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VIA ELECTRONIC SUBMISSION AT REGULATIONS.GOV

November 25, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, DC 20201

RE: RIN 0938-AR93
Comments on CMS Notice Of Proposed Rule Concerning Basic Health Program

Dear Administrator Marilyn Tavenner and Secretary Kathleen Sebelius:

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, labor unions, 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.

NILC submits the following comments concerning the proposed rule for implementation of the Basic Health Program (BHP) (78 Fed. Reg. 59122 (Sept. 25, 2013)) established under § 1331 of the Patient Protection and Affordable Care Act (ACA). We appreciate that CMS has done thorough work to draft rules that emphasize the importance of coordination with other insurance affordability programs and the agency's effort to remain consistent with policies and protections for Medicaid, the Children's Health Insurance Program (CHIP) and Exchange programs. The offered comments suggest methods by which CMS can further ensure that the BHP is a viable option for eligible members of immigrant families.

In general, NILC believes that the BHP could be an important option for individuals and families with incomes under 200% of the federal poverty level (FPL), including lawfully present individuals with incomes under 133% FPL who are ineligible for Medicaid by reason of immigration status. Used effectively, a BHP could create a more seamless application and administration of health insurance to such families. The spirit of these comments is to highlight those sections that promote this opportunity and suggest additional regulatory language to further this principle. Also

important to immigrant families are the principles of linguistic and cultural accessibility; privacy, security and confidentiality of personally identifiable information; and nondiscrimination. These comments also seek to address these issues as they relate to the proposed rule for the BHP.

The proceeding comments are presented in three categories: regulations with particular impact on noncitizens, regulations that impact the effectiveness of the BHP in providing health insurance for low-income individuals, and regulations that impact the viability of a state implementing a BHP.

I. REGULATIONS WITH PARTICULAR IMPACT ON NONCITIZENS

Access to health insurance programs for immigrant families, especially for mixed-status families that contain a mix of immigration and citizenship statuses, can be a complicated process and frequently results in different answers for different individuals in a household. Further, states have varying immigrant eligibility requirements for Medicaid and the Children's Health Insurance Program (CHIP) that may result in more confusion, especially for a family member not applying for insurance for him or herself who is attempting to enroll eligible family members in coverage. In an immigrant family with income at 100% FPL, there may be complications even among those eligible for ACA and Medicaid programs, for example a parent who is lawfully present in the U.S. but not eligible for Medicaid by reason of immigration status may be able to purchase coverage through a BHP and a young child who is a U.S. citizen may be covered under Medicaid. Such complications may be compounded if the family also contains an adolescent with deferred action under the Deferred Action for Childhood Arrivals (DACA) policy and a second parent who is undocumented, both of whom are not eligible for affordable health insurance in the Exchange, BHP, or non-emergency Medicaid. Although the BHP will not be an option for undocumented individuals and DACA recipients, since immigrant families' access to insurance affordability programs is inherently complex, resulting in disproportionately lower utilization of health care and coverage, every opportunity to simplify these processes should be seized.

Therefore, NILC commends CMS for embracing § 1331(b)(4)[1] of the ACA, which requires coordination with other state programs. The requirement under § 1413 of the ACA mandates that states provide a streamlined application for the various programs, which the proposed regulations affirm include BHP under proposed § 600.310(a), and is an important step in assuring a "no wrong door" approach to the application process. Under the principle, an individual is directed to the right insurance affordability program regardless of where the individual applies. By creating continuity with regulations for other programs—Medicaid, CHIP, and the Exchanges—the proposed regulations also make it more viable for states to design innovative processes that make obtaining health coverage for eligible individuals in immigrant families as seamless as possible.

[1] Pub. L. 111-148, § 1331(b)(4), 124 Stat. 119 (2010), *codified* at 42 U.S.C. § 18051(b)(4) (2012).

