November 25, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2380-P
Baltimore, MD 21244-8016

RE: CMS-2380-P – Comments on September 25, 2013 Notice of Proposed Rulemaking: *Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity*

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments in response to the proposed regulations related to the Basic Health Program, published in the Federal Register on September 25, 2013.

We commend CMS for its efforts to implement the Basic Health Program (BHP). BHP has the potential to greatly benefit low-income consumers and help ensure the success of the Affordable Care Act (ACA). Enabled by meaningful administrative rules, the Basic Health Program could reduce premiums and out-of-pocket costs for financially-strapped households, improve enrollment rates, reduce barriers to needed care, and support continuity of care. In short, the Basic Health Program has the potential to help the Affordable Care Act meet its key goals of making affordable coverage available to everyone and maintaining stable, continuing care for those enrolled.

We appreciate the chance to offer comments on these proposed regulations. We support many of the provisions in the proposed regulations, and offer suggestions for changes that would help this program meet its potential. Specifically, our recommendations are aimed at ensuring consumer protection and input, promoting adequate and stable financing states need to be able to take up this option, facilitating continuity of care, and encouraging delivery system innovations that improve care quality.

We submit the following comments. Please note, our comments are listed in order of the sections in the proposed rules; the order of the issues raised in our comments does not reflect their priority.

We commend the provisions in the proposed rule that would:

Make clear that a state must determine an individual eligible for BHP when they are enrolled in Medicaid or CHIP coverage that does not provide minimum essential coverage (§600.305) . The U.S. Department of Treasury rules exclude Medicaid coverage of pregnancy-related services provided under 42 U.S.C. § 1396a(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX), even if such coverage is comprehensive, from the definition of "minimum essential coverage." Proposed section 600.305 would appropriately permit a woman who is eligible for, or enrolled in, such to take advantage of the BHP, if she so desired. The decision means that women will not have to switch or obtain other health insurance coverage just during the period of pregnancy. As CMS recognizes in the preamble, pregnant women enrolled in Medicaid and a BHP should receive all of Medicaid's cost-sharing protections since Medicaid would serve as the secondary payer. By allowing pregnant women to access the complete package of benefits available through both Medicaid and BHP, CMS recognizes the importance of guaranteeing access to health care services during pregnancy when the health and well-being of the mother and the fetus are at stake.

Allow BHP to adopt Medicaid's continuous open enrollment policy (§600.320(d)). The BHP population, similar to the population served in Medicaid, will likely experience frequent income fluctuations and be vulnerable to times of financial hardship that may lead them to lose coverage due to nonpayment of premiums. Given this context, continuous open enrollment will no doubt reduce churn and minimize the length of gaps in coverage that do occur. This option is particularly important in states that have already expanded coverage through an 1115 waiver to the population that will be served by BHPs, and provide continuous open enrollment to that population, so that current enrollees do not lose existing protections.

Require Basic Health Programs to use the Medicaid appeals process (§600.335(b)). We commend CMS on using existing Medicaid rules for BHP notices and appeals to afford enrollees the high standard of consumer protections in Medicaid that were specifically designed for a low-income population, like the population eligible for BHP. The alternative of requiring an applicant to go through different appeals for different benefits (e.g., a state Medicaid hearing process for Medicaid benefits and another state or federal forum to adjudicate disputes related to the BHP) would be unworkable. We suggest that CMS amend this subsection to specifically require BHPs to abide by the Medicaid requirements as codified at 42 C.F.R. Part 431, Subpart E. Those requirements are constitutionally mandated, since every application for Basic Health is an application for Medicaid.

Require compliance with the rules that apply to QHPs offering abortion coverage in the Marketplace (§600.405(e)). Congress considered including a prohibition on coverage for abortion care in the ACA and rejected that proposal.[1] Instead, § 1303 includes specific conditions under which abortion services can be covered. These conditions impose additional burdens on standard health plans that offer coverage of abortion services, unreasonably segregating abortion coverage from other health care coverage, and are as such unjust and harmful to women. However, it is clear Congress intended that abortion services would remain available when the specific conditions described in § 1303 are met.

The preamble to this proposed rule, however, is confusing and misleading. First, the preamble states, "If *states provide abortion services* for which federal funding is prohibited, the state is not eligible for *any* federal contribution, and payments for those services must be kept in separate allocation accounts" (emphasis added). This language is incorrect and is possibly a typographical error. If not corrected, the preamble could be interpreted to mean that a state providing abortion services for which federal funding is prohibited, even when federal funds were not used to cover those services, would lose all federal funding for BHP. That, of course, is contrary to law, and CMS should clarify in the preamble to the final rule that federal law restricts only how federal funds can be used.

