculation questions not addressed in the statute that will presumably be clarified in the delayed BHP regulations. These relate to details such as risk adjustments, financial support for program administration costs, and the logistics of end-of-year reconciliation.⁸²

The federal funds are to be used to “reduce the premiums and cost-sharing of or to provide additional benefits to” BHP enrollees.⁸³ If the state has a BHP, people who are eligible for it would not be allowed to purchase subsidized Marketplace insurance.⁸⁴ They would instead be eligible for the BHP.⁸⁵ BHP benefits must be at least as comprehensive as those required to be offered on the Marketplace.⁸⁶ The ACA specifies that the BHP is to be coordinated with Medicaid and other state-administered health programs “to maximize the efficiency of such programs and to improve the continuity of care.”⁸⁷ The expectation is that the state would craft coverage that adopts benefit design and other system features similar to that provided in the state’s Medicaid managed care program, thus reducing the impact of churn around the 138% FPL income level.⁸⁸

If an expansion state adopts the BHP, that program becomes a key part of the coverage continuum for those without employer-provided insurance or Medicare.⁸⁹ It would have a particularly prominent role for adult citizens: those below 138% FPL would be covered by Medicaid,⁹⁰ then up until 200% FPL by the BHP;⁹¹ from

79. *Id.* at § 18051(d)(3)(A)(i).

80. *Id.*

81. *See infra* note 160.

82. *See* Bachrach et al., *supra* note 10, at 1 (discussing “significant questions and challenges” involved with the implementation of the BHP).

83. 42 U.S.C. § 18051(d)(2) (Supp. V 2012).

84. *Id.* at § 18051(e)(2).

85. *Id.*

86. *Id.* at § 18051(a)(2)(B).

87. *Id.* at § 18051(c)(4).

88. *See* Cassidy, *supra* note 7, at 2–3 (discussing the BHP’s ability to eliminate churning between Medicaid and Marketplace plans “for those below 200 percent of the poverty” level).

89. *See* Bachrach et al., *supra* note 10, at 3–4 (discussing the continuum of coverage and benefits of the BHP for those who do not have employer provided insurance or qualify for Medicaid).

90. *See Subsidy Calculator*, *supra* note 71 (noting that “states have the option to expand Medicaid eligibility to all people with incomes below 138% of the poverty level.”).

91. *Bachrach et al.*, *supra* note 10, at 3

that level to 400% FPL by Marketplace insurance with sliding-scale federal subsidies;⁹² and at higher incomes by Marketplace insurance without subsidies.⁹³ Particularly in light of this coverage continuum, impacts of the BHP cannot be considered in isolation.

Key issues and options are discussed in more detail in the following section of this article.⁹⁴ Suffice it to say here that interested states would have a very difficult time deciding whether to incorporate the BHP into their Marketplace modeling without knowing how the program would be regulated and funded. Washington State expressed strong interest in transitioning its state Basic Health program to an ACA-authorized BHP, formally requested federal guidance in early 2012, and submitted a proposed framework in June 2012.⁹⁵ Several other states, notably including Minnesota, California, and Massachusetts also actively considered adopting the BHP, pending federal guidance.⁹⁶

On February 6, 2013, the Administration issued “sub-regulatory guidance”⁹⁷ announcing that the program’s rollout would be delayed until 2015.⁹⁸ This document, technically a “Frequently Asked Questions” missive, promised that the proposed rules would issue in 2013, with final rules to follow in 2014 “so that the program will be operational beginning in 2015 for states interested in pursuing this

92. *Id.*

93. *Id.*

94. *See infra* Part IV.

95. *See generally* Washington State Health Care Authority, *Washington State Proposal for a Federal Basic Health Option* (June 18, 2012), <http://www.leg.wa.gov/JointCommittees/HRI/Documents/July%202012/BHPO%20Proposal%20June%2018.pdf> (explaining a proposed framework to establish a BHP and seeking federal guidance).

96. *See Cassidy, supra* note 7, at 6 (stating that “Washington, Massachusetts and California are taking steps to implement a Basic Health Program” while others are awaiting federal clarifications on “specific details of the program.”); *see also* Bachrach et al., *supra* note 10, at 3 n.1 (“At the time of this writing, analyses of BHP have been published for the following states: California (two studies), Connecticut, Maryland, Massachusetts, Minnesota, New York, North Carolina, and Tennessee.”). Other states involved in 2013 BHP learning collaborative included Oregon, New York, Rhode Island, and the District of Columbia. *See* MEDICAID AND CHIP MAC LEARNING COLLABORATIVES, BHP ELIGIBILITY AND ENROLLMENT LEARNING COLLABORATIVE (PowerPoint Slides from virtual meeting May 6, 2012) (on file with the author).

97. Timothy Jost, *Implementing Health Reform: The Basic Health Program and Federal Medicaid Matching Rates*, HEALTH AFF. BLOG (Feb. 7, 2013), <http://healthaffairs.org/blog/2013/02/07/implementing-health-reform-the-basic-health-program-and-federal-medicaid-matching-rates/> (discussing the HHS submission of two subregulatory guidance documents: 1) “Notice to Establish a New System Records” and, 2) “Questions and Answers: Medicaid and the Affordable Care Act”); *see also* Mary Whisner, *Some Guidance About Federal Agencies and Guidance*, 105 LAW LIBR. J. 385, 392 (2013) (discussing sub-regulatory guidance as a tool of administrative law).

98. *Medicaid and CHIP FAQs: The Basic Health Program*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb. 2013), <http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-BHP.pdf>

option.”⁹⁹ During a February 14, 2013 Senate hearing, Senator Cantwell criticized the Administration for failing to issue timely regulations and for thus in effect “taking pages out of the law.”¹⁰⁰ Proposed rules published on September 25, 2013 reiterate that interested states may establish a BHP effective January 1, 2015.¹⁰¹

The BHP has certainly suffered from the increasing complexity of ACA implementation. State-level opposition to the ACA has made an already complex endeavor much more so.¹⁰² Many states will not expand Medicaid in 2014, and this includes states with a high percentage of citizens below 138% FPL.¹⁰³ More than thirty states will not run their own Marketplaces in 2014 but will instead default to federal operation or a partnership model, a situation the statute and its funding do not smoothly accommodate.¹⁰⁴ At the federal level, the continued drumbeat for repeal¹⁰⁵ hinders attempts at even technical corrections, much less statutory refinements, or appropriation amendments.¹⁰⁶

99. *Id.*; see also Phil Galewitz, *HHS Delays Basic Health Plan Option Until 2015*, THE KAISER HEALTH NEWS BLOG (Feb. 7, 2013), <http://capsules.kaiserhealthnews.org/?p=16689> (discussing the delay of the Basic Health Plan Option until 2015).

