January 12, 2015

Judith Arnold
Director, Division of Eligibility and Marketplace Integration
New York State Department of Health
99 Washington Avenue
Albany, NY 12210

Re: Draft New York State Basic Health Program Blueprint

Dear Ms. Arnold:

Health Care for All New York (HCFANY), a coalition of more than 160 organizations dedicated to securing affordable, quality health coverage for all New Yorkers, and Medicaid Matters New York (MMNY), a coalition that advocates on behalf of New York's Medicaid beneficiaries, appreciate the opportunity to submit comments on the New York State Department of Health's (DOH) draft Basic Health Program Blueprint (the Blueprint) released on December 12, 2014.

We applaud New York State for showing bold leadership in taking up the Basic Health Program (BHP), a program that will boost the overall health of New Yorkers, while potentially generating significant state savings.

The Blueprint lays out a promising start to the full and successful implementation of a strong BHP in New York. Our comments highlight potential consumer concerns and areas where the Blueprint could be further clarified or strengthened.

Affordability

We strongly support the reduced cost-sharing proposed in the Blueprint. While the NY State of Health Marketplace has greatly increased the affordability of health insurance, many low- to moderate-income residents continue to struggle to afford health insurance. Among these New Yorkers, 40 percent have credit card debt, 26 percent have medical debt, and 32 percent report having no savings at all.[1] The BHP will ensure that affordable health insurance is well within reach for consumers likely to fluctuate between Medicaid and the private insurance market and those who cannot afford Marketplace coverage even with existing premium tax credits and cost sharing reductions

We recommend further reducing cost-sharing for two populations: 1) women who become pregnant while enrolled in the BHP, and 2) those consumers earning between 150 and 200% the Federal Poverty Level (FPL).

[1] Community Service Society. (2009). The Unheard Third 2009: Job Loss, Economic Insecurity, and a Decline in Job Quality. Retrieved from: http://hcfany.files.wordpress.com/2009/10/unheard-third-2009-release-10-7-09.pdf.

The Blueprint should be amended to address the cost-sharing implications for women who become pregnant while enrolled in the BHP. We recommend the state model BHP cost-sharing and services for pregnant women after Medicaid coverage. This alignment will promote greater access to necessary perinatal services, while preserving continuity of care.

We are unclear if the co-payment schedule included in the Blueprint is final or simply for illustrative purposes. In the event the schedule is not merely illustrative, we would urge the state to reduce the BHP co-payments for certain benefits for beneficiaries between 150 and 200% FPL. Table 1, below, compares the cost-sharing of the proposed BHP with the QHP cost-sharing levels after applicable premium tax-credits and cost-sharing reductions. For physical, occupational and speech therapies; emergency room services; ambulance services; and urgent care, consumer cost-sharing requirements are the same for both the QHP and BHP products. Co-payments for these services should be lowered in the BHP to ensure improved affordability across all services.

Table 1: Cost-Sharing Comparison for Consumers between 150 – 200% FPL

	Basic Health Program	Silver QHP (150-200)
Federal Poverty Level	**150 - 200%**	**150-200%**
Actuarial Value	**90-95%**	**86-88%**
Premium	$20	$57-121
TYPE OF SERVICE		
Deductible (single)	$0	$250
MAXIMUM OUT-OF-POCKET LIMIT (single) includes the deductible	$2,000	$2,000
COST SHARING – MEDICAL SERVICES		
Inpatient Facilitiy	$150 per admission	$250 per admission
Outpatient Facility (Clinic)	$50	$78
Outpatient Facility (Private)	$50	$78
Surgeon	$50	$75
PCP	$15	$15
Specialist	$25	$35
PT/OT/ST Therapies	$25	$25
ER	$75	$75
Ambulance	$75	$75
Urgent Care	$50	$50
DME/Medical Supplies	5%	10%

We support the use of a two-tier cost-sharing structure: one level for those earning less than 150% of FPL, and another for those between 150 and 200% FPL. The simplified cost-sharing structure will promote affordability and administrative simplicity. We are additionally grateful that the state has adopted co-premiums of no more than $20 per month, especially considering the financial strain faced by many potential BHP enrollees.

Benefits

We support the comprehensiveness of benefits included in the BHP benefits package. Access to a full range of health care benefits will help ensure that BHP consumers can make significant personal health gains. We particularly applaud the inclusion of a full reproductive health benefit. We are thankful for New York's decision to ensure access to this important service. We would like clarification on how all women covered under BHP will be able to access reproductive health care services.

We additionally request clarity regarding the prescription drug formulary included in the BHP benefit package. Specifically, we wish to understand if the formulary will be at the discretion of a procured BHP carrier, or if it will be more closely aligned with a typical Medicaid formulary. The generosity of the formulary will be particularly important for the Aliessa immigrant population, who may be accustomed to the Medicaid formulary.