Second, the preamble states that, "abortion services are prohibited from inclusion as an essential health benefit." This is not consistent with HHS rules. HHS has clearly stated that a state can select a benchmark that covers abortion. Therefore, abortion can be an

[1] Huma Khan & Z. Byron Wolf, *Senators Defeat Anti-Abortion Amendment in Health Care Bill By 54-45, ABC News,* Dec. 8, 2009, *available at* http://abcnews.go.com/Politics/HealthCare/senators-defeat-abortion-amendment-health-care-bill/story?id=9279079 (last visited Sep. 6, 2011).

essential health benefit. HHS rules go on to state that a QHP can fulfill the essential health benefits requirements even if it does not include abortion coverage.

Moreover, the ACA is clear that it does not "preempt or otherwise have any effect on State laws regarding the prohibition of (or *requirement of*) *coverage*, *funding*, or procedural requirements on abortions." ACA § 1303(c)(1) (emphasis added); *see also* 45 C.F.R. § 156.28(h)(1) (implementing ACA § 1303(c)(1)). The ACA requires issuers to cover state-selected benefits packages and to defer to state law. *See* ACA § 1303(c)(1). A state can, therefore, take action to ensure that the standard health plans within the state cover abortion services. States can also use state-only funds to cover abortion services. We urge CMS to make clear that the ACA does not have any effect on State rules requiring coverage or funding of abortion services.

Provide flexibility for states in setting up their BHP programs in 2015 (§600.410(c)). We appreciate that the proposed rule provides states an exemption from these contracting requirements for the first year, so this contracting process will not be a barrier to states' getting a BHP up and running by 2015. However, we have concerns about the competitive contracting processes required for standard health plans in BHP beyond 2015, as they would render a BHP impossible in most if not all PCCM states, as described in greater detail below.

Allow states to contract with non-licensed HMOs that participate in Medicaid or CHIP (§600.415). Contracting with Medicaid plans for BHP coverage will allow states to stretch each health care dollar further, since Medicaid plans typically are significantly more efficient than private market plans. This provision will improve coverage rates and access to care. It will also promote continuity of care as beneficiaries' income fluctuates between Medicaid and BHP levels by facilitating people's maintenance of the same providers as they move between programs.

Permits variations in standard health plans offering coverage across states in regional compacts (§600.420). The proposed rule ensures that a plan is not penalized because it provides or does not provide benefits in one state, but not another, solely because of state laws requiring or restricting coverage.

Ensure BHP enrollees receive a plan with an actuarial value (AV) at least as high as they would get in the Marketplace, accounting for their cost-sharing reductions (§600.520). This is an essential protection that ensures BHP meets a "do no harm" standard implicit in the Basic Health statute by ensuring that those eligible for BHP are no worse off than they would have been had they enrolled in the Exchange.

Provide states with reasonable financial certainty through quarterly payments (§600.615) and retrospective adjustments only in the cases of a mathematical error in applying the payment formula or when aggregate enrollment for the quarter differs from the predicted amount. (§600.610) Our understanding of the proposed rule is that CMS will *not* require the state to make retrospective adjustments to their quarterly payments 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 in the Marketplace – in the prospective payment formula. It protects states against unpredictable financial risk which would serve as a significant barrier to states taking up BHP. We strongly 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.

We urge you to amend the following provisions in the proposed regulations to:

A. ***Develop specific transparency and public input requirements for states submitting a BHP blueprint (§600.115(c) Development and Submission of BHP Blueprint).***

We suggest that you expand the public notice opportunity suggested at 42 CFR § 600.115(c) to include more detailed steps for public notice and comment as the Basic Health Program Blueprint is developed. Given that BHP is a brand new program that will cover large numbers of low-income adults, ensuring that there is 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 which help to ensure that there is time for meaningful public input.

There are a number of other elements in the proposed BHP regulation related to transparency that we commend and urge you to keep in the final rule:

- 42 CFR § 600.110(c) –HHS must make BHP blueprints available online.

- 42 CFR § 600.115(c)(1) – The state must also seek public comment on significant revisions that alter the core elements of the blueprint required under 42 CFR § 600.145(e).
- 42 CFR § 600.115(c)(2) – Federally-recognized tribes have to be included in the process, and by creating public comment and notice periods, others will also have a chance to participate in the process.

B. *Define the type of "significant change(s)" that would require a state to revise its BHP blueprint to capture a broad range of changes (§600.125(a))*.