100. Phil Galewitz, *Valentine’s Day Surprise: Senate Democrats Blast Obamacare Implementation*, THE KAISER HEALTH NEWS BLOG (Feb. 14, 2013), <http://capsules.kaiserhealthnews.org/?p=16879> (quoting Sens. Maria Cantwell, criticizing the administration for failing to meet a 2014 deadline to start a BHP, “[y]ou are overwhelmed by the details and technology, I get that point. . . . It seems as if the agency is taking pages out of the law.”).

101. Basic Health Program, 78 Fed. Reg. 59,122, 59,123 (proposed Sept. 25, 2013) (to be codified at 42 C.F.R. pt. 600).

102. See Michael Cannon, *The Obstacle is That Americans Don’t Want It*, N.Y. TIMES, Sept. 26, 2013, <http://www.nytimes.com/roomfordebate/2013/05/29/is-obamacare-too-complicated-to-succeed/americans-dont-want-obamacare>.

103. See *Status of State Action on the Medicaid Expansion Decision, as of September 20, 2013*, KAISER FAMILY FOUND., <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#map> (last visited July 1, 2013) (listing state decisions in expanding Medicaid and running their Marketplaces).

104. See *State Decisions for Creating Health Insurance Exchanges, as of May 28, 2013*, KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/health-insurance-exchanges/#map> (last visited July 1, 2013) (listing state decisions in creating health insurance exchanges). Oklahoma brought one of several lawsuits challenging the authority of the federal government to provide subsidies as to insurance purchased through federally run Marketplaces. Amended Complaint for Declaratory and Injunctive Relief, *Pruitt v. Sebelius*, No. CIV–11–30–RAW, 2013 WL 405610, at *2 (E.D. Okla. Sept. 19, 2012). Among other complications, funds for outreach to explain this new insurance purchasing arrangement were significantly linked to funding for state establishment of its marketplace, and Health and Human Services Secretary Kathleen Sebelius faced congressional questioning about solicitation of private funds to inform people about the Marketplaces. See Robert Pear, *Cabinet Secretary Solicits Large Donations to Publicize Health Care Law*, N.Y. TIMES, May 12, 2013, <http://www.nytimes.com/2013/05/13/us/politics/health-secretary-raises-funds-for-health-care-law.html> (discussing Sebelius’ fundraising efforts to “ensure the success of President Obama’s health care law” and questions from the Senate health committee regarding the legality of these efforts).

105. See Robert Pear, *House Votes to Delay Two Requirements of the Health Care Overhaul*, N.Y. TIMES, July 17, 2013, http://www.nytimes.com/2013/07/18/us/politics/house-votes-to-delay-two-requirements-of-health-care-overhaul.html?_r=0 (noting that “[s]ince early 2011, the House

Citing the complexity of the implementation challenges, the Obama Administration delayed enforcement of the employer mandate until 2015¹⁰⁷ and delayed adoption of some features of the small business insurance Marketplaces.¹⁰⁸ In addition, the Administration issued a torrent of ACA regulations on all manner of ACA provisions besides those relating to insurance access.¹⁰⁹ Members of Congress expressed concern that Marketplace and Medicaid rollouts will lead to a “train wreck.”¹¹⁰ Amidst all these implementation challenges, regulatory obligations, and political realities there seems now to be a focus on “getting the lights on,” on getting the essential aspects of the Marketplaces and expanded Medicaid up and running.¹¹¹ Left to a later day are less essential provisions and potential refinements, including the BHP.¹¹²

has voted more than 35 times to repeal all or part of the law, to scale it back, or to cut financing for its operation.”).

106. See Jonathan Weisman & Robert Pear, *Partisan Gridlock Thwarts Effort to Alter Health Law*, N.Y. TIMES, May 26, 2013, <http://www.nytimes.com/2013/05/27/us/politics/polarized-congress-thwarts-changes-to-health-care-law.html?pagewanted=all> (discussing the lack of needed changes to the ACA due to a “polarized Congress.”).

107. Mark J. Mazur, *Continuing to Implement the ACA in a Careful, Thoughtful Manner*, U.S. DEP’T OF TREASURY (July 2, 2013), <http://www.treasury.gov/connect/blog/pages/continuing-to-implement-the-aca-in-a-careful-thoughtful-manner.aspx> (reporting that “[t]he Administration is announcing that it will provide an additional year before the ACA mandatory employer and insurer reporting requirements begin.”).

108. See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 15,553, 15,554 (proposed Mar. 11, 2013) (to be codified at 45 C.F.R. pts. 155–156) (stating the purpose of proposed rule was to provide additional time for small business owners to prepare for employee choice model and increase stability of small group market).

109. See *Major ACA Regulations Issued by Agencies*, ANCOR (Mar. 5, 2013), <http://www.ancor.org/newsroom/news/major-aca-regulations-issued-agencies> (stating that on Friday, March 1, 2013 alone, five regulation were issued by government agencies regarding ACA provisions).

110. See Robert Pear, *Democratic Senators Tell White House of Concerns About Health Care Law Rollout*, N.Y. TIMES, Apr. 25, 2013, <http://www.nytimes.com/2013/04/26/us/politics/democratic-senators-tell-white-house-of-concerns-about-health-care-law-rollout.html> (quoting Senator Max Baucus, Democrat of Montana and chairman of the Finance Committee about concerns of White House rollout of health care law, “I just see a huge train wreck coming down”).

111. See Jeffrey Young, *Obamacare Health Insurance Exchanges will be Open On Time: Official*, HUFFINGTON POST (Sept. 24, 2013), http://www.huffingtonpost.com/2013/09/24/obamacare-exchanges_n_3984375.html (stating that the Marketplaces were cornerstone of President Obama’s health care reform law, and that the administration never wavered from the October 1, 2013 implementation date); see also Jeffrey Young, *Medicaid Expansion: States Must Meet Obamacare Standards if They Want to Get Full Federal Funding*, HUFFINGTON POST (Dec. 10, 2012), http://www.huffingtonpost.com/2012/12/10/medicaid-expansion-obamacare_n_2272151.html (stating the Obama administration’s decision that states must meet full Medicaid expansion criteria before being eligible to receive full ACA funding).

