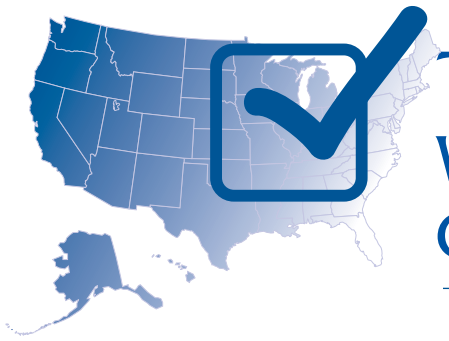

The Basic Health Option: Will It Work for Low-Income Consumers in Your State?

Families USA • July 2011

Introduction

The Affordable Care Act will expand health coverage in two ways: People with incomes below 133 percent of the federal poverty level will be eligible for Medicaid, and those with incomes above this level will be able to enroll in plans that are offered in the new health insurance exchanges. For the first time, people with incomes below 400 percent of poverty ($89,400 for a family of four in 2011) will be able to get premium credits to help them afford the cost of coverage purchased through the exchanges. In addition, the Children's Health Insurance Program (CHIP) will continue to cover children in families with low incomes (incomes of at least 200 percent of poverty in most states).

The law is clear that these health coverage programs should be implemented as seamlessly as possible to help families and individuals who have incomes that fluctuate across the 133 percent line during the year and to help families with children who are enrolled in CHIP while the parents are eligible for premium credits for coverage through the exchanges. Although there are many pieces to this puzzle, what consumers should see is the big picture: a simplified framework of health coverage with a robust provider network, a comprehensive package of covered services, and easily understood rules for out-of-pocket costs.

The Affordable Care Act provides an option to states called the Basic Health program that could help them create a more seamless experience for families. The Basic Health option allows states to create a separate program for people who are not eligible for Medicaid and who earn up to 200 percent of poverty, and states can receive money from the federal government to run such programs. This option has the potential to help minimize the problems that come with having multiple coverage programs—or it could add a new layer of complications. On the positive side, the more a state's Basic Health program resembles its Medicaid and/or CHIP programs in terms of having the same provider network, covered benefits, and cost-sharing requirements, the easier it will be for families whose incomes fluctuate during the year. Similarly, if a state's Basic Health program includes the providers and benefits that are already in CHIP, then parents can be in the same program with their children (rather than having different coverage in the new exchanges).

On the other hand, advocates must be aware of the potential pitfalls of the Basic Health option as well: Creating a separate program will not necessarily offer a real advantage to consumers unless it is designed to provide seamless coverage. Advocates must consider whether the federal dollars that are available to support the Basic Health program will be adequate to create such a program, as well as whether the state would be willing to supplement federal dollars with its own. Since this population could be served by the exchange with no cost to the state, a state may not be willing to supplement the federal dollars it receives. Another issue to consider is provider payment rates: If providers in a state have enough clout to press for significant increases in their reimbursement, this will limit how far the federal dollars will go in terms of benefits and cost-sharing. (Of course, a Basic Health program's reimbursement rates should be sufficient to ensure access to providers.)

This issue brief provides a framework for consumer advocates to think systematically about the Basic Health option. We go over the basics, discuss the problems a Basic Health option might address, and then raise some key issues and factors that can influence the direction that a Basic Health program might take in states with different financial and political constraints.

The Basics of the Basic Health Option

What Is the Basic Health Option?

Section 1331 of the Affordable Care Act outlines the Basic Health option as follows: It gives states the option to provide coverage to people who are ineligible for Medicaid and who have incomes at or below 200 percent of poverty through the Basic Health option, as an alternative to receiving premium credits to purchase coverage through an exchange.[1] A state that pursues Basic Health is choosing to create a new, separate program for people with incomes below 200 percent of poverty who are not eligible for Medicaid. If a state selects this option, these individuals would not qualify for premium credits for coverage through the state's exchange. Instead, they would receive coverage through a health insurance plan that contracts with the state.