What might be considered a small change in some programs could be much more significant in BHP, since, without BHP, consumers will 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.[2]

Specifically, we encourage you 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; or
- the contracting process.

C. *Ensure that terminations notices are accessible to limited English proficient (LEP) enrollees and enrollees with disabilities (§ 600.140(a)(3)).*

We anticipate BHPs will enroll many LEP individuals, particularly since legal immigrants who have not held their status for five years will be eligible for Basic Health but excluded from Medicaid. Moreover, in many states, Basic Health programs will serve people with disabilities unable to qualify for Medicaid due to income. Thus, BHPs must ensure that all notices are translated, available in alternative formats, and provide enrollees with information about requesting accommodations. By requiring BHP termination notices to meet the standards for Exchange notices, this rule will partly meet that goal. We note that the rule requires BHPs to meet the standards at 45 C.F.R. §

[2] 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).

155.230(b), but those provisions merely refer to 45 C.F.R. § 155.205(c). For simplicity's sake, we suggest that these rules incorporate 45 C.F.R. § 155.205(c) directly.

In addition, we suggest that, given the vulnerability of the low-income BHP population, CMS add specificity to the requirements for BHP. We recommend that CMS require translations when a BHP meets a threshold of 500 LEP individuals or 5% of those eligible to be, whichever is less. The 5% is utilized in both the DOJ/HHS LEP Guidance as well as recently revised regulations governing marketing by Medicare Part C & D plans. The 500 comes from an existing Department of Labor regulation. We also recommend that CMS require BHPs to provide their taglines in 15 languages so that a greater number of LEP individuals will understand that the termination enrollment notice is important and they can call the Exchange to obtain more information. It is also important that all information provided by BHPs to enrollees be written at a low literacy level so that individuals, and particularly LEP individuals, can understand the information.

D. Ensure that Basic Health Programs provide eligibility notices that are accessible to LEP individuals and those with disabilities (§600.330(e)).

Again, we anticipate that BHPs will enroll many LEP individuals, particularly since legal immigrants who have not held their status for five years will be eligible for Basic Health but excluded from Medicaid. Thus, BHPs must ensure that *all* notices are translated into threshold languages, and provide enrollees with information about requesting interpreter services and other needed accommodations. If LEP individuals cannot communicate with BHP, they likely will not receive crucial information about eligibility, enrollment, how to access services, and how to exercise their rights to file complaints or appeals. This communication with BHPs prior to an individual even getting to a healthcare provider – is essential to ensuring that LEP individuals can enroll and benefit from healthcare reform as equally as English-speaking individuals. As such, at a minimum CMS must require BHP eligibility notices to meet the standards for Exchange notices at 45 C.F.R. § 155.205(c).

In addition, we again suggest that, given the vulnerability of the low-income BHP population, CMS add specificity to the requirements for BHP. We recommend that CMS require BHPs to provide translated notices when a BHP meets a threshold of 500 LEP individuals or 5% of those eligible to be, whichever is less. The 5% is utilized in both the DOJ/HHS LEP Guidance as well as recently revised regulations governing marketing by Medicare Part C & D plans. The 500 comes from an existing Department of Labor regulation. We also recommend that CMS require BHPs to provide their taglines in 15 languages so that a greater number of LEP individuals will understand that the termination enrollment notice is important and they can call the Exchange to obtain

more information. Also, all notices provided to enrollees should be written at a low literacy level so that enrollees, and particularly LEP enrollees, understand the information.

Moreover, in many states, Basic Health programs will serve people with disabilities unable to qualify for Medicaid due to income. CMS must ensure that BHP notices advise all enrollees of their right to an accommodation under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (Section 504). For persons who are determined to be persons with communications related disabilities, CMS also must ensure that BHP notices are available in different formats and/or other languages consistent with the requirements of federal and state law, including the ADA, Section 504, and Title VI of the Civil Rights Act regarding non-English proficient persons with specific needs (for example, written notices in large print, Braille, audio, computer disc, and/or a copy provided to a designated representative) to enable persons with print-related disabilities to effectively challenge service and eligibility denials, terminations, delays, or administrative decisions regarding any of the foregoing adequately. Again, at a minimum, CMS must require BHP eligibility notices to meet the standards for Exchange notices at 45 C.F.R. § 155.205(c).

Finally, while this subsection governs eligibility notices, the proposed rule is silent on the standards for notices of service denials, terminations or reductions. These notices, and any other notices provided to BHP enrollees, should meet the same high standards of readability and accessibility.

E. Require Basic Health Programs to use the Medicaid Managed Care grievance process for service complaints (§600.335(b)).