112. See Galewitz, *supra* note 99 (stating the Obama administration has delayed the rollout of the BHP because “it basically ran out of time to put out guidelines to get the program running by 2014” and that Health and Human Services will work to have the program available by 2015).

IV. THE FUTURE OF BASIC HEALTH COVERAGE—QUESTIONS AND OPTIONS

In deciding whether to incorporate the delayed BHP or a related option into the state insurance coverage continuum in the coming years, states face several challenging questions. BHP regulations will shape their analyses but are unlikely to provide definitive answers. That is because the answers, definitive and not, are quite tied to the functioning of Medicaid and the Marketplace, and to the characteristics of those who might fall into a coverage gap between the two.¹¹³ A March 2012 report by the Kaiser Family Foundation¹¹⁴ and a November 2012 Health Policy Brief published in *Health Affairs*,¹¹⁵ among other resources, provide overviews of key considerations in any state. In addition, there are several reports that analyze the particulars as to specific states.¹¹⁶ The following highlights a few of the key questions, particularly in light of the regulatory delay, and of evolving options.

A. *Can a BHP be Designed to Make Coverage More Affordable and Enhance Continuity of Coverage?*

The potential to make coverage more affordable for low-income people drives much of the interest in the BHP.¹¹⁷

Populations at the low end of the [Marketplace subsidy] scale face what has been described as an affordability cliff: while those with incomes under 139% FPL have no or minimal premium or cost-sharing obligations under Medicaid, those with incomes just above 139% FPL will be obligated to contribute approximately 3.3% of their

113. See *Analysis of the Basic Health Program*, MD. DEP'T OF HEALTH AND MENTAL HYGIENE 9 (Jan. 17, 2012), <http://dhmh.maryland.gov/docs/BHP%2001%2018%2012%20Report%20Analysis%20FINAL.pdf> (reporting a primary policy justification for BHPs is reducing number of individuals forced to enroll in different insurance plans as they move between Medicaid and Marketplace plans). Furthermore, the analysis reports the lack of provider and benefit continuity for transitioning between Medicaid and Marketplace plans prompted the review of the BHP. *Id.*

114. Bachrach et al., *supra* note 10.

115. Cassidy, *supra* note 7, at 4–6.

116. See, e.g., Matthew Buettgens & Caitlin Carroll, *The ACA Basic Health Program in Washington State*, URBAN INST. (Aug. 2012), <http://www.urban.org/UploadedPDF/412572-The-ACA-Basic-Health-Program-in-Washington-State.pdf> (reporting the financial and enrollment estimates of a BHP in Washington State); see also Bachrach et al., *supra* note 10, at 3 (noting the number of states that have conducted a state-specific BHP study).

117. See Rosemarie Day et al., *Reform Center Health Intelligence: The Basic Health Plan—An Emerging Option for States*, MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM 1 (Mar. 24, 2011), http://healthreform.mckinsey.com/~media/Extranets/Health%20System%20Reform/Intels/Health%20Intel%20Basic%20Health%20Plan_032411.ashx (reporting that many states are likely to give the BHP consideration because it offers a more affordable alternative for providing health care to individuals with low incomes, and would allow states to provide coverage for individuals between 138% and 200% of the FPL).

income, or about \$45 per month for subsidized coverage through the [Marketplace], not including additional out-of-pocket costs that could run as high as \$174 per month.¹¹⁸

The premise behind the program is that with the state as an active purchaser, premiums and cost-sharing would be reduced and/or benefits increased as required by the provision.¹¹⁹

In addition, unlike people in Marketplace plans, people in a BHP would not face the financial risk of owing the federal government subsidy money if their incomes went up and a year-end reconciliation showed that they received too much in health insurance subsidies.¹²⁰ It is possible, though, that a state might be able to design its BHP to impose some kind of financial recoupment for people whose incomes rise while in the program. Lower out-of-pocket expenses and freedom from the possibility of end-of-year reconciliation obligations should make BHP coverage more affordable than Marketplace coverage and thus encourage eligible people to enroll, though of course this depends somewhat on where the Marketplace rates settle.¹²¹

B. *Can a BHP Reduce Churn?*

Reducing churn and its associated problems are other key goals of the BHP option.¹²² Wage fluctuations and shifts in family composition can cause a family,

118. Bachrach et al., *supra* note 10, at 5.

119. See Patient Protection and Affordable Care Act, 42 U.S.C. § 18051(c)(1) (Supp. V 2012) (stating States shall establish competitive processes, to include negotiations of cost-sharing and premiums, as well as, the negotiation of any benefits additional to the basic health benefits described in § 18022(b), for contracting with standard health plans); see also *Premium and Cost-Sharing Subsidies in the Affordable Care Act*, CMTY. CATALYST 1 (Sept. 2010), http://www.communitycatalyst.org/doc_store/publications/Affordability_in_ACA.pdf (stating premium tax credits available through the ACA will lower the cost of premiums and cost-sharing costs).

120. *Basic Health Program Report*, INS. DIV. DEP'T OF COM. AND CONSUMER AFF. ST. OF HAW. 5 (Feb. 2013), http://hawaii.gov/dcca/ins/reports/Basic_Health_Program_Final_Report.pdf (stating that in a BHP there is no risk of enrollees owing money back to the government due to differences between beginning of the year estimations and enrollees actual incomes at the end of the year); see also Julia James, *Health Policy Brief: Premium Tax Credits*, HEALTH AFF. 3 (Aug. 1, 2013), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_97.pdf (stating that in a marketplace subsidy plan, if an income changes from what was used for estimation, the amount difference will either be refunded or owed to the government).

121. See *Basic Health Plan Could Provide Nearly Half a Million New Yorkers with More Affordable Insurance*, N.Y. ST. HEALTH FOUND. (June 30, 2011), <http://nyshealthfoundation.org/news-events/news/basic-health-plan-could-provide-nearly-half-a-million-new-yorkers-with-more> (discussing possible cost impacts on individuals of a BHP compared to Marketplace plans).