For instance, policy experts have contemplated ways that states could design BHP programs to make coverage more affordable and accessible for low-income residents, including "Medicaid look-alike coverage" or plans designed like "CHIP for adults." The purpose of such plans would be to make it appear to a family that it is all one insurance program with the same available providers, only with different out-of-pocket costs for family members based on the affordability program for which the individual is eligible, and with the different back-end funding mechanisms run by the state.[2] For example, in the family described above, the lawfully present parent and the U.S. citizen child could obtain insurance from the same issuer with identical provider networks, but the parent would pay the BHP's premium and the cost-sharing rates. Although we would argue the best scenario would be to have both individuals covered under Medicaid if the household income qualifies, under existing law the ability at least to coordinate health coverage would be helpful for immigrant families.

Although NILC acknowledges the importance of allowing states flexibility to create viable BHPs by allowing states to choose either Exchange or Medicaid practices in many situations, we also recognize that the group of individuals who would be eligible for a BHP—particularly lawfully present individuals who would be eligible for Medicaid but for their immigration status—bear a lot of similarities to those who are eligible for Medicaid. Thus in general, we encourage CMS to embrace Medicaid standards and to consider this when providing further guidance to states and in evaluating BHP Blueprints.

Finally, to ensure as many eligible individuals enroll in a BHP as possible, including eligible individuals in immigrant families, the BHP must comply with the ACA's language access, confidentiality and nondiscrimination protections. NILC appreciates that CMS makes explicit reference to such protections in these proposed rules. CMS should scrutinize state Blueprints to ensure that the program is accessible for limited-English proficient (LEP) individuals and complies with the ACA's privacy, security and confidentiality protections.

a. NILC supports the following provisions:

1. ***Multiple references to coordination with other state plans***: In the description of BHP Blueprints (§ 600.110(a)(5)), eligibility and enrollment (§ 600.330), and contracting (§ 600.410(e)(5)), the proposed rules helpfully affirm that a state should coordinate a BHP with other affordability programs, as provided for explicitly in Section 600.425. These regulations helpfully enforce the statutory requirements under Section 1331(b)(4) of the statute.
2. ***Inclusion of existing LEP standards***: In notification of termination of a BHP (§ 600.140(a)(3)), enrollment assistance (§ 600.150(a)(4)), and appeals processes (§ 600.335) included in the proposed rules, CMS helpfully embraces existing language that either explicitly or through sub-reference to existing regulations provide that states must conduct processes in a manner accessible to LEP individuals.

[2] *See* STAN DORN, URBAN INSTITUTE & STATE COVERAGE INITIATIVES, THE BASIC HEALTH PROGRAM OPTION UNDER FEDERAL HEALTH REFORM 8–9 (March 2011).

3. ***Application of privacy and security standards***: In proposed § 600.350, CMS cross-references regulations implementing the privacy and security protections of personally identifiable information in the Exchange. Compliance with these protections is critical to protect and encourage the application and enrollment of eligible individuals in immigrant families.
4. ***Affirmation of nondiscrimination protections***: By stating explicitly in proposed § 600.165 that a BHP falls under § 1557 of the ACA and Title VI of the Civil Rights Act of 1964 (among other nondiscrimination standards), the proposed regulations bolster the ability of the HHS Office for Civil Rights and (if implemented under regulations enforcing ACA § 1557) individual or organizational plaintiffs to hold states and their contractors accountable for discrimination based on national origin and other protected categories. Such protections are particularly important for mixed-status families as they can be used to confront policies or practices that deter eligible individuals from accessing programs because of the immigration status, or perceived immigration status, of a family member (such as a citizen child whose undocumented parents do not obtain BHP care for the child because of intimidation or the unnecessary request for immigration status of the nonapplicant parent).

b. NILC recommends the following additions or clarifications:

1. ***Prohibit additional immigration-status restriction***: Proposed § 600.145(d) includes affirmation that the state may not set additional restrictions that would exclude individuals eligible under the statute. NILC recommends that CMS include "immigration or citizenship status" among the specific prohibitions. The following is the suggested language:

