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VIA ELECTRONIC SUBMISSION

October 31, 2011

Attention: CMS–9980–NC
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244–8016

RE: **CMS–9980–NC**
Request for Information Regarding State Flexibility To Establish a Basic Health Program Under the Affordable Care Act

Dear Sir/Madam:

The National Immigration Law Center (NILC) specializes in the intersection of health care and immigration laws and policies, offering technical assistance, training, and publications to government agencies, non-profit organizations and health care providers across the country. For over 30 years, NILC has worked to promote and ensure access to health services for low-income immigrants and their family members.

Below are our comments on select questions in the Request for Information Regarding State Flexibility To Establish a Basic Health Program Under the Affordable Care Act (76 Fed. Reg. 56767, September 14, 2011)(hereafter referred to as "Request for Information") to help ensure that as many eligible individuals as possible have the most affordable health coverage available to them, as intended by the Affordable Care Act.

A. General Provisions

States should consider establishing a Basic Health Program ("BHP") for individuals with incomes below 200% FPL if access and affordability to comprehensive coverage for this population is better than what would be available to them in the state's health insurance exchange. States that elect a Basic Health Program should ensure that this population receives at least as much protection and benefits as would be available in the exchange.

<u>Affordability</u>

States should research, study and then consider whether individuals with incomes below 200% FPL would actually be able to afford the insurance premiums and cost-sharing in the insurance exchange. Low-income families are often unable to afford out of pocket costs for health care, even if at a reduced amount, due to competing priorities of paying for basic necessities such as rent, food, and transportation. In most cases, individuals in this population may be unable to afford the second level benchmark plan in the exchange even with the affordability credits, likely leaving these individuals

uninsured. In addition, depending on how the Secretary of Health and Human Services and the states assess unaffordability for purposes of providing an exemption from the requirement to obtain minimum essential coverage, these individuals could be found ineligible for an exemption and subject to a tax penalty. Thus, determining whether and how individuals with incomes below 200% can obtain truly affordable health insurance is a key factor for a state to consider in electing BHP.

Accessibility

Due to the flexibility the state may have to contract with providers for a Basic Health Program, states should also consider whether BHP would increase accessibility to health care services for individuals below 200% FPL. First, in order to ensure that individuals are able to find a provider in their geographic area, provider networks offered in the exchange or under BHP must not only be adequate, but diverse and accessible to hard to reach populations, who often represent the majority of the newly eligible individuals in the state. Second, provider networks offered through a Basic Health Program must meet or exceed the standards for cultural competence and linguistic access required in the state's Medicaid program or in the exchange. States should assess the racial and ethnic composition as well as the language proficiency of their population with incomes below 200% in order to determine properly the standards that providers must meet to be included in the network. At a minimum, states should make sure that the provider network under BHP is at least as geographically diverse and culturally and linguistically competent as those available in the exchange.

Eligibility criteria

Under Section 1331(e)(1)(D) of the ACA, individuals below age 65, with incomes below 200%, who are ineligible for other minimum essential coverage, and who are citizens or lawfully present in the U.S., are eligible for the Basic Health Program. States should determine the number of individuals in their state potentially eligible for the Basic Health Program based on these criteria and the unique characteristics of this population.

Specifically, studies have shown that individuals with incomes below 200% FPL experience frequent changes in their income during the year due to changes in their family, job, or other circumstances. As a result of this income volatility, individuals may be eligible to enroll in a qualified health plan through the exchange at the time of open enrollment, but months later may become income eligible for Medicaid. States should determine the income volatility of this population in their state and the likelihood that individuals in this group will become eligible for Medicaid due to income during a twelve month period, and the resulting impact on the affordability of insurance for these individuals.

Moreover, states should determine the availability of affordable employer sponsored coverage for this income population in their states. For instance, many low-income, lawfully present immigrants are employed, but work in industries or businesses that do not offer employer sponsored coverage or where employer sponsored coverage is unaffordable. It is unclear whether employer sponsored coverage for these individuals will become accessible and affordable after 2014. Thus, states should determine which industries and size of employers that individuals with incomes below 200% currently work in and the likelihood that employer sponsored coverage will be available for this population after 2014.

Finally, states should determine how many individuals with incomes below 200% FPL live in mixed status families, as the election of BHP could provide more affordable care options to these households. The complex eligibility rules in Medicaid and CHIP can place children in low-income immigrant families in one program while excluding their lawfully present parents and/or siblings. These family members must seek subsidized coverage through the exchange. Thus in one family, individuals could be enrolled in more than two plans with different benefits, cost-sharing, premium costs, and providers. If a state elects to operate a Basic Health Program and integrates it closely with its Medicaid or CHIP program, a mixed status immigrant family earning below 200% FPL is more likely to secure affordable coverage for everyone in the family with a better chance of maintaining continuity of care. However, states should retain flexibility to preserve existing state-funded health coverage for lawfully present immigrants, especially where continuity of care and affordability for this population is better served through these programs than in the exchange or BHP. States should ensure that eligible individuals in mixed status families do not face harm or reduction of benefits as a result of their election of BHP.