122. See Basic Health Program, 78 Fed. Reg. 59,122, 59,140 (proposed Sept. 25, 2013) (to be codified at 42 C.F.R. pt. 600) (discussing income variability that “can result in individuals moving back and forth between Medicaid and an Exchange, a phenomenon known as ‘churning’”, and how the BHP could reduce churn).

or members of a family, to move back and forth between coverage within Medicaid, the BHP if it exists, and the Marketplace.¹²³ Transitioning from one type of coverage to another can be disruptive, sometimes forcing people to change physicians, clinics, or medications, and thus leading to gaps in coverage.¹²⁴ “It has been estimated that, once coverage is expanded in 2014, within six months of enrollment, more than one-third of all low-income adults—about 28 million people—may experience enough of a change in income to churn between Medicaid and [the Marketplace].”¹²⁵

If the BHP is structured similarly to Medicaid plans, with similar provider networks and other design features, churn should decrease at the 138% FPL level.¹²⁶ The ACA specifically requires coordinating the BHP with Medicaid and other state-administered health programs.¹²⁷ For reasons of continuity as well as cost, states are likely to look to existing Medicaid managed care plans.¹²⁸ That then raises a related concern about the rates to be offered to health care providers. If they are closer to Medicaid rates than private insurance rates, that fact might dissuade providers from signing up, limiting networks and making the plans less desirable.¹²⁹

It is possible that a BHP could increase overall churn, though perhaps without as significant deleterious effects as would exist without the BHP. Increased overall

123. See Matthew Buettgens et al., *Churning Under the ACA and the State Policy Options for Mitigation: Timely Analysis of Intermediate Health Policy Issue*, URBAN INST. 7 (June 2012), <http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf> (reporting that many individuals move in and out of Medicaid and across coverage plans due to fluctuations in their hours or wages); Cassidy, *supra* note 7, at 2 (stating that family size changes through the birth of a child may change the family’s relation to the poverty level, and further lead the family to moving to a different type of insurance coverage, or gaining or losing federal subsidies).

124. Cassidy, *supra* note 7, at 2.

125. *Id.*

126. See John A. Graves et al., *Balancing Coverage Affordability and Continuity under a Basic Health Program Option*, 365 NEW ENGL. J. MED. e44(1), e44(3) (2011) (stating that the BHP would reduce churn at the 138% FPL level).

127. See Patient Protection and Affordable Care Act, 42 U.S.C. § 18051(c)(4) (Supp. V 2012) (stating that “[a] State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], the State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.”).

128. See Bachrach et al., *supra* note 10, at 6 (stating that states are likely to look at Medicaid managed care plans as useful delivery system for BHP, due largely to Medicaid managed care plans existing infrastructure and low capitation rates).

129. See *id.* at 7 (noting that Medicaid reimbursement rates in most states are typically lower than the providers receive from commercial reimbursement rates, resulting in questionable ability of Medicaid to sustain a robust network of providers). *Id.* If BHP reimbursement rates closely mirror Medicaid rates, the BHP may have a similar problem with attracting and sustaining providers. BHP may need to enhance plan premiums in order to raise provider reimbursement rates. *Id.*

churn could occur for two reasons. First, by adding in another program along the coverage continuum, there would be more potential transition points.¹³⁰ Second, the “affordability cliff” would be pushed to the 200% FPL level, the point at which people would shift between the BHP and the Marketplace.¹³¹ A 2011 study published in the *New England Journal of Medicine* concluded that a BHP would likely reduce churning at the 138% FPL level but that overall churn would be increased because of the new “affordability cliff” at 200% FPL.¹³²

Other studies predict that overall churning would decrease if states had a BHP and posit that churn might be less of a problem at the higher level, where people are more likely to have some financial reserves and a higher likelihood of employer-sponsored coverage.¹³³ Strategies to mitigate upper-level churn include variable cost-sharing within the BHP (turning the affordability cliff into a slope) and attention to coordination with provider networks.¹³⁴ If the BHP is to serve as a bridge between Medicaid and the Marketplace, it is crucially important to address continuity of care at both transition points.

C. *Would a BHP Enhance or Undermine the Viability of the Marketplace?*

In a state that adopts the BHP, the ACA requires that all those eligible obtain insurance coverage through that vehicle, thus removing many people from the Marketplace.¹³⁵ In terms of the expected impact on the Marketplace, questions

130. Graves et al., *supra* note at 126, at e44(3) (analyzing different data models that demonstrate operating a health care system with Medicaid, BHP, and Marketplace plan would increase churn). Under a three-program model 44% of all eligible adults remain eligible for their initial program after one year, and 33% remain eligible for their initial program after two years. *Id.* Conversely, under the baseline ACA model, 63% remain eligible for their initial program after one year and 49% after two years. *Id.*

131. *Id.* at e44(2) (reporting that introducing a new BHP would likely lead to “coverage disruption when moving above or below 200% of the poverty level”).

132. *Id.* at e44(3) (finding that under a BHP, “churning” would decrease at the 138% FPL, however that decrease would be more than offset by the increase in churning at 200% FPL).

133. See Bachrach et al., *supra* note at 10, at 6 (stating that while any loss in continuity of coverage is troubling, the loss can be better absorbed by those in higher income brackets because they have increased access to resources and can better manage affordability cliffs); Ann Hwang, et al., *Creation of State Basic Health Program would lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges*, 31 HEALTH AFF. 1314, 1317 (2012), <http://content.healthaffairs.org/content/31/6/1314.full.pdf+html> (finding that the BHP would reduce churn for low income adults).

134. See Bachrach et al., *supra* note 10, at 5–6 (discussing churn and delivery system options to reduce its impacts).

135. Patient Protection and Affordable Care Act, 42 U.S.C. § 18051(e)(2) (Supp. V 2012) (stating that all eligible individuals will not be treated as a qualified individual eligible for enrollment in a qualified health plan offered through a Marketplace and all eligible individuals must enroll with the state-offered BHP).

include not just the number of people involved but also their risk profile.¹³⁶ As the Kaiser report notes, “[t]he risk profile of the BHP eligible population will affect the premiums in the [Marketplace], driving them up if the BHP population is healthier than those remaining in the [Marketplace] or lowering the premiums if the BHP population is sicker.”¹³⁷ And the premium costs impact the level of funding for the BHP.¹³⁸ It all interrelates.