The statute requires that states coordinate their Basic Health programs with Medicaid, CHIP, and any state-funded coverage programs in order to increase efficiency and improve continuity of care. It will be important for advocates to think through how Basic Health will coordinate with these other programs in their state, as well as with the new, state-based exchanges.

Who Is Eligible for Basic Health?

The following state residents are eligible for Basic Health if they do not have access to affordable, comprehensive, job-based health insurance:

- Citizens with incomes between 133 and 200 percent of poverty who are under the age of 65 and who are not eligible for Medicaid, and
- Lawfully present immigrants with incomes up to 200 percent of poverty who are under the age of 65 and who are not eligible for Medicaid.[2]

How Much Will Enrollees Pay for Premiums and Cost-Sharing in Basic Health?

States can set premiums and cost-sharing for their Basic Health programs, but these out-of-pocket costs must meet the following requirements:

- Premiums in Basic Health can be no higher than the amount an individual would pay if the individual purchased coverage through an exchange and received premium credits. This means that premiums can be no higher than 3 percent of household income for a family with income at 133 percent of poverty, and no higher than 6.3 percent of household income for a family with income at 200 percent of poverty.[3]
- In terms of cost-sharing, for enrollees with incomes below 150 percent of poverty, Basic Health would pay for at least 90 percent of the cost of benefits, on average, according to the statute. For enrollees with incomes between 150 and 200 percent of poverty, Basic Health would pay for, on average, at least 80 percent of the cost of benefits.
- Note that we are waiting for federal guidance to clarify these maximum amounts, because the statute appears to include a drafting error. Many people who are familiar with the statute believe that Congress intended Basic Health plans to pay at least as much toward the cost of care as exchange plans—at least 94 percent of benefits for people with incomes up to 150 percent of poverty, and at least 87 percent of benefits for people with incomes between 150 and 200 percent of poverty.[4]

States can set premiums and cost-sharing in Basic Health below these federal maximums if their funding allows.

Which Plans Can Participate in Basic Health?

States must use a competitive process to select and contract with one or more health plans for their Basic Health program. The statute requires that, in order to participate in Basic Health, plans that contract with the state must do the following:

- Meet an 85 percent medical loss ratio requirement—that is, 85 percent of each dollar collected in premiums must go to medical care and quality improvements;
- Include innovative features, such as care coordination and care management, as well as incentives for the use of preventive services;
- Provide suitable access to health care providers in various localities and take into account differences in the health care needs of enrollees;
- Be managed care organizations or have similar attributes to managed care; and
- Report to the state and to enrollees on its quality and performance.

What Benefits Will Basic Health Enrollees Receive?

Plans that participate in Basic Health programs must cover, at a minimum, a list of essential benefits that plans in the exchanges will also be required to provide. The Secretary of Health and Human Services (HHS) is currently working with the Institute of Medicine on a process to further define the essential health benefits package.

The Affordable Care Act defines a broad set of benefit categories that the essential benefits package must cover, including the following:

- emergency services;
- hospitalization;
- ambulatory patient services;
- preventive and wellness services and chronic disease management;
- rehabilitative and habilitative services and devices;
- prescription drugs;
- laboratory services;
- maternity and newborn care;
- pediatric services, including oral and vision care; and
- mental health and substance use disorder services, including behavioral health treatment.[5]

How Is Basic Health Funded?

States that decide to take up the Basic Health option will receive federal funding that is equal to 95 percent of the value of the premium credits and the cost-sharing subsides that eligible people would have received in the exchange.[6] The Secretary of HHS will determine how much a state receives to operate a Basic Health program based on factors that include, but are not limited to, the income, age, and health status of enrollees, along with geographic differences in health spending. States will be required to establish a trust fund for the money they receive to operate a Basic Health program, and, depending on how their Basic Health program is structured (e.g., benefits offered and provider reimbursement rates), states may not end up spending their full allotment of federal dollars. Any savings that a state generates from operating a Basic Health program must be used to lower premiums and cost-sharing or to provide additional benefits to enrollees.

Federal guidance on how the Secretary of HHS will approve and certify Basic Health programs and on how the amount of financing for each participating state will be determined is yet to be issued. This forthcoming guidance should clarify these issues.