As noted above, we appreciate that the proposed rule will require BHPs to use Medicaid appeals processes for eligibility appeals. We urge CMS to add provisions to the final rule to ensure similarly that BHPs require Standard Health plans to establish internal grievance procedures for denials, terminations, or reductions in service, consistent with those procedures required of managed care organizations in Medicaid pursuant to 42 U.S.C. § 1396u-2(b)(4) and 42 C.F.R. §§ 438.400-.424. Grievances can be an important way to identify healthcare delivery and access problems. Similar to requirements governing Medicaid managed care, plans operating in a BHP should be required to establish a grievance and appeals process whereby an enrollee, or provider on behalf of the enrollee, can communicate dissatisfaction with services provided by the BHP or challenge the denial of coverage or payment for services. In the case of a state contracting with capitated managed care organizations, enrollees or their designated representative should also be entitled to an external appeals process, decided by an independent, neutral entity, within a certain number of days after a final determination

by a BHP to deny them coverage for services. In contrast to the Medicaid rules, BHPs should not be permitted to require enrollees to exhaust their internal appeals before proceeding to external review. Nor should the internal review process be permitted to toll the time required for a final decision.

To streamline the internal review process, states could allow optional access to a QHP appeals process, provided that it did not in any way prejudice or obstruct the BHP process. For example, an individual could be offered the option to pursue an internal QHP plan grievance, so long as this choice does not preclude the individual from pursuing an external BHP appeal, otherwise harm or delay access to an external appeal, or interfere with the individual's right to obtain a timely decision (generally within 90 days of the date of the request or within days in expedited circumstances).

To effectively serve as part of a monitoring strategy, BHPs should be required to inform enrollees about their rights to file grievances and appeal decisions as well as the process for doing so using simple and clear language. Assistance should be available to consumers in completing forms and navigating the process. In addition, BHPs must also follow requirements for timely processing of appeals and allow for expedited resolution of appeals in certain urgent cases.

As suggested in the preamble, the final regulations should require BHPs to track and monitor grievances and appeals, as part of their overall quality strategy. Regular collection and review of such information is critical to determining whether complaints and grievances represent an isolated incident or a systemic problem. Moreover, this information should be made available to the public to provide additional oversight and review.

F. Ensure that all aspects of the appeals process are accessible to LEP enrollees and those with disabilities (§600.335(c)).

As described in detail above, BHPs are likely to serve high numbers of LEP individuals and persons with disabilities. We appreciate the language at proposed section 600.335(c) to require that BHP appeals be conducted in a manner accessible to individuals with limited English proficiency and persons with disabilities. In addition to explicitly ensuring that BHPs provide all notices to enrollees in a manner accessible to LEP individuals and those with disabilities, as described above, we urge CMS to provide additional specificity in this requirement by requiring BHPs to provide interpreters throughout the appeal process when they are needed by enrollees, and to affirm that all aspects of the process comply with the requirements of federal and state law, including the ADA, Section 504, and Title VI of the Civil Rights Act.

G. Allow states to provide 12-month continuous eligibility (§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 require the state to redetermine their eligibility at that time.

But the income of the low-income individuals served by BHP is uniquely variable. They tend to receive an hourly wage rather than a salary. This makes their income immediately impacted by seasonal, market or other workplace changes. Further, wage workers are more likely to experience to periodic layoffs and re-hire. Indeed, we know that half of people below 200% FPL are predicted to experience a shift in eligibility from Medicaid to BHP or Marketplace coverage, or the reverse.[3] Under this policy, we can expect a significant portion of BHP enrollees to experience reportable income changes that would trigger eligibility redetermination and necessitate their transfer to a new health coverage program.

Twelve-month eligibility would help ensure the levels of coverage stability and reduce the administrative burdens for public agencies and insurers of 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. Of course, enrollees should be permitted to request a review of eligibility and transfer to any other program for which they are eligible at any time, if they wish.

H. Explicitly allow states flexibility to include additional benefits at state option (§600.405).

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 (NPRM at 42 CFR 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 "[p]ayment for these benefits would come from either state funds or trust fund surplus." *Basic Heath Program; Proposed Rule*, 78 F.R. 59122, 59129 (Sep. 25, 2013). However, these elements of the preamble are not reflected in the proposed regulation text.

[3] Benjamin Sommers & Sara Rosenbaum, *Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges*, 30 HEALTH AFF. 228 (2011), *available at* http://content.healthaffairs.org/content/30/2/228.full.html.