Studies estimate that the BHP would reduce the number of individuals covered by Marketplace plans by roughly one third and the number of subsidy-eligible individuals by half.¹³⁹ Whether these individuals are healthier or sicker than the general Marketplace pool might vary from state to state.¹⁴⁰ A variety of strategies have been proposed to mitigate a BHP’s impacts on the Marketplace, some of which the federal regulations could address.¹⁴¹ The proposed regulations seek specific comments on the contemplated approaches to risk adjustment and reinsurance intended to account for the health status of BHP enrollees.¹⁴² For example, the proposed rules describe a plan “to develop a risk adjustment factor to include in the [forthcoming] BHP funding methodology rather than include BHP in the individual market risk pool.”¹⁴³ This is in contrast to an approach that would include the BHP population in the individual market for purposes of risk adjustment calculation.¹⁴⁴ With any assessment, though, the number of enrollees is critical.

As the Marketplaces open, there is increasing uncertainty about how many people will sign up and the characteristics of the resulting risk pool, particularly in states that have resisted ACA implementation and defaulted to federally run

136. See Bachrach et al., *supra* note 10, at 8 (noting the BHP could reduce Marketplace participation by as much as one third, potentially impacting risk profile of Marketplace enrollees and weakening Marketplace viability).

137. *Id.*

138. See *id.* at 4 (stating that BHP federal funding is tied to enrollee premiums and cost-sharing subsidies the enrollees would have qualified for had they decided to purchase insurance in the Marketplace).

139. *Id.* at 8

140. See, e.g., Buettgens & Carroll, *supra* note 116, at 25 (finding that Washington’s BHP population would be older than the same cohort in other states). See Day, *supra* note 117, at 3–5 (detailing the uncertainty of the insurance risk profile of individuals who would enroll in the BHP, and explaining the benefits to the Marketplace and detriments to the BHP if the members of the BHP are less healthy than individuals in the Marketplace).

141. See Bachrach et al., *supra* note 10, at 9–10 (proposing various options, including those that would combine the BHP and the individual market into a single risk pool, and options which would “include the BHP in the risk adjustment and reinsurance systems used in the Exchange”).

142. Basic Health Program, 78 Fed. Reg. 59,122, 59,134 (proposed Sept. 25, 2013) (to be codified at 42 C.F.R. pt. 600).

143. *Id.*

144. *Id.*

Marketplaces.¹⁴⁵ Will enrollees be young enough, healthy enough, male enough? It is not clear how the various incentives and penalties will play out. In April 2013, six months before the Marketplaces' opening, a significant percentage of Americans were either unsure if the ACA was even still on the books or sure that it was not.¹⁴⁶ With this level of misinformation, it will be a challenge to educate the uninsured about the Marketplaces and subsidies and to get a sufficient number of healthy people into these insurance pools. Even in states committed to robust Marketplaces from the outset, expected enrollment numbers are a moving target and may continue to be for some time.¹⁴⁷ This current reality certainly complicates BHP modeling.

One impetus for the interest in a BHP or a related option to address low-income Marketplace shoppers is concern about the "bronze trap."¹⁴⁸ The concern is that low-income people might buy a bronze-level health insurance plan (as opposed to a silver, gold or platinum one) because of its comparatively low monthly premium, and then not be able to pay the associated higher cost-sharing.¹⁴⁹ The copays, co-insurance, and deductibles might then go unpaid, a problem for insurers and providers. This "bronze trap" effect could be potentially significant. Going forward, it will be important to track cost-sharing challenges related to the various plan levels.

The structure of the federal tax subsidies to be offered on the Marketplaces exacerbates this concern. The premium-support subsidies are pegged at the second-

145. See Sarah Kliff, *For Obamacare, Four More (Uncertain) Years*, WONKBLOG (Jan. 21, 2013) <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/21/for-obamacare-four-more-uncertain-years/> (discussing possibility of lower enrollment rates in states, such as Oklahoma, that are defaulting to the federally facilitated Marketplace and otherwise resisting the law, compared to states running their own Marketplaces and otherwise supporting ACA implementation). More than half the states are not running their own Marketplaces in the first year of the program, and are instead defaulting to a federally facilitated Marketplace or a partnership model. See *State Decisions for Creating Health Insurance Marketplaces*, KAISER FAMILY FOUND. (May 28, 2013), <http://kff.org/health-reform/state-indicator/health-insurance-exchanges/#>

146. See *Kaiser Health Tracking Poll: April 2013*, KAISER FAMILY FOUND. (Apr. 18-21, 2013), <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2013/> (asking American's to describe their understanding of the current status of the health care law as one of the following: "It is still the law of the land and is being implemented" (59%), "It has been overturned by the Supreme Court and is no longer law" (7%), "It has been repealed by Congress and is no longer law" (12%), or "Don't know/Refused" (23%)).

147. See generally Kelly Kennedy, *States Predict More Insurance Customers*, USA TODAY, Aug. 20, 2013, <http://www.usatoday.com/story/news/politics/2013/08/09/19/health-care-law-uninsured-estimates-obama/2671489/> (discussing enrollment predictions in the state-run Marketplaces).

148. Kelsey McCowan, *How to Make Sure Health Reform Offers Affordable Insurance to all Low Income Families*, SCHOLARS STRATEGY NETWORK (Apr. 2013), http://www.scholarsstrategynetwork.org/sites/default/files/ssn_basic_facts_heilman_ob_solving_healthcare_reforms_affordability_problem_1.pdf.

149. See *id.* (explaining that the low premiums of bronze plans are desirable to families with "modest incomes," but might result in the family delaying or foregoing medical care because of the associated high copayments and deductibles).

lowest cost silver plan and may be used to purchase any of the plans (so that the subsidy would go further if applied towards a bronze-level premium than if applied to a platinum-level premium).¹⁵⁰ The other type of subsidy is a sliding-scale cost-sharing subsidy available to Marketplace shoppers with incomes between 100% and 250% FPL.¹⁵¹ This is in addition to the premium subsidy and is intended to help defray the burden of co-pays, co-insurance and deductibles.¹⁵² This subsidy, however, is available only for those enrolled in silver plans. It is not available to someone who purchases a bronze plan.¹⁵³ This is one of the many seemingly small details of the ACA's access provisions that can have a big practical impact.

