

Cantwell Amendment #C15 (AS MODIFIED) to America's Healthy Future Act of 2009

Short Title: The Basic Health Plan

Overview: This amendment provides a federally funded, non-Medicaid, state plan which combines the innovation and quality of private sector competition with the purchasing power of the states.

Under this amendment, the federal government would provide funds to participating states in order to allow such states to provide affordable health care coverage through private health care systems under contract. People with incomes above Medicaid eligibility but below 200 percent of the federal poverty level (FPL) would be eligible for participation in these plans.

This approach takes advantage of an innovative, non-Medicaid coverage model that has worked at the state level for more than 20 years. State governments would use their share of federal dollars to negotiate with health care systems for high-quality, cost-effective coverage options to provide better value to individuals and families in their states. Eligible individuals and families would have access to several affordable pre-negotiated coverage options through the Basic Health Plans rather than being limited to independent negotiating through the Exchange with individual tax-credit subsidies. By using negotiated purchasing, Basic Health Plans could provide improved benefits and reduced costs.

Description of Amendment: The Secretary of Health and Human Services would work with participating states to establish state Basic Health Plans.

State Basic Health Plan Funding: For purposes of this amendment, a state's Basic Health Plan funding level would be based on the sum of the value of individual tax-credits which would otherwise be assumed for the eligible enrollee population in that state. Funds distributed to the states would be provided to independent state-based trusts and would be used by the states to negotiate credible coverage for Basic Health Plan enrollees only.

Eligibility: The Basic Health Plan would be available to people with incomes from 133 to 200 percent of FPL. States could enroll the following income-eligible persons in their Basic Health Plan, as of July 1, 2013: persons who (1) are under age of 65; (2) do not have access to affordable employer sponsored coverage that meets minimum creditable coverage standards; (3) are residents of an area served by the plan; (4) have gross family income above 133 percent of FPL and below 200 percent of FPL; (5) choose to obtain basic health care coverage from a participating health care plan; and (6) remain current in payment of their share of the premiums.

Benefit package and premium assistance: Minimum benefit package and premium cost sharing levels in the Basic Health Plan would be set at the levels provided for this population in the Making Coverage Affordable section of the Chairman's mark. The premium assistance for the eligible population would be available through the Basic Health Plan instead of through the tax credits otherwise provided for in the mark. The population above 200 percent FPL would have access to tax credits as available in the mark.

States would be encouraged to include innovative features in their health plan contracting, including but not limited to: care coordination and care management for enrollees, especially for those with chronic health conditions, incentives for use of preventive services, and establishment of a patient/doctor relationships that maximize patient involvement in health care decision-making, including awareness of the incentives and disincentives in using the health care plan.

Health care plan contracting: States would negotiate contracts with health care systems to ensure that coverage is available to all eligible persons in the state. The state Basic Health Plan administrators would be responsible for conducting a competitive procurement, with negotiation of payment rates and benefit packages that may exceed the minimum requirements outlined above. The Secretary of HHS would be required to verify that state Basic Health Plans are operating within federal cost and eligibility verification guidelines.

The state administrators are to consider and make suitable allowance for differences in health care needs of enrollees, and differences in local availability of health care provider resources. The state administrators would be encouraged to find ways to integrate their Basic Health Plan negotiations with any Medicaid or other state administered health care programs to maximize efficiency and improve the continuity of care between all state administered health programs. State administrators would seek to contract with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market. A minimum medical loss ratio of 85 percent would be required of all participating plans. State administrators, in conjunction with HHS, would establish specific performance measures and standards for participating health care systems that focus on quality of care and improved health outcomes. Participating health care systems must report to the state on the measures. Their performance and quality information would be made available to the Secretary of HHS and the Basic Health Plan enrollees, to help enrollees choose the best health care system.

State administrators should seek participation by multiple health plans to allow enrollees a choice between two or more plans, whenever possible. A participating health care system can be a licensed health maintenance organization, a licensed health insurer, or a network of health care providers established to offer Basic Health Plan services. States entering into health care choice compacts outlined in the Chairman's mark would be eligible to form multi-state risk pools for the purposes of negotiating with health care systems.

COST SAVINGS: States would be able to negotiate lower cost coverage through managed health care plans than individuals could negotiate for themselves with their individual tax credit subsidies. Evidence from similar programs on the state level has shown that a savings of at least 25 percent can be achieved from state negotiations.

For purposes of this Amendment, 85% of the funds dedicated to providing individual tax credit subsidies for individuals from 133 to 200% of poverty would be distributed to states choosing to create Basic Health Plans based upon the funding formula outlined above. To the extent a state chooses to create a Basic Health Plan, no tax credit subsidy would be available to individuals otherwise eligible as members of the covered enrollee population. Tax credit subsidies would be available to citizens of states that have chosen not to create Basic Health Plans.