We suggest that you add explicit language to the regulation text that allows states to add additional benefits at state option beyond those offered by the commercial insurance benchmark plan. While some states may want to use the commercial market EHB benchmark plan already selected in their state, other states may choose to include additional benefits beyond the reference plan. The state's choice of benefit design may depend on a number of factors including how the state assesses the population's needs, and how they plan to administer the program, and how they plan to organize service delivery. As you know, some states may run the BHP from their state marketplace, and some may do it from the Medicaid or Human Service agency. Some states would choose to build off of benefits and delivery system commercial market, and others would build on the Medicaid delivery system in order to make it work best and need flexibility to add benefits.

We suggest that after 600.405(b) you add (c) to specify additional benefits that standard health plans must include, as follows:

"(c) *Additional benefits at state option*. The state may specify additional benefits that standard health plans must include."

I. Provide additional guidance on substituting and supplementing benefits(§600.405)

The preamble states that CMS intends to allow BHPs to substitute benefits according to the Exchange rules at 45 CFR § 156.115(b). The extent of flexibility allowed under §156.115(b) is problematic for the low-income and vulnerable population that will be served by BHPs. Under § 156.115(b), an issuer of a plan offering EHB may substitute a benefit as long as: the benefit is actuarially equivalent to the benefit that is being replaced, the change is made only within the same EHB category, and it is not a prescription drug benefit.

This authority completely undercuts the letter and intent of the ACA in a number of areas, including non-discrimination and meaningful coverage of the ten EHB statutory categories. Allowing insurers this flexibility to substitute services creates dangerous potential for discrimination or insurance rating through benefit design.

Instead of adopting the substitution of benefits standards of §156.115(b), CMS should require that EHB-benchmark standards serve as a minimum for states or insurers to add to, but not reduce, the scope of services. We urge CMS to affirm that insurers should have no role in setting or altering the benefits standard for the BHP, under any conditions.

The preamble also states that CMS intends to allow BHPs to supplement benefits according to the Exchange rules at 45 CFR § 156.110(b). We believe that the supplementing approach that HHS proposes to adopt for the BHP is flawed. Per §156.110(b), a base-benchmark plan that does not include items or services within one or more of the EHB statutory categories must be supplemented by the addition of the entire category of such benefits offered under any other benchmark plan option (with some limited exceptions.) Yet, this only requires supplementation if a base-benchmark plan is not providing any coverage in one or more of the EHB categories. A base-benchmark plan that is grossly inadequate however, would not need to be supplemented. This flies in the face of the statutory intent, which was precisely to ensure adequate coverage in these ten areas regardless of the shortcomings of the insurance market.

CMS should define an "adequate" standard for the categories and require coverage of that minimum. Congress included the ten statutory categories because they are important to health care, and Congress recognized that this coverage was "essential" regardless of the typical employer package. It simply makes no sense for the ACA to list these critical services but then require nothing more than bare minimal coverage.

CMS must ensure that BHPs provide adequate coverage in all ten categories. "Adequate" should be defined by reference to some objective standards for each category and should be based on the services needed to meet the needs of the covered populations.

J. Strengthen the requirement of non-discrimination in benefit design (§600.405(d)).

We commend HHS for the inclusion of a prohibition against discrimination. The proposed rule states that the terms of 45 CFR 156.125 will apply to standard health plans offered through the BHP. Under §156.125**,** an issuer "does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." Vigorous monitoring and strong enforcement of these non-discrimination provisions will be important.

HHS must consider four provisions of the ACA as it uses its authority to ensure that the EHB and plans offering the EHB do not discriminate:

- § 1557 prohibits discrimination on the basis of race, color, national origin, sex, age and disability in health programs or activities that receive federal financial

assistance, are administered by an Executive agency, or were established by Title I of the ACA.

- § 1302(b)(4)(B) requires that the Secretary "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life."
- § 1302(b)(4)(C) requires the Secretary to "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."
- § 1302(b)(4)(D) requires the Secretary to ensure "that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or the individuals' present or predicted disability, degree of medical dependency, or quality of life."

The preamble references only § 1302(b)(4) and the rule states only the protections available under that provision; it therefore reflects an incomplete and insufficient standard. Because the protections under § 1557 also apply, the final rule must expressly state a comprehensive and consistent nondiscrimination standard. In addition, we strongly suggest that the final rule explicitly prohibit BHPs from discriminating on the basis of race, color, national origin, language, sex, sexual orientation or gender identity in their benefit design.

K. Require that a state adopt Medicaid or Exchange standards for network adequacy and essential community providers (§600.410(d)).