D. How Would the BHP Federal Funding Compare to the States' Costs for the Program?

A motivating idea for this state option is that it would be operated using federal dollars, so that a state would not be out many or any of its funds, and the federal government would save money (compared to what it otherwise would have spent).¹⁵⁴ And, of course, that more low-income people would get better coverage. To plan, particularly in times of strained state budgets, states need some certainty about how the federal funding will be calculated, how any reconciliation would work, and the timing of funding decisions.¹⁵⁵ The Kaiser report provides an extensive consideration of the variables with alternate scenarios.¹⁵⁶ The funding calculus is a moving target, partly because it is tied to the cost of premiums and cost-sharing within the Marketplace;¹⁵⁷ these numbers will become more solid as

150. Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,382 (May 23, 2012) (codified at 26 C.F.R. §1.36B(b)(3)(B)(2012)); *see also* January Angeles, *Making Health Care More Affordable: The New Premium and Cost-Sharing Assistance*, CTR. ON BUDGET AND POLICY PRIORITIES (Apr. 3, 2013), https://law.blackboard.umaryland.edu/bbcswebdav/pid-386529-dt-content-rid-1370516_1/courses/201309.96535.law.543D/CBPP%20Premium%20and%20Cost%20Sharing.pdf (explaining that an individual may use their premium tax credit to purchase a more expensive gold or platinum plan, but the individual will have to pay the difference between the premium credit and the more expensive plan).

151. Patient Protection and Affordable Care Act 42 U.S.C. § 18071(c)(1)(B) (Supp. V 2012)).

152. BERNADETTE FERNANDEZ & ANNIE L. MACH, CONGRESS. RESEARCH SERV., R42663, HEALTH INSURANCE EXCHANGES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA), at 9 (Aug. 15, 2012), *available at* <http://www.fas.org/sgp/crs/misc/R42663.pdf>.

153. *Id.* at 26; *see also* 42 U.S.C. § 18071(c)(1)(B)(Supp. V 2012).

154. *See* Bachrach et al., *supra* note 10, at 11–17 (explaining that while federal funding may cover the entire BHP program, states are concerned that the federal funding available will be insufficient, and states are attempting to “minimize the risk of inadequate federal funding” through a variety of strategies and estimations about the program’s anticipated costs).

155. *See id.* at 11–15 (discussing the risks to states implementing the BHP, should federal funding prove to be insufficient, specifically in regards to the mechanism for implementing annual financing reconciliation.).

156. *Id.*

157. *See id.* at 13–15 (discussing how cost-sharing subsidies will be tied to factors that must be adjusted for each enrollee, making it difficult to predict the cost of the premium tax credits and

coverage begins. In addition, there are some statutory ambiguities,¹⁵⁸ and a number of regulatory choices to be made about how the funds are calculated, distributed, and reconciled.¹⁵⁹ The proposed rule sets forth a variety of factors to be used in calculating the payments to participating states,¹⁶⁰ with specific details on payment to be issued later.¹⁶¹

Furthermore, the state's costs to run the program are bound up with its choices of the benefits covered, the reimbursement rates paid to providers, and the level of cost-sharing imposed on beneficiaries.¹⁶² All of these are variable.¹⁶³ The Urban Institute modeling for Washington State concluded that a BHP "would likely be feasible," covering more people, at significantly lower cost to them, and with payments to providers potentially one third higher than payments within Medicaid.¹⁶⁴ The report cautions, however, that there are several "sources of uncertainty" related to the funding and that its modeling required a number of budgetary assumptions.¹⁶⁵

In states that had precursor programs, the administrative complexities of setting up the program, contracting with plans, and coordinating across the coverage continuum could certainly be less daunting. Program scaffolding, popular recognition, and historic support, as are found with Washington's precursor program, could facilitate transition to the related BHP.¹⁶⁶ The ease of such a transition depends on a number of factors, including similarities of the two

cost-sharing subsidies, which equates to the amount of funding the states receive from the federal government).

158. For example, the statute is not clear whether the state is to receive 100% or 95% of the cost-sharing funds. See 42 U.S.C. § 18051((3)(a)(i) (Supp. V 2012) ("95 percent of the premium tax credits . . . and the cost-sharing reductions"). The proposed rules interpret this as meaning 95% of the cost-sharing funds. Basic Health Program, 78 Fed. Reg. 59,122, 59,133 (proposed Sept. 25, 2013) (to be codified at 42 C.F.R. § 600.605(a)(2)) ("We have carefully considered this issue, and have interpreted the statute to read that the payment amount equals 95 percent of the cost-sharing reductions").

159. See Basic Health Program, 78 Fed. Reg. 59122, 59133-59134 (proposed Sept. 25, 2013) (to be codified at 42 C.F.R. § 600.605(a)(2)) (discussing other proposed methods for determining elements of BHP payment of federal funding to the States).

160. *Id.* at 59,133-34.

161. *Id.* at 59,123 (" details on payment . . . will be issued separately.").

162. See Bachrach et al., *supra* note 10, at 16-17 (discussing state flexibility to set consumer premiums and cost-sharing, as well as the provider network and reimbursement rates, giving them some control over the revenue calculation that will impact costs).

163. See *id.* at 17.

164. Buettgens & Carroll, *supra* note 116, at 24-25.

165. See *id.* at 25 (explaining various programmatic uncertainties tied to enrollment and cost).

166. See *id.* at 6-7 (suggesting that Washington could alter its Section 1115 waiver to continue eligibility for certain populations and that this option "may not be difficult to administer"); see also Angeles, *supra* note 150, at 8 (explaining how a state that already uses managed care organizations to provided services to Medicaid beneficiaries could build on that infrastructure for its BHP).

programs, their size and characteristics of the coverage networks.¹⁶⁷ The regulatory delay, of course, undercuts the transitional value of precursor programs.¹⁶⁸

States have a variety of potential options that can be viewed as both placeholders pending BHP regulatory analysis, and also as alternatives in their own right.¹⁶⁹ They share many of the BHP's goals and also its challenges. They also share its uncertainty because guidance remained sketchy even as 2014 approached.¹⁷⁰ The Administration has expressed a willingness to work with interested states to "identify similar flexibilities in coverage systems."¹⁷¹

One state working with the federal government on a placeholder option is Minnesota.¹⁷² Minnesota's legislature decided to continue its precursor program of state-subsidized insurance as a vehicle for the BHP.¹⁷³ Thus, MinnesotaCare is expected to continue with state funding (and matching federal funding tied to Medicaid) through 2014.¹⁷⁴ At that point, the program is expected to transition to a

167. See Bachrach et al., *supra* note 10, at 6–7 (explaining that while states may benefit from utilizing an already established Medicaid managed care program as a "delivery system" for the BHP, often Medicaid plans have narrower networks of providers, and the lower reimbursement rate for Medicaid services may not attract and sustain "robust provider networks" for the BHP).