   (e) No caps on program enrollment. A State implementing a BHP must not be permitted to limit enrollment by <u>using any criteria not identified in this section, including, but not limited to,</u> setting an income level below the income standard prescribed in section 1331 of the Affordable Care Act having a fixed enrollment cap or imposing waiting lists.
2. ***Affirm importance of LEP accessibility plans in Blueprint applications***: The proposed rule includes a number of references to ensuring accessibility for LEP individuals (see, *supra*, section I(a)(2)), but reference to inclusion of such protections is not included among the requirements in proposed § 600.110(a) for requirement in the Blueprint. NILC suggests explicitly stating that accessibility plans, including LEP programs, be included in the Blueprint to ensure that CMS scrutinize plans for linguistic accessibility. Suggested language to follow proposed § 600.110(a)(14):

   <u>(15) A description of the State's plan to address accessibility requirements in enrollment procedures at section 600.150, appeals processes at section 600.335, announcement of termination of a BHP at section 610.140, and any other relevant sections under this subpart</u>
3. ***Reference additional privacy and security protections:*** As mentioned above, NILC supports the inclusion of § 600.350, which cross-references 45 CFR 155.260(b) and (c) implementing some of the ACA's privacy and security

protections of personally identifiable information. In addition, NILC recommends cross-referencing all subparagraphs following subparagraph (c) in § 155.260. Suggested amendments to proposed § 600.350:

The State must comply with the standards and procedures set forth in 45 CFR 155.260(b) (g) ~~and (c)~~ as are applicable to the operation of the BHP.

4. ***Amend the definition of lawfully present***: While NILC supports the consistent application of the definition of "lawfully present" across insurance affordability programs, including at § 600.5, NILC echoes comments submitted previously[3] and continues to urge HHS to amend 45 CFR § 152.2 by:
   A. Recognizing the list is not exhaustive;
   B. Including individuals who status makes them eligible to apply for work authorization, rather than those who have been granted employment authorization;
   C. Including individuals granted a stay of removal by the Department of Homeland Security, an immigration judge, the Board of Immigration Appeals or by a federal court; and
   D. Removing the exception under subsection (8) that prevents lawfully present individuals granted deferred action under the Deferred Action for Childhood Arrivals (DACA) program from accessing insurance affordability programs, including the BHP.

II. REGULATIONS TO PROTECT COVERED INDIVIDUALS

We again commend CMS for making the regulations implementing the BHP consistent with existing insurance affordability programs. The individuals who would be potentially eligible for coverage under a BHP are lower-income and because of their limited resources, efforts to model a BHP on programs for which they may be familiar already will help ensure that eligible individuals obtain coverage. The following comments highlight some areas that NILC finds particularly helpful to a successful BHP and provides suggestions on how to improve provisions for potentially covered individuals.

a. NILC supports the following provisions:

1. ***Require enrollment assistance that is accessible and explanatory***: Proposed § 600.150 provides clear rules that will allow for more informed decision making by potential enrollees by requiring disclosure of BHP coverage options, additional benefits that may be provided, tiers of coverage, premiums, covered services,

[3] See NILC's comments submitted on February 21, 2013 to HHS in reference to CMS-2334-P, the proposed rule on Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals, and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing available at http://nilc.org/document.html?id=872.

cost-sharing, and participating providers. These kinds of consumer protections will foster greater participation in the BHP.

2. ***Allow a BHP to adopt Medicaid's continuous open enrollment policy***: The provision in proposed § 600.320(d) recognizes that many individuals in this covered population will likely experience frequent income fluctuations and be vulnerable to times of financial hardship that may lead them to lose coverage because of nonpayment of premiums due to lack of available funds, even if their income level has not changed so as to affect eligibility. Allowing continuous open enrollment will minimize gaps in coverage and reduce churn. This option is particularly important in states that have already expanded coverage which includes continuous open enrollment to this population, because these states may want to use BHP to ensure that current enrollees do no lose protections they have had for years.
3. ***Require BHPs to use the Medicaid appeals process***: NILC has previously advocated for use of Medicaid processes in eligibility appeals because these processes were designed for low-income individuals that are a similar demographic to those eligible for BHP. We support the inclusion of this process under proposed § 600.335(b) as an effective way to ensure that individuals have a robust appeals process.
4. ***Ensure that BHP enrollees receive a plan with actuarial value at least as high as they would get in the Exchange***: An important element of the BHP is that it "does no harm" and that any individual who obtains health coverage under a BHP does not have a higher cost. NILC appreciates that CMS included this under proposed § 600.520.