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. If networks do not have sufficient available providers, enrollees' geographic access, ability to see appropriate providers, and waiting times are compromised. HHS, recognizing the seriousness of this issue in the federal marketplace, and to implement the federal regulation requiring sufficiency in number and type of providers, including "essential community providers," issued guidance that requires QHPs to meeting minimum network adequacy standards. 45 C.F.R. §§ 156.230 (network adequacy), 156.235 (ECPs). In addition, detailed network adequacy standards apply to Medicaid managed care plans, intended to assure access to care for vulnerable individuals. 42 C.F.R. §§ 438-206-.208.

BHP enrollees' access to health care services under the BHP is only minimally discussed in the proposed rules. We appreciate that proposed §600.415(b)(1) will require states to include network adequacy standards in their contracts with Standard Health Plans, but urge CMS to include additional specifics. Proposed §600.410(d) requires states to negotiate plan contracts based on a number of factors. The primary

ones are premiums, benefits, costs and “innovative features.” Network adequacy considerations are relegated to an “other considerations” category in this list of factors; one of these considerations is “local availability of, and access, to health care providers.”

BHP enrollees, who are the lower-income segment of the Exchange population, should not have less protection than QHP enrollees. They will have more limited plan choice than QHP enrollees, and should have network adequacy protections at least as strong. States should also be allowed to align BHP network adequacy standards with Medicaid standards. This will be an important option for states doing joint procurement of Medicaid and BHP. We recommend that, at a minimum, §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.

We also suggest that CMS work with states to implement network adequacy standards for their BHPs that exceed minimum standards. It is not sufficient to only count the numbers and types of providers. It is critical that network adequacy standards require access to all covered services. For instance, BHPs should be encouraged to take into consideration the fact that many religiously-controlled hospitals and clinics may not provide all of the covered services, and individual providers may refuse to offer covered services. These restrictions may limit access to comprehensive reproductive health services and information, as well as end of life care and information about treatment options. An adequate network must include providers that offer all covered services. Moreover, in the event that an enrollee is not able to access the reproductive health services that she needs within the network, in particular due to provider religious or moral objections, the BHP must be required to allow the enrollee to access services out-of-network without penalty, including in the case of emergencies.

CMS should work with states to establish specific criteria to measure the number of providers in a network. The goal of such criteria is ensuring that enrollees have meaningful access to the health care services they need. CMS should encourage states to establish specific standards under which BHPs ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, whether administered by MCOs or by the state itself under a primary care case management form of managed care. In addition, CMS should work with states to establish specific timeliness standards under which BHPs assure that services are accessible without unreasonable delay.

L. Provide flexibility for states that administer Medicaid through PCCM to participate in BHP (§§ 600.410 and 600.415).

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, set out at 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.

Provide flexibility in competitive contracting (§600.410).

The competitive bidding requirements in §600.410 are too strict relative to the way that PCCM states contract with individual practices. These practices are not submitting sealed bids and not engaging in price competition. But in having to meet strict Patient-Centered Medical Home certification requirements, PCCM practices are effectively competing on the basis of quality. This type of competitive bidding should be sufficient under the regulations. In any event, the competitive bidding requirement should allow a non-risk administrative services organization (ASO) assisting the PCCM practices and contracted with through a competitive bidding process to meet this requirement, even if such contract was previously in place under Medicaid (i.e., grandfathering of ASO entities already under contract with the state, if those related contracts were competitively bid).

Further, we suggest broadly defining what constitutes competitive contracting to encourage development of innovative models of care delivery. Specifically, initially permitting less than two responsible bidders serving a local health care market could be helpful to states pursuing far-reaching delivery system reform. Under community-based coordinated care-global budget models and other kinds of ambitious efforts, it may take time for many competitors to emerge. CMS could challenge such states to adopt strategies to prevent the risks to consumers typical of a marketplace that lacks vigorous competition and to take steps to foster competition in future Basic Health contracting.

Provide flexibility regarding contracting parties (§600.415).

Under PCCM, states contract individually with medical practices to coordinate care for their Medicaid patients; they don't contract with an entire network of providers under one large contract. But the only choices for an "offeror" which a state may contract with, under proposed §400.415, are insurers, licensed and unlicensed HMOs, and a "network of health care providers."

While these regulations ideally should be revised to provide that contracting with individual practices that meet stringent medical home requirements under a PCCM system satisfies the contracting requirements, an alternative would be to allow any PCCM state that also contracts with a statewide ASO for administrative functions related to the PCCM program to qualify as an "offeror." Contracting with this kind of entity, if it recruits or assists the PCCM practices, should be an additional option under §600.415, even if the state, and not the ASO, contracts directly with the individual PCCM practices.