Could a State Use Medicaid to Cover this Population Instead?

States can cover people with incomes above 133 percent of poverty in their Medicaid programs. They receive federal matching funds for any Medicaid expansion they undertake for such people at their regular federal medical assistance percentage rate (FMAP). Though this percentage may change from year to year in any given state, in 2011, FMAP rates for Medicaid among states ranged from 50 percent to approximately 75 percent.[7] Thinking ahead to the Medicaid expansion, states should determine whether it is more financially advantageous to cover people with incomes above 133 percent of poverty through Medicaid or Basic Health. We expect the Centers for Medicare and Medicaid Services (CMS) to put out regulations later this year to further explain the federal funding formula for Basic Health. When this information is available, states should calculate whether Medicaid or Basic Health would better assist them in serving consumers in this income group. (Note that lawfully present immigrants who have been in the country for fewer than five years cannot be covered in Medicaid [no matter their income], but they can be covered in Basic Health if their family income is at or below 200 percent of poverty.)

What Problems Might the Basic Health Option Address in Your State?

As states begin implementing their exchanges, some are starting to consider the Basic Health option. In addition, advocates may want to know more about this option and whether their state should pursue it. Unfortunately, there is no "one-size-fits-all" answer to whether a state should take up the option. Implementing Basic Health could be a good idea or a bad idea, depending entirely on a state's unique situation.

This section outlines four potential problems that states could address by implementing a consumer-friendly Basic Health program.

Problem 1:
Lack of continuity in care and coverage

Low-income adults and families often experience fluctuations in their incomes. Once the Medicaid expansion and exchanges are implemented in 2014, such fluctuations in income may cause adults to move between eligibility for Medicaid and the premium credits that will be provided to help buy coverage in the exchanges. These income fluctuations are likely to result in low-income individuals "churning"—moving on and off different types of coverage. Research suggests that these income fluctuations can be frequent among lower-income people (those with incomes below 200 percent of poverty): Within a year, 50 percent of these adults will likely experience a shift from Medicaid to the exchange or the reverse.[8]

To make matters worse, as people's incomes change and they move between programs, it may take a few weeks to get them enrolled in a new program and for their coverage to become effective. As a result, low-income individuals and families may experience gaps in coverage as they move from one program to another. In addition, they may have to switch insurance plans or health care providers if the state's Medicaid health plans do not participate in the exchange, or if the provider networks are different in Medicaid than in the exchange plans.

How might a Basic Health program address this?

A state can design a Basic Health program to provide seamless coverage for individuals and families with incomes up to 200 percent of poverty. While the funding streams will be different for Medicaid, CHIP, and Basic Health, a state could design its Basic Health program in a way that promotes continuity of care and coverage for individuals and families as they move along the income scale and between programs. To achieve this goal, the state can contract with health plans to provide coverage in Medicaid, CHIP, *and* Basic Health, and the state can ensure that the provider network across all three programs includes an array of providers that meets the needs of this population. That way, families would not have to switch plans and providers when they move between programs.

Problem 2:
Lack of seamless coverage among families

As is true today, when the exchanges are up and running in 2014, it will not be uncommon to have members of the same family enrolled in different coverage programs. For example, in nearly every state, children in families with incomes between 133 and 200 percent of poverty will be enrolled in CHIP, but their parents will be eligible for premium credits to purchase coverage in their state's exchange. In addition, families that are made up of both lawfully present immigrants and U.S. citizens and that have incomes below 133 percent of poverty could be split between Medicaid and their state's exchange.

How might a Basic Health program address this?

Basic Health gives states a greater opportunity to provide seamless coverage for parents and their children. States can structure Basic Health by building upon existing programs in their state, such as Medicaid and CHIP, to offer coverage that is more coordinated and that is operated by the same agency. Moreover, by encouraging health plans to participate in Medicaid, CHIP, and Basic Health, states can create a system that allows adults and children with family incomes under 200 percent of poverty to receive coverage under the same plans and through the same provider networks (as opposed to splitting families among various plans and providers). This will also give families the opportunity to align coverage and renewal dates for the entire family, and it will also make it easier for families to navigate the sometimes cumbersome process of selecting plans and providers for each family member.