b. NILC recommends the following additions or clarifications:

1. ***Require that a state adopt Medicaid or Exchange standards for network adequacy and essential community providers***: Network adequacy has been identified as a critical issue in the new health insurance marketplaces, and it has long been a concern in Medicaid managed care plans.[4] If networks do not have sufficient available providers, enrollees' geographic access, ability to see appropriate providers, and waiting times are compromised. HHS incorporated these concerns into regulations for the Quality Health Plans bought through Exchanges by crafting minimum network adequacy standards[5] and existing

[4] *See, e.g.,* National Committee for Quality Assurance (NCQA), "Network Adequacy & Exchanges: How delivery system reform and technology may change how we evaluate health plan provider networks" (2013), http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf.

[5] 45 C.F.R. §§ 156.230 (network adequacy), 156.235 (ECPs); *see also* CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE & MEDICAID SERVS., AFFORDABLE EXCHANGES GUIDANCE 6-10 (2013), *available at* http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

regulations govern Medicaid managed care plans.[6] NILC is concerned, however, that under the proposed regulations, BHP enrollees, who are the lower-income segment of the Exchange population, would have less protection than QHP enrollees. Although we appreciate proposed §§ 600.415(b)(1) and 600.410(d) provide some requirements for adequacy standards, they are relegated to "other considerations," which also includes "local availability of, and access, to health care providers." We recommend that §600.410(d) be revised to require that states align BHP network adequacy standards with either their QHP standards or their Medicaid managed care standards.

2. ***Allow states to provide 12-month continuous eligibility***: Another mechanism to promote stability in insurance coverage is to allow for 12-month continuous eligibility in proposed § 600.340. The proposed rules require BHP enrollees to report changes in circumstances, at least to the extent that they would be required to report such changes if enrolled in coverage through the Exchange, and requires the state to redetermine their eligibility at that time. Individuals within the BHP threshold, however, are more likely to receive an hourly wage that makes their income more impacted by seasonal, market or other workplace changes. Twelve-month eligibility would help ensure the levels of coverage stability common among higher income groups and reduce the administrative burdens for public agencies and insurers serving this population. It would also be consistent with existing state options to institute 12-month continuous eligibility in Medicaid and CHIP. For families with parents on BHP and children in CHIP, this would allow the whole family to have the same eligibility terms.
3. ***Clarify that cost-sharing subsidies are to be administered in a manner that is invisible to the consumer***: Although we commend CMS for requiring in proposed § 600.520(c)(3) that states ensure consumers are not held responsible for monitoring cost-sharing reductions, we urge CMS to provide further clarification that guides states to develop procedures that shield low-income people from unnecessary costs. We would appreciate clarification that consumers should not be required to pre-pay the full amount of cost-sharing, including the subsidy amount, and then seek reimbursement of the subsidy.
4. ***Ensure that states do not terminate coverage of BHP enrollees who fail a* de minimis *part of their premium payment***: Although we appreciate that proposed § 600.525 incorporates disenrollment procedures from the Exchange or Medicaid, thus creating consistency for enrollees, we urge CMS to ensure that states do not terminate coverage of enrollees who fail to pay only a *de minimis* part of their insurance premiums. This would be overly punitive for enrollees who have paid most of the premium due and run contrary to the goals of the ACA in decreasing the number of uninsured.
5. ***Give states the option to provide BHP to low-income adults when an offer of employer-sponsored insurance is unaffordable and give states flexibility in how they fund coverage of this group***: Now known as "the family glitch," a drafting error in the Affordable Care Act leaves hundreds of thousands of children and spouses, who could have received premiums for coverage in the marketplace,

[6] 42 C.F.R. §§ 438-206-438.208.

without an affordable coverage option. While we know CMS cannot fix the drafting error through the BHP regulations, we suggest that the agency give states flexibility in how they fund coverage of this group in the BHP. We suggest that in proposed § 600.305(a)(3)(ii), states be given the option to cover spouses otherwise caught in the family glitch through BHP, and that they be given the greatest flexibility allowable in how they choose to fund it.