We note that §1331(c)(1) of the ACA refers to "entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 18022(b) of this title." But this language does not **require** that all such aspects be in any given BHP contract if the conditions in the state do not logically allow for inclusion of such terms (for example, if copays are not required for BHP enrollees or a subset of such enrollees in a particular state, it would not make sense for the contract to mandatorily include any such terms). Thus, a contract with a non-risk statewide ASO involved in administering a PCCM program need not include these terms.

If some detail is viewed as necessary regarding the requisite activities of a contracted ASO qualifying them to be an offeror in a PCCM state, we recommend that the ASO must be engaged in at least the first two of the following activities and at least two of the additional listed activities:

- Recruiting of PCCM providers
- Assisting practitioners in becoming and remaining certified patient-centered medical homes under the PCCM program
- Assisting practitioners with intensive care management for more complex patients
- Providing disease management to enrollees
- Conducting utilization reviews when submitted by the PCCM providers or others
- Providing customer service to enrollees

M. Explicitly provide flexibility for states to have either a single benefit package or a single offeror of coverage (§600.420).

We are concerned that the proposed §600.420 is ambiguous. The rule may be interpreted to require BHP states to offer a choice of "standard health plans" without clearly stating that this may be a choice between either benefit packages or between plans offered by different carriers. The proposed rule could be interpreted to require only the former, but we believe the statute is inclusive and permits the latter. In the interest of state flexibility to create choice that is most beneficial to BHP consumers, both options should be available to states.

Limiting state options regarding choice could be detrimental to consumers for a number of reasons. Requiring multiple benefit packages could add significantly to administrative costs. Federal BHP funds are not available for administrative costs, so these costs are likely to be passed on to these low-income, price-sensitive consumers. In addition, if states are required to offer multiple benefit packages, it would defeat a state's ability to align with Medicaid and would create needless complexity and confusion – for example by requiring a lesser-benefit package to be offered when a very comprehensive one is provided by a state for a zero premium.

States should also be able to offer a choice of benefit packages when there are not two managed care organizations available. This is the only way to ensure that a state can participate in BHP if it has low managed care organization penetration and only one plan is available to contract, or if there are two plans and one drops out.

45 C.F.R §600.420 requires states to "include in its BHP Blueprint an assurance that at least two standard health plans are offered under BHP, and if applicable, a description of how it will further ensure enrollee choice of standard health plans." The preamble language in the proposed rule at page 59131 indicates, on the one hand, the agency's intent to ensure choice of benefit packages, and on the other hand, its intent to protect consumers "in the event that a single standard health plan becomes unavailable," because "BHP, unlike Medicaid, does not have a fee-for-service program available" in that event. This clearly refers to choice-of-plan as a choice of offerors.

While we do not support an inflexible requirement of benefit package choice or offeror choice, we believe CMS has the authority and responsibility to review Blueprints to ensure that they comply with the statutory intent of offering meaningful choice to consumers to the maximum extent feasible. This authority should serve as a check on a state that might be overly restrictive in its offerings to consumers.

In light of the statutory language and goal of BHP state flexibility, the proposed rule should be clarified as follows:

(a) *Choice of standard health plans.* The State must include in its BHP Blueprint an assurance that at least two standard health plans, or at least one standard health plan offered by two or more offerors, are offered under BHP, and if applicable, a description of how it will further ensure enrollee choice of standard health plans. When certifying a Blueprint under §600.120, the Secretary shall waive this requirement based upon a finding that it is not feasible for a state to offer a choice of plans or offerors. Such a finding shall be reviewed annually.

N. Clarify that cost-sharing subsidies are to be administered in a manner that is invisible to the consumer. (§600.520(c)(3)).

We appreciate HHS' responsiveness to consumer concerns regarding cost-sharing administration, by requiring in §600.520(c)(3) that states ensure that consumers are not held responsible for monitoring cost-sharing reductions. We would appreciate further 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. Since we know all BHP enrollees will qualify for these reductions, there should be no reason not to administer the cost-sharing in a seamless manner.

O. Ensure that states do not terminate coverage of BHP enrollees who fail to pay a de minimis part of their premium payment (§600.525).

We support the proposal to align disenrollment procedures and consequences for nonpayment of premiums with the state's disenrollment policies for either the Exchange or Medicaid. However, we urge HHS to ensure that states do not terminate coverage of enrollees who fail to pay only a de minimis part of their insurance premiums. Doing so would be overly punitive in the case of an enrollee has paid most of the premium due.