Problem 3:
Ensuring adequate benefits

Plans that operate in the exchanges and plans that participate in Basic Health must both cover a list of essential benefits. (For a list of the broad set of benefit categories that essential health benefits must cover, see "What Benefits Will Basic Health Enrollees Receive?" on page 4).

It is possible, however, that a benefit that is now mandated under state law or that is now provided under a state's Medicaid or CHIP program might not be included in the federally defined essential benefits package. Furthermore, these additional benefits might also not be covered in the health plans that are offered in a state's exchange.

How might a Basic Health program address this?

Under Basic Health, states are required to provide *at least* the essential health benefits package. States can negotiate with health plans to offer additional benefits, or they can use any savings they have achieved in their Basic Health program to expand their benefits package or provide lower cost-sharing. In addition, states can incorporate other features into their Basic Health program, such as dental care, as well as providing interpreter services, culturally competent care, or transportation to medical appointments. Such additional services could make the Basic Health benefit package look more like a state's Medicaid or CHIP benefit package could create a more seamless experience for enrolled families. However, a state's ability to provide additional benefits would be limited by the amount of funding that is available to operate its Basic Health program and any savings that are generated.

Problem 4:
Ensuring reasonable premiums and cost-sharing

In the exchanges, individuals and families with incomes above Medicaid eligibility will receive premium credits to help them pay for coverage through the exchanges. In addition, people with incomes up to 250 percent of poverty will receive assistance with cost-sharing. In most states, the amount that people will pay for subsidized health coverage in the exchange will be far less than what they would have to pay for coverage now. However, some people may need even more help.

How might a Basic Health program address this?

Premiums in Basic Health can be no higher than the cost of subsidized coverage in the exchanges. That means that, for families with incomes up to 133 percent of poverty, premiums can be no more than 3 percent of household income, and for families with incomes up to 200 percent of poverty, premiums can be no more than 6.3 percent of poverty. However, states could set premiums lower than these levels in their Basic Health programs—if they were able to do so within their federal funding constraints or were able to use state resources to further subsidize premiums. Similarly, states could require participating plans to lower cost-sharing overall for Basic Health enrollees, or they could require plans to structure their cost-sharing in a way that seemed most helpful to low-income enrollees (for instance, by minimizing deductibles or aligning cost-sharing with CHIP requirements for children).

Look before You Leap: Questions to Consider

In many states today, there is a tension between controlling costs and ensuring access to care and providers. And for Basic Health programs in particular, states will face tension between having a rich benefits package with the lowest cost-sharing possible and encouraging providers to participate in Basic Health plans by providing adequate reimbursement. Depending on how a state structures its Basic Health program, it may achieve savings. But if those savings come at the expense of provider reimbursement rates, provider networks and enrollees' access to services could suffer. Moreover, states that are thinking about pursuing the Basic Health option should consider whether the provider networks in their existing health coverage programs have the capacity to take on Basic Health enrollees or if they would need to be strengthened to do so.

In addition, it is important to keep in mind that states that choose to take up the Basic Health option are, in fact, creating another health coverage program in the state. Many states today have a Medicaid program that is separate from CHIP, and some states also have separate state-funded coverage programs. When the state exchanges are up and running, they will be yet another vehicle for coverage, and they will be affected by the Basic Health option. Creating a Basic Health program may affect the bargaining power of the state's exchange and the ability to spread costs across exchange plans. Therefore, it is important that states coordinate Basic Health with existing and new coverage programs in order to ensure a more streamlined system of coverage.

Here are some questions that advocates may want to consider in determining whether their state should pursue the Basic Health option.

- **How can the state build on its existing health coverage programs?**

  Advocates may want to look at their state's Medicaid, CHIP, or other state-funded coverage programs to see if the state can build on one of these existing programs to create an effective Basic Health program that simplifies coverage. It is important to design a Basic Health program that builds on the strengths of Medicaid and CHIP, since these programs are designed to address the needs of low-income people.