The NPRM requires a BHP to cover low-income adults even when a worker has an offer of employer coverage that is affordable for the worker but unaffordable for his/her spouse (NPRM at 600.305(a)(3)(ii)). The NPRM refers to the IRS requirement to maintain *minimum essential coverage* and allows individuals whose premium exceeds 8 percent of household income to be eligible for BHP (IRC 5000A(e)(1)(A)). However, under the NPRM, a BHP would only receive federal funds for people who would have qualified for a premium tax credit in the exchange (NPRM at 600.605). Under current IRS rules, spouses would not be eligible for *premium tax credits in the marketplace* if the worker's offer of coverage alone requires a contribution of less than 9.5 percent of household income (1.36B-2(c)(3)(v)(C).

As currently drafted in the NPRM, the BHP requires this group of low- and moderate-income adults to be eligible for BHP, but does not allow federal funds to finance their coverage. We suggest that CMS revise the rules to give states the option to cover this group, since the payment methodology does not adequately compensate states for this coverage. We also suggest CMS explicitly give states flexibility to fund people caught in the family glitch and potentially allow them to use BHP trust fund carry over to cover this group.

6. ***Develop specific transparency and public input requirements for states submitting a BHP blueprint:*** We suggest that you expand the public notice opportunity suggested at proposed § 600.115(c) to include more detailed steps for public notice and comment as the BHP Blueprint is developed. Given that BHP is a brand new program that will cover large numbers of low-income adults, ensuring adequate time for public notice and comment is of particular importance. We suggest that the BHP blueprint follow the simple but effective steps that are now a routine part of the application requirements for Medicaid § 1115 waivers and extensions of existing Medicaid § 1115 waivers. These steps would allow the public to comment both as the state develops a BHP blueprint, and as HHS is considering approval of the Blueprint and ensure that the public has an opportunity to discuss and understand key elements of the BHP as states take steps toward building the program. The Medicaid rules also include specific timeframes help to ensure that there is time for meaningful public input.
7. ***Define the type of "significant change(s)" that would require a state to revise its BHP blueprint to capture a broad range of changes*:** Proposed § 100.125(a) should be broadened to reflect that what might be considered a small change in some programs could be much more significant in BHP, since, without BHP, consumers would be able to access coverage through the Exchange. Anything that could potentially alter the calculus of whether consumers would be better off

in BHP versus in the Exchange should be subject to public input.[7] Specifically, we encourage CMS to define "significant program change" in such a way that would ensure public input before a state makes a change in its BHP program that would affect:

- premiums or out-of-pocket costs
- the benefit package
- choice of plans or providers
- the appeals, enrollment or renewal process
- the contracting process

III. REGULATIONS TO MAKE STATE PROGRAMS MORE VIABLE

A final key to providing for a successful BHP is ensuring that the regulations make the program more viable for states. Although NILC does not specialize in advocacy for state governments, we endorse the following comments as tools to ensure that states are more likely to adopt a BHP.

a. NILC supports the following provisions:

1. ***Allow states to contract with non-licensed HMOs that participate in Medicaid or CHIP***: Contracting with Medicaid managed care administrators for BHP coverage under proposed § 600.415 will allow states to stretch each health care dollar further, since Medicaid plans typically are significantly more efficient than private market plans. This will lower out-of-pocket costs for consumers, improving coverage rates and access to care. This would also address NILC's priority of providing continuity between the different programs, as it would allow a person whose income fluctuates between Medicaid and BHP to maintain the same provider, or for each eligible member of an immigrant family to have coverage from the same insurer and the same network of providers, such as in a family in which a parent is BHP-eligible and a child is Medicaid-eligible.
2. ***Providing financial certainty through quarterly payments to states and limits on retroactive adjustments***: A state seems unlikely to participate if the financing options are too risky, so NILC appreciates that CMS has made efforts to provide clarity to the process. Our understanding of the proposed rule is that under proposed § 600.610, CMS will *not* require the state to make retrospective adjustments to their quarterly payments made under proposed § 600.615 to account for BHP enrollees' income changes throughout the quarter. Rather, the proposed rule will account for enrollee income changes—and the corresponding repayment amount that would be owed by the individual for their advanced premium tax credits if they were enrolled through an Exchange—in the