168. See *id.* at 8 (explaining the financial risk that states run if they build a BHP on a non-capitated delivery model before receiving final federal guidance); Paul Demko, *State Rolls Out MinnesotaCare 2.0*, POLITICS IN MINN. (June 19, 2013), available at <http://politicsinminnesota.com/2013/06/state-rolls-out-minnesotacare-2-0/> (discussing how the state is attempting to bring its established MinnesotaCare plan in line with the federal guidelines, even though the final rules for the BHP will not be issued until 2015).

169. See *infra* notes 174–177 and accompanying text (discussing the decision by Minnesota to continue funding its MinnesotaCare program as a placeholder until the BHP plans are federally funded in 2015).

170. See Demko, *supra* note 168 (discussing Minnesota's decision to continue funding their state program MinnesotaCare until federal funding is available in 2015, while making reforms to the plan in "anticipation of what are likely BHP requirements").

171. *Medicaid and CHIP FAQs: The Basic Health Program*, *supra* note 98; see also *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, CTRS. FOR MEDICARE & MEDICAID SERVS. at 6–7 (Dec. 10, 2012), available at <http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf> (explaining the government's willingness to work with states who wish to implement a Marketplace "bridge" plan offered by a managed care organization that also offers a state Medicaid plan). These "bridge" plans would only be available to a limited population that is transitioning from Medicaid/CHIP to private insurance. *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, CTRS. FOR MEDICARE & MEDICAID SERVS. at 6–7 (Dec. 10, 2012), available at <http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf>.

172. See M.S.A § 256L.02(5) (seeking "federal approval to implement MinnesotaCare" as a BHP); see also Catharine Richert, *Affordable Care Act Has Unique Proving Ground in Minnesota*, MINN. PUB. RADIO (July 9, 2013), <http://minnesota.publicradio.org/display/web/2013/07/09/health/affordable-care-act-minnesota-proving-ground> (discussing the state of Minnesota's decision to fund MinnesotaCare, the state's basic health program, until 2015 when federal funding will become available).

173. See Richert, *supra* note 172 (discussing Minnesota's legislature decision to continue fund MinnesotaCare until BHP funding becomes available in 2015).

174. *Id.*; see also MINN. HUMAN SERVS., 2014–15 BIENNIAL BUDGET; ACA: NEW MINNESOTACARE-NEW, last accessed Oct. 18, 2013, available at <http://mn.gov/dhs/images/CI->

BHP, with the broader federal funding.¹⁷⁵ This transition will be a helpful model for other interested states.

The Administration specifically indicated that a “bridge option” might gain approval.¹⁷⁶ This idea can be viewed as expanding Medicaid upwards into the Marketplace territory.¹⁷⁷ A state could designate one or more of its Medicaid managed care plans as QHPs at the silver coverage level on the Marketplace.¹⁷⁸ These would be available “on a limited-enrollment basis to certain populations.”¹⁷⁹

A “narrow bridge” would apply to individuals transitioning from Medicaid or Children’s Health Insurance Program (CHIP) coverage to the Marketplace.¹⁸⁰ They would be eligible for the QHP bridge plan that would presumably include the same provider network and low cost-sharing obligations.¹⁸¹ In addition, in low-income families where only some members (likely young children or pregnant women) qualified for Medicaid or CHIP, this arrangement possibly could be designed to allow the entire family to be on the same insurance plan.¹⁸²

This sort of “one card option”¹⁸³ ideally would promote continuity of coverage and its attendant health benefits. It is unclear how this type of bridge option would impact the rest of a state’s Marketplace. For example, the ACA’s Marketplace framework assumes that all the plans offered are available to all eligible shoppers, and this model would set aside a low-cost plan as available only

95_HC75_ACA_New_MinnesotaCare_Demo_Waiver.pdf; *see also* Demko, *supra* note 168 (discussing that MinnesotaCare costs are currently shared almost evenly between state and federal funding, however in 2015 the federal government will likely pay 85% of the cost).

175. Richert, *supra* note 172.

176. *See Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid, supra* note 171, at 6 (detailing the terms under which a Marketplace “may allow an issuer . . . to offer a qualified health plan as a Medicaid bridge plan”).

177. *See id.* (explaining that an individual can retain many qualities of his or her Medicaid coverage after transitioning into the Marketplace).

178. *Id.* at 6–7 (“In general, an Exchange may allow an issuer with a state Medicaid managed care organization contract to offer a qualified health plan as a Medicaid bridge plan . . .”).

179. *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid, supra* note 171, at 6.

180. *See* Bachrach et al., *supra* note 10, at 19 (discussing early versions of this potential option and related state proposals).

181. *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid, supra* note 171; Bachrach et al., *supra* note 10, at 19.

182. *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid, supra* note 171, at 6.

183. *Id.*

to some.¹⁸⁴ Would that skew the available subsidies (which are pegged to the second least expensive plan in the silver category)?¹⁸⁵

Under some scenarios, this limited-enrollment QHP could potentially be expanded to become a “broad bridge” for all of those ineligible for Medicaid, otherwise eligible for subsidized coverage, and with incomes below 200% FPL.¹⁸⁶ This is, of course, the BHP population.¹⁸⁷ The coverage structure and funding model would be different than under a BHP, though it would address similar concerns.¹⁸⁸

One idea emerging as an option to Medicaid expansion evinces the Administration’s willingness to consider a variety of coverage models in the wake of the Supreme Court’s decision that made the Medicaid expansion optional.¹⁸⁹ In states where lawmakers are resistant to expanding Medicaid, one possible approach that has been forwarded by a few of those states is a “premium assistance” model.¹⁹⁰ This would use federal Medicaid expansion money (the federal matching funds for newly eligible Medicaid enrollees that begin at full cost in 2014 and then ratchet down to 90% in 2020 and beyond) to buy coverage on the Marketplace for those with incomes between 100% FPL and 138% FPL.¹⁹¹ In some ways this

184. See Bachrach et al., *supra* note 10, at 19 (explaining that former Medicaid beneficiaries could receive unique benefits in the Marketplace); see *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, *supra* note 173, at 11 (explaining that when enrolling in a federally-facilitated Marketplace, consumers will be presented with all QHPs that they are eligible for, not the QHPs that might be best for them in particular).