- **What do the state's Medicaid and CHIP provider networks look like today?**

  Does the state use managed care or primary care case management for its existing Medicaid and/or CHIP programs? Can the state build upon an existing infrastructure of providers that have the experience and capacity to work with a low-income and vulnerable population? What modifications to the state's existing network would need to be made to include this population? For example, if a state chooses to build on CHIP to implement Basic Health, the state should make sure that the provider network includes providers that will meet the needs of low-income adults as well as children. In addition, if a state decides to use a provider network from a plan in its exchange, it should make sure that the network has the experience and capacity to meet the needs of the Basic Health population.

- **What steps will the state need to take to estimate how much funding it will receive if it pursues the Basic Health option?**

  It is essential that states estimate the amount of federal money they could receive for Basic Health and determine whether it would adequately finance the program. Some states are already beginning to undertake such analyses and will need to refine their estimates along the way to ensure they align with federal guidance that is forthcoming, which should provide clarity on how the amount of money states would receive from the federal government will be calculated.

- **Does the state currently cover lawfully present immigrants who are not eligible for Medicaid because they have immigrated recently?**

  States, particularly those that already provide state-funded coverage to these populations, should consider whether a Basic Health program would be in the best interest of these low-income consumers, and how such a model would fit into their state's health coverage system. Financially, it may make sense for these states to consider Basic Health, as states will be able to draw down federal funding to cover certain populations that they are already covering using state-only dollars.

- **Should states that currently provide Medicaid coverage to adults with incomes greater than 133 percent of poverty transition this population into a Basic Health program?**

  States may want to evaluate if it is in the state's best interest to do this. Some considerations for such states include whether the state can preserve its Medicaid eligibility levels through another mechanism; whether the state would draw down more federal dollars for this population through its federal Medicaid match or through Basic Health; and whether, given the politics in the state, a Basic Health program would likely include more or fewer benefits and better or worse access to providers than its Medicaid program.

- **How will provider reimbursement rates be set in Basic Health?**

  Will providers be paid the rates they receive under an existing public program, such as Medicaid or CHIP; will they be paid at commercial rates; or will they be paid at a rate between the two (e.g., Medicaid plus a percentage)? Advocates should evaluate how the provider community in their state will respond to the reimbursement rates that are set under Basic Health, because that could have a direct effect on the availability of a sufficient number of providers and on the state's ability to afford an appropriate benefits package for this population.

- **What will the state do to ensure that Basic Health plans have sufficient consumer protections?**

  What consumer protections currently exist in the state's Medicaid and CHIP programs and in the state's private health insurance market? We hope that HHS issues robust guidance on consumer protections in the Basic Health option. If HHS does not, states should look to see

what consumer protections people receive in Medicaid, CHIP, and the private market in the state and strive to ensure that the strongest set of consumer protections possible be included in a Basic Health program. Consumer protections within Basic Health should include *at least* the following: appeals rights, ongoing public input, transparency, advanced notice before changes are made to an individual's eligibility and benefits, no annual and lifetime limits, consumer assistance, and adequate access to care.

- **How will reducing the number of people who will remain eligible for the state's exchange affect premiums in the exchange?**

  If a state has a Basic Health program, fewer people will be left to participate in its exchange,[9] which could lessen the state's ability to bargain effectively with insurers to secure lower premiums and good value for consumers. It could also affect the capacity of the state exchange to have a robust risk pool—that is, its ability to attract healthy as well as sick people to the exchange so that the high medical expenses of some would be balanced out by the lower medical expenses of healthier people. These issues could be more significant in states with a small number of insurers in the market and/or a smaller population (and thus a smaller number of possible exchange customers), and in states that choose to create separate exchanges for individuals and small businesses. Tools such as "risk adjustment" (in which plans that have a disproportionate share of sicker enrollees receive compensation from plans that have healthier, lower-cost enrollees) are designed to address these problems. However, risk adjustment and other tools may not completely solve the problem of adverse selection, so states should still assess these issues when considering a Basic Health program. [10]