[7] For guidance on how to define the type of program changes that would trigger resubmission of a blueprint, CMS could look to the types of changes that would trigger a State Plan Amendment in Medicaid. Medicaid law currently requires State Plan Amendments for any "material changes in State law, organization, or policy, or in the State's operation of the Medicaid program." 42 C.F.R. § 430.12(c)(1)(ii).

prospective payment formula. It protects states against unpredictable financial risk that would serve as a significant barrier to states taking up BHP. We support this decision, and we would appreciate clarifying language that confirms that states will not be required to make retrospective adjustments to their quarterly payments to account for BHP enrollees' income changes.

b. NILC recommends the following additions or clarifications:

1. ***Explicitly allow states flexibility to include additional benefits as a state option***: In the NPRM, the Basic Health Program is required to include, at a minimum, the essential health benefits and to use as a reference plan one of the commercial insurance benchmark plan options at proposed § 600.405. In addition, the preamble of the NPRM suggests that a state can choose to add additional benefits to its standard health plan, but this language is not included in the actual regulation text. The NPRM preamble says that adopting the determination of the exchange about which mandated benefits are inside the reference plan premium structure, is "not the same as a state choosing to add additional benefits only to its standard health plan(s), and "Payment for these benefits would come from either state funds or trust fund surplus."[8] However, these elements of the preamble are not reflected in the proposed regulation text. We suggest adding the following language after proposed § 600.405(b) to provide explicit regulation text that allows for additional benefits at state option beyond the commercial insurance benchmark plan:

   (c) Additional benefits at state option. The state may specify additional benefits that standard health plans must include.
2. ***Provide flexibility for states that administer Medicaid through PCCM to participate in BHP***: As proposed, the regulations will make it impossible for those states that administer Medicaid through Primary Care Case Management (PCCM) to participate in a BHP unless they agree to create an entirely different system of contracting and health care delivery for the smaller BHP population. Even if a state were willing and able to do this, however, this would severely undermine the basic BHP goal of encouraging continuity of care with the Medicaid program, ACA § 1331(c)(4), because a completely different network of providers and delivery system would be imposed on anyone moving above and below 138% of the FPL. In addition, the significant savings of administrative costs under PCCM would be lost if an entirely new administrative system had to be created to operate in tandem with it. Accordingly, the proposed regulations need to be revised to provide the flexibility for PCCM states to readily participate in the BHP while preserving continuity of care.
   A. *Provide flexibility regarding contracting parties*: Proposed § 400.415 does not allow for the type of direct state contracts with medical practices as administered under PCCM. Options include revising the language to allow contracting with individual practices that meet

[8] Basic Heath Program; Proposed Rule," 78 Federal Register 186, (September 25, 2013), pp. 59129

PCCM requirements, or allow states that use administrative service organizations (ASOs) to qualify those ASOs as the "offeror."

B. *Provide flexibility in competitive contracting*: The contracting requirements under proposed § 600.410 are strict in a way that does not allow the same type of bidding commonly used by PCCPs. A suggestion is to have entities that meet the strict bidding requirements under PCCM certification also qualify for BHP contracting.

CONCLUSION

We appreciate the opportunity to comment on the proposed rule to implement the Basic Health Program. We believe consideration of the abovementioned comments will help make the BHP more viable and improve insurance options for low-income individuals, including eligible individuals in immigrant families.

If you have any questions, you may contact Jenny Rejeske at rejeske@nilc.org.

Sincerely,

Jenny Rejeske
National Immigration Law Center