Eligibility and Enrollment

We generally support the eligibility and enrollment protocols proposed in the Blueprint. We applaud the adoption of continuous enrollment. Continuous enrollment will facilitate greater BHP take-up rates. Additionally, we strongly support the decision to align income verification protocols with existing Marketplace procedures, rather than using Medicaid rules. Under the Blueprint proposal, the Marketplace will give consumers 90 days of coverage at the cost-sharing level that corresponds with their stated income during which they can submit appropriate documentation. This procedure will help eliminate unnecessary gaps in coverage potentially caused by document delays.

We urge the state to reconsider its decision not to provide continuous coverage under the BHP. Continuous coverage minimizes confusion about health insurance coverage and the disruptions in care that can be caused by having to change insurance providers, and therefore provider networks, mid-year. Continuous coverage is particularly important for people who have unpredictable and fluctuating income. Such individual's projected annual income could change from month-to-month causing an individual to shift in and out of BHP coverage and between different insurance programs and products. Moreover, the Aliessa population should retain the right to continuous coverage that their counterparts in the Medicaid program have.

Because there are people who may want to opt out of continuous coverage, we recommend that the BHP program offer optional continuous coverage whereby a person may remain in BHP despite a change in eligibility or have the option of dropping BHP coverage prior to the end of the 12-month eligibility period in order to enroll in other health insurance. We acknowledge this may require federal approval, and urge the state to make such a request.

Considering that a substantial number of BHP beneficiaries will be from the Aliessa state-funded Medicaid population, we request the state to adopt Medicaid point-in-time income determination protocols for all BHP consumers, basing eligibility on current monthly income rather than projected annual income.

Reconciliation
We request clarification on whether BHP recipients will be subject to an income reconciliation process like the one used for Advanced Premium Tax Credit recipients. We ask that reconciliation not occur for BHP recipients and that if such a process is used, there be no recoupment.

Transition of the Aliessa Population
As the Aliessa population transitions into the BHP, DOH will need to work carefully to ensure that this population is no worse off than they would be under the state-only Medicaid program. We have several questions pertaining to the availability of certain Medicaid benefits within BHP for the Aliessa population. These questions include, but are not limited to, the following:

- What will the process be for ensuring that Aliessa immigrants have the same copays and copay protections currently available under the Medicaid program?
- Will Aliessa immigrants have access to OTDA fair hearings, like their counterparts in the Medicaid program and will they be entitled to the same due process protections as those available under Medicaid, including aid-continuing?
- Will Aliessa applicants be entitled to a BHP effective date of the month of application and three month's retroactive coverage?
- Will Aliessa immigrants get Medicaid protections such as "prescriber prevails"?

Access to Community Providers
We are concerned that the proposed provider reimbursement scheme may inadvertently undermine Federally Qualified Health Centers' (FQHCs) financial security. A potential reduction in the reimbursement rate received by FQHCs could put downward pressure on the number of providers serving the BHP population. 86 percent of FQHC patients are below 200% FPL and a majority receive Medicaid. It is likely that many potential BHP enrollees currently receive care at an FQHC.

FQHCs are entitled to a federally mandated reimbursement per-visit rate for all Medicaid visits – whether fee-for-service or managed care - known as a "prospective payment system" (PPS.) Federal law permits Medicaid Managed Care Organizations (MCOs) to pay FQHCs a negotiated per-visit rate lower than PPS as long as it is "not less" than the amount they pay to non-FQHC providers for the same services. To ensure that FQHCs are reimbursed their total PPS rate federal law requires the State to make a direct supplemental payment to FQHCs to cover the difference between the MCO rate and the PPS rate, i.e. "wraparound" payment.

Under the Blueprint, it remains unclear as to whether or not FQHCs will receive the PPS rate for visits by consumers who would have previously been covered by Medicaid. The PPS rate ensures that FQHCs are able to provide high-quality, cost effective health care, including care-coordination, primary care and preventative services, for vulnerable populations that may not otherwise have access to these services. In order to prevent

inadvertent financial strain on FQHCs once BHP is implemented, we respectively request that DOH ensure that FQHCs be "made whole" and are compensated at the same reimbursement rates under BHP as they would under Medicaid.

We look forward to continuing to work with you as the BHP becomes a reality in New York. Again, we whole-heartedly support the state's leadership in choosing to implement this innovative program. The BHP will serve as an important step towards dependable, affordable and comprehensive health insurance coverage for many New Yorkers and a model of other states to follow.

Very truly yours,

Elisabeth Benjamin
Health Care for All New York

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