Conclusion

The Basic Health option provides states with the flexibility to expand coverage that has more comprehensive benefits, lower premiums and cost-sharing, and that meets the needs of its resident while also giving states the opportunity to create a more seamless experience for families. While this option has the potential to help minimize the problems that come with having multiple coverage programs, it could also add a new layer of complications. Therefore, as advocates begin to think about whether their state should pursue the Basic Health option, they should carefully take into consideration their state's financial and political constraints, provider network(s), the infrastructure of existing coverage programs, and the effect that a Basic Health program would have on their exchange. Each of these factors will affect whether the state can successfully implement a consumer-friendly Basic Health program. Furthermore, states that are considering Basic Health should make sure that such a program works well for low-income individuals and families, since ensuring that consumers have access to comprehensive, affordable coverage is paramount.

Endnotes

[1] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1331.

[2] Lawfully present immigrant adults who have been living in the U.S. for fewer than five years are not eligible for Medicaid. Many states also apply this rule to lawfully present immigrant children and pregnant women, although they are not required to do so. A few states do not allow lawfully present immigrants to enroll in Medicaid at all, even if they have been in the U.S. for longer than five years. HHS has yet to define lawfully present immigrants with respect to the Basic Health program. However, CMS issued guidance on July 1, 2010, that clarifies the definition of "lawfully present" for the purpose of implementing the state option to provide Medicaid and CHIP coverage to children and pregnant women under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This definition of lawful presence includes several categories of immigrants who have permission to live or work in the U.S. A few of these subcategories require the individual to have been granted employment authorization. See the guidance for a complete list online at https://www.cms.gov/smdl/downloads/SHO10006.pdf. In addition, HHS used the same definition for "lawfully present" in the Interim Final Rule for the Pre-Existing Condition Insurance Plan Program, which is available online at http://edocket.access.gpo.gov/2010/pdf/2010-18691.pdf.

[3] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1331, Subtitle E (a)(2)(A)(i), and Subtitle E, Section 1401 (a)(A)(i).

[4] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1331, Subtitle E (a)(2)(A)(i), and Subtitle E, Section 1402 (c)(B)(i); Janet Varon, *The Basic Health Option: Considerations for States Implementing Federal Health Reform* (Washington: National Health Law Program, December 6, 2010), available online at http://www.healthlaw.org/images/stories/Short_Paper_2_The_ACA_and_the_Basic_Health_Option.pdf.

[5] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1302 (b)(1).

[6] The statute is unclear on whether states that take up Basic Health will receive federal funding equal to 100 percent or 95 percent of the cost-sharing subsidies that eligible people would have received in the exchange. We hope that forthcoming federal guidance on Basic Health will clarify this.

[7] Kaiser Family Foundation, statehealthfacts.org, *Federal Medical Assistance Percentage (FMAP) for Medicaid with American Recovery and Reinvestment Act (ARRA) Adjustments, FY2011*, available online at http://www.statehealthfacts.org/comparemaptable.jsp?ind=916&cat=4, accessed on June 1, 2011.

[8] Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges," *Health Affairs* 30, no. 2 (February 2011): 228-236.

[9] One analyst estimates that, in an average state, 16 percent of the population will be eligible to purchase coverage through an exchange. If the state had a Basic Health option, it is estimated that the percent of the population that would not be covered by Basic Health and that would be eligible for the exchange would shrink to 14 percent. Of course, the percentage will depend on a state's total population and residents' incomes and insurance status. See Stan Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States* (Washington: State Coverage Initiatives, March 2011), available online at http://www.statecoverage.org/files/TheBasicHealthProgramOptionUnderHealthReform.pdf.

[10] Sarah Lueck, *States Should Structure Insurance Exchanges to Minimize Adverse Selection* (Washington: Center on Budget and Policy Priorities, August 17, 2010), available online at www.cbpp.org/cms/index.cfm?fa=view&id=3267.

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Families USA would like to thank the following people who provided comments on earlier drafts of this piece:

Jennifer Babcock, Association for Community Affiliated Plans

Elisabeth Benjamin, Community Service Society of New York

Rachel Klein, Enroll America

Andrea Maresca, formerly with Association for Community Affiliated Plans

Janet Varon, Northwest Health Law Advocates

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