185. Bachrach et al., *supra* note 10, at 19 (explaining that bridge plan premiums would not factor into the benchmark plan’s value, and since tax subsidies are based on the benchmark plan’s value, they would disproportionately favor bridge plan enrollees).

186. California is one of the states that actively pursued a bridge option. See, e.g., *Bridge Plan: A Strategy to Promote Continuity of Care & Affordability Through Contracts with Medi-Cal Managed Care Plans*, COVERED CAL. 1 (Jan. 17, 2013), http://www.healthexchange.ca.gov/BoardMeetings/Documents/January17_2013/VI_B_Affordability-Continuity_of_Care_Options_BRB.pdf (discussing legislation authorizing establishment of limited-enrollment QHPs, the impacts in California of a narrow and a broad bridge, and the unresolved questions).

187. See Bachrach et al., *supra* note 10, at 1 (explaining that BHPs apply to those whose income is between 139% and 200% of the FPL).

188. Compare *id.* (noting that the BHP “allows states to use federal tax subsidy dollars to offer subsidized coverage for individuals” to promote “continuity among plans and providers as . . . income fluctuates above and below Medicaid levels.”) with *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, *supra* note 173, at 6 (stating that bridges treat Medicaid managed care plans as private QHPs, and they are “intended to promote continuity of coverage between Medicaid or CHIP and the Exchange.”).

189. Julie Piotrowski, *Health Policy Brief: Premium Assistance in Medicaid*, HEALTH AFF. 1 (June 6, 2013), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_94.pdf (explaining that although states now have the option not to expand Medicaid, the potential for negative consequences is encouraging them to consider alternatives such as the premium assistance model). This option is a possibility because the Marketplace subsidies begin at 100% FPL rather than the Medicaid level of 138%. As discussed at *supra* note 62, this subsidy level might be a drafting error. *Supra*, note 62 and accompanying text.

190. Piotrowski, *supra* note 189, at 1.

191. See *id.* at 2.

“Private Option” Medicaid model can be viewed as expanding the Marketplace down into Medicaid.¹⁹² The Arkansas legislature endorsed this approach and the state pursued it with federal regulators under a possible demonstration waiver.¹⁹³ Proponents suggest that it would allow more people to be covered by insurance as compared to a non-expansion, support the private insurance market, and reduce churn as compared to a standard Medicaid expansion.¹⁹⁴

One big hurdle for this premium assistance idea is cost, as private insurance is generally substantially more expensive than Medicaid coverage,¹⁹⁵ and a state interested in this approach must show that it is cost-effective compared to enrolling the population in Medicaid.¹⁹⁶ The Congressional Budget Office determined that covering each beneficiary through a Marketplace plan would, on average, be about 50% more expensive compared to Medicaid coverage.¹⁹⁷ Arkansas estimates that in its state the cost differential would be much less, closer to 13% or 14%.¹⁹⁸ Coverage through the Marketplace plans would need to be consistent with Medicaid requirements, including as to scope of benefits and cost-sharing restrictions, among other concerns.¹⁹⁹ This Medicaid premium assistance idea is not the BHP, and not really a BHP alternative or placeholder. It does, however, reinforce the potential role of state innovation and the importance of attention to options for low income people along the coverage continuum.

192. *See id.* at 2, 3 (noting that the premium approach utilizes funds traditionally appropriated for Medicaid to purchase private insurance for people traditionally covered by Medicaid).

193. *Id.* at 6 (“State health officials in Arkansas are aiming to submit their premium assistance waiver request in June . . .”); *see also* ARK. DEP’T HUMAN SERV., ARKANSAS DRAFT 1115 WAIVER FOR PUBLIC COMMENT (2013), <https://www.medicaid.state.ar.us/Download/general/comment/InitialHCIWApp.doc> (last visited Oct. 6, 2013) (indicating the potential basis for the waiver).

194. *See* Piotrowski, *supra* note 189, at 2, 4–5 (explaining that full state implementation of Medicaid would have covered 16 million more people, and since states no longer have to expand Medicaid, the premium approach may fill that gap in states that choose not to expand Medicaid; additionally, the premium approach may remove “any potential coverage gaps created when someone’s income rises and they become ineligible for Medicaid.”).

195. *See id.* at 4 (reporting that “[t]he Congressional Budget Office determined that covering each recipient through an exchange will, on average, cost the federal government an additional \$9,000 per year versus \$6,000 through the regular Medicaid delivery system.”).

196. *Id.*

197. *See id.*

198. *Id.*

199. *See id.* at 3 (explaining that HHS requires premium plans to be comparable to Medicaid in terms of benefits and cost-sharing).

V. CONCLUSION

Effectively implementing the ACA's access provisions will be a challenging, on-going process, with state action at the forefront.²⁰⁰ As the expansion states work towards near universal coverage, they should pay close attention to the practical challenges faced by those in the income bands around the transition from Medicaid to Marketplace.²⁰¹ It is in this transition, this gap, that the benefits of health care continuity will face key affordability and network challenges.²⁰²

If the ACA's goal is not merely access to health insurance, but more broadly access to health care, and more broadly still, good health, then states need to mind the gap. As people, by virtue of income or family composition changes, move from one insurance platform to another, they need sure footing.²⁰³ The ACA's BHP might be able to provide that footing.²⁰⁴ We will not know, though, until the federal regulations take shape and more solid answers emerge as to the program's possible impacts on low-income people, on the Marketplaces, and on state budgets.

Whether or not many states ultimately pursue a BHP, consideration of this option draws attention to insurance affordability and care continuity challenges. These challenges are particularly acute for those with low incomes, but they fundamentally animate all aspects of the ACA with its goals of increasing coverage, reducing costs, and improving quality across the coverage continuum as broadly conceived.²⁰⁵

200. *See supra* Part III (explaining that states will be the pioneers in implementing and addressing problems with the ACA).

201. *See supra* text accompanying notes 70–76 (explaining the disruptive churn and cost variations faced by those who fluctuate between Medicaid and private insurance).

202. *See supra* notes 71–73, 76 (explaining the “affordability cliff” and potential network discontinuity between Medicaid and Marketplace plans).

203. *See supra* text accompanying notes 123–25 (detailing the prevalence and effects of churn).

204. *See supra* Part IV (assessing the potential for BHPs to promote affordability and continuity while reducing churn).

205. *See supra* Part I (summarizing the goals of the ACA).