P. Include in the federal BHP payment 100 percent of the cost-sharing reduction for which the eligible individual would have qualified in the Marketplace (§600.605).

The proposed rule fails to recognize a fundamental distinction between the premium tax credits and the cost-sharing reduction amounts provided to states, resulting in an erroneous conclusion that states may only receive 95% of cost-sharing reductions.

The intent of §1331(d)(3)(i) of the ACA is to provide states with 95% of the tax credits that would otherwise be provided to enrollees, with the expectation that states can efficiently manage these funds, negotiating standard plan premium rates that save at

least 5% over commercial market plans. Once purchased, however, these standard plans must charge enrollees cost-sharing no higher than the Exchange would. Proposed 42 CFR §600.520(c). That is, the state must provide for cost-sharing reductions *to the enrollee* (sometimes referred to as "actuarial boost") at least equivalent to what they would receive in an Exchange silver plan. States have no discretion (nor should they) to negotiate or bargain with enrollees to lower these subsidies; they must provide 100% of them to enrollees.

Under the proposed rule, however, states receive only 95% of these funds from the federal government and are thus left financing the other 5% from the BHP trust fund[4]. But the only other money in the BHP Trust Fund is from the 95% premium tax credits. The inescapable conclusion is that states must use some of this tax credit money to make up for insufficient cost-sharing dollars. So the tax credits available to a state purchase standard health plans would be *less than* 95% of the tax credits, possibly making a Basic Health program prohibitive.

Example: The silver benchmark premium in a state's exchange is $500. An enrollee's subsidy is $400, and his average cost-sharing reduction is $80. Under the proposed rule, a BHP state would receive a premium tax credit of $380 and a cost-sharing reduction payment of $76. The state must ensure that the enrollee receives an $80 cost-sharing reduction, so $4 is allocated from the tax credit for this purpose. $376 remains to subsidize a silver-equivalent plan—*less than* 95% of the premium tax credit.

Based on the above analysis, it seems clear that in order to avoid effectively reducing premium tax credits <u>below</u> 95%--and potentially passing these reductions on to very low-wage consumers--states need to receive 100 percent of the cost-sharing reductions that BHP enrollees would have been eligible for in the Exchange.

In order to avoid the unfortunate result of "raiding" tax credit funds to provide cost-sharing subsidies, the statute must be interpreted to provide states with 100% financing of cost-sharing subsidies. This interpretation is consistent with the literal reading of the statute. Section 1331(d)(3)(i) specifies that the Secretary should transfer to the state an amount:

> equal to 95 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals […].

[4] We estimate this amount to be in the range of $3-6 per member per month.

A plain reading of this statutory language indicates that Congress intended to offer 95% financing for the premium tax credits and 100% financing for the cost-sharing reductions. Congress placed the comma after the word "1986" to indicate that the 95% only applies to the tax premium credits and does not apply to the cost-sharing reductions. If Congress had intended the 95% to apply to the cost-sharing reductions, there would be no need for a comma and the commencement of a separate clause concerning the cost-sharing reductions. Accordingly, the proposed rule should be revised to ensure that a state that opts for a BHP, and the vulnerable consumers that would be served by such a program, receives adequate financing. This approach still allows the federal government to save money through a state's election of BHP (since they only spend 95 percent of what they would have spent on premium tax credits).

Q. *Provide states with explicit options for paying the administrative costs of BHP, including using some of the user-fee assessments built into Exchange carrier rates (§600.705(d))*.

We understand that BHP funds may not be used for administrative costs, but we would appreciate regulations and/or guidance that provide states with options for paying the administrative costs of BHP. We understand from earlier communications that CMS intends to allow states to impose user fees and assessments, including those that are built into carrier rates in the Exchange, to cover administrative costs picked up by the BHP instead of the Exchange. These are logical funding sources for BHP administrative costs, since a BHP enrollee population will be carved out of the Exchange. Helping states identify funds for the administrative costs of BHP is essential to BHP's success, since the administrative costs could otherwise create a barrier to states taking up BHP.

We reserve judgment on the decision to remove BHP from the regular ACA risk adjustment approach until we have the opportunity to evaluate how risk adjustment applies to BHP payments to states in the forthcoming proposed Payment Notice.

Thank you for the opportunity to provide comments on this proposed rule, and for keeping consumers a priority as you implement the Affordable Care Act. If you have any questions regarding our comments, please contact Abbi Coursolle (310-736-1652; coursolle@healthlaw.org), Staff Attorney, at the National Health Law Program.

Sincerely,

/s/

Emily Spitzer
Executive Director