B. Standard Health Plan Standards and Standard Health Plan Offerors

Consumer protections needed

The U.S. Department of Health and Human Services (HHS) should ensure that the consumer protections required in the exchange or in Medicaid are required at a minimum in the state's Basic Health Program. Some key examples include:

- Individuals must be afforded due process protections, including clear and adequate notices in the appropriate language at the time of enrollment, renewal, and from the plan;
- Application and enrollment materials, as well as enrollment systems, should be linguistically accessible and culturally appropriate;
- No steering or unsolicited marketing to consumers should be allowed;
- Only the information strictly necessary for eligibility determination and enrollment should be solicited and required, consistent with the requirements in Section 1411(g) of the ACA. This includes ensuring that non-applicants are not required to provide personal information, such as

citizenship status or Social Security Numbers, in processing eligibility and enrollment of applicants;

- Confidentiality and privacy of information of individuals must comply with the standards and protections required in the exchange;
- Clear notices of the cost-sharing and plan benefits to be provided by all plans operating in a Basic Health Program;
- Cost-sharing limits should be the same as in a state's Medicaid program;
- Individuals enrolled in a BHP plan should have the same access to a state's consumer ombudsman, patient navigators, and other consumer programs provided to individuals eligible for the exchange.

D. Coordination with Other State Programs

Immigrant families that include members with a range of immigration and citizenship statuses are often referred to as "mixed-status families." Due to the variation in immigrant eligibility rules for Medicaid, the exchange, and BHP, many lawfully present immigrants whose income would make them eligible for Medicaid are instead eligible for the exchange or the Basic Health Program. Yet their family members, such as their children, may be eligible for and enrolled in Medicaid. Thus, coordination with a state's Medicaid program and BHP for mixed status families would be critical for states that elect a BHP. This coordination would allow a mixed status family with income below 200% FPL to apply as a family and provide information for family members who may be eligible for different programs at one-time and through one application. We recommend that the eligibility and enrollment process between Medicaid, the Exchange, and BHP be well-coordinated and that the "no wrong door" policy under the ACA apply to any screening and enrollment into the BHP.

Integrating BHP with a state's Medicaid program on the front end, and also in terms of benefits, would provide a seamless transition from the consumer's perspective, especially in states that currently provide state-funded Medicaid to low-income, lawfully present immigrants. A state could transition BHP eligible individuals from its state-funded Medicaid to BHP on the back end without needing to disenroll and re-enroll this population, which could cause churning, disruption in coverage, and harm to health outcomes and continuity of care. HHS should provide clear guidance confirming that states continue to have the flexibility to maintain state-funded health coverage for immigrants, especially where continuity of care and affordability for this population is better served in the state program than in the exchange or BHP. At a minimum, a state must ensure that eligible individuals in mixed status families do not face any harm or reduction in benefits as a result of its election or non-election of BHP.

Finally, many state health programs provide critical services for individuals with special needs or special populations. We recommend that HHS direct states electing BHP to ensure that eligible individuals can continue to seek

care through these state programs in addition to any benefits available under BHP. At a minimum, before disenrolling or terminating eligibility for state programs for BHP eligible individuals, states should be required to provide individuals adequate time and assistance in coordinating their care to ensure continuity of and maintenance of a comparable level of care.

F. Eligibility

Income eligibility for lawfully present immigrants

The description of eligible non-citizens in paragraph (4) of the Background section of the Request for Information could be read mistakenly to exclude lawfully present immigrants with income between 133 and 200% of the Federal poverty level.[1] Any final guidance or regulations addressing eligibility for the Basic Health Program should clarify that lawfully present non-citizens who are ineligible for Medicaid can qualify for coverage in the Basic Health Program if their income is between 0 and 200% of the Federal poverty level.

Education and Outreach

We recommend at a minimum that HHS require states to meet the standards for education and outreach required for the exchange. However, we recommend that HHS require states to meet the Medicaid standards for linguistic access and outreach to vulnerable, hard to reach populations if a state elects BHP. The Medicaid standards and requirements would be more appropriate for enrolling individuals with incomes below 200% FPL, who are BHP eligible, because these individuals are more likely to mirror the characteristics of the Medicaid population. States can easily build on successful outreach and education efforts used in their Medicaid population to ensure that all individuals who are eligible for BHP are aware of the program and can enroll easily.

Thank you for your attention to these comments. If you have any questions, please feel free to contact me at (213) 639-3900 ext. 114 or at ambegaokar@nilc.org. We look forward to the opportunity to review future guidance and specific rule-making on the Basic Health Plan option under the Affordable Care Act and appreciate HHS seeking this initial input from stakeholders.

Sincerely,
/s/
Sonal Ambegaokar
Heath Policy Attorney
National Immigration Law Center

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[1] 76 Fed. Reg 56767, 56769 (Sept. 14, 2011).