

November 22, 2013

Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-2380-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Via Electronic Submission ([www.regulations.gov](http://www.regulations.gov))

RE: 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 Administrator Tavenner:

The Georgetown University Center for Children and Families respectfully submits the following comments to the Centers for Medicare and Medicaid Services, Department of Human Services 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 families 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 families, 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 protections and input from low-income families; 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 the priority we place on them.

**We commend the provisions in the proposed rule that would:**

***Prohibit enrollment limits or caps or waiting lists for BHP coverage (Section 600.145(d)).*** We applaud the requirements in the proposed rule that ensure BHP coverage is available to all eligible persons who apply. Prohibiting restrictions on coverage beyond statutory requirements is vital to ensure that low income consumers, including any children and pregnant women eligible for the BHP, have access to affordable insurance under the ACA.

***Allow BHP to adopt Medicaid's continuous open enrollment policy (§600.320(d)).*** The BHP population 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 which includes continuous open enrollment to this population, because these states may want to use BHP to ensure that current enrollees do not lose protections they have had for years.

***Require Basic Health Programs to use the Medicaid appeals process (§600.335(b)).*** From the enrollee perspective, it will be very important to ensure that once in BHP, an individual will be able to access needed providers and address any eligibility concerns through a robust appeals process, since they are unlikely to be able to afford any other option for coverage or care. By using existing Medicaid rules in these areas, HHS will 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.

***Provide flexibility for states in setting up their BHP programs in 2015 (§600.405).*** 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 (see more on that 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 will lower out-of-pocket costs for low-income families, improving coverage rates and access to care. It will also promote continuity of care as beneficiaries' income fluctuates between Medicaid and BHP by allowing people to maintain the same providers and benefits as they move back and forth.

***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.

While we appreciate the NPRM's proposal to institute a method of prospective payments to states that substantially reduces the risk that they would have to repay funds to the federal government, we remain concerned that in two areas the proposed rules fail to maximize the opportunity to support the financial viability of a BHP in the States: (1) the NPRM misconstrues the plain meaning of the statute which authorizes 100 percent federal financing to support the consumer's cost-sharing reductions; and (2) it fails to provide guidance on permissible ways for states to finance administrative costs of a BHP, given that trust funds may not be used for these costs. Any financial barriers to a state may cause it not to pursue a BHP and result in the most vulnerable low-income families opting for low-value Bronze plans or gaps in coverage because they are unable to maintain consistent premium payments for silver or higher level plans. These two issues are further discussed below.

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

***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 help to ensure that there is time for meaningful public input.

Key elements of the Medicaid 1115 Waiver Approval that we suggest the BHP Blueprint follow are provided below. The complete rules are available at 42 CFR §431 or at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8292.pdf>

Transparency and specific timeframes for input as the state develops the BHP blueprint:

- 30-day notice and public comment period at the state level
- The state's draft BHP blueprint must contain a sufficient level of detail to ensure meaningful input from the public.
- The state must keep a current webpage to share the draft BHP blueprint and related materials allow interested parties to sign up for an email notification to be kept in the loop on the application.
- The state must hold at least 2 public hearings on separate dates and locations that offer the public a chance to learn about the draft BHP blueprint and comment on it.
- The state's proposed BHP blueprint for HHS must include similar specifics to those provided in the initial waiver proposal, document the public process conducted by the state and include a report on how the state considered issues raised by the public.

Additional transparency and specific timeframes for input as the state shares its proposed BHP Blueprint with HHS:

- Within 15 days of state's submission of proposed BHP blueprint to HHS, HHS must send the state a notice of receipt which initiates a 30-day comment period.
- HHS will publish the notice of receipt, the proposed BHP blueprint and other relevant materials on its website along with an email address through which the public can send comments that will be made publicly available.
- To ensure the public has adequate time to provide input in this stage, no federal decision on a blueprint would be made until 45 days after the notice of receipt.

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

- 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 process, and by creating public comment and notice periods, others will also have a chance to participate in the process.
- 42 CFR § 600.110(c) – Requirement that HHS make BHP blueprints available online.
- 42 CFR § 600.410(d) – Tracking and monitoring of grievance and appeals.

***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, individuals would be able to access coverage through the Exchange. Anything that could potentially alter the calculus of whether people would be better off in BHP versus in the Exchange should be subject to public input.<sup>1</sup>

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
- the contracting process.

***Give states the option to provide Basic Health 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 (600.305(a)(3)(ii)).***

Now known as “the family glitch,” a drafting error in the Affordable Care Act leaves many children and spouses, who could have received premiums for coverage in the marketplace, without an affordable coverage option. While we know that you can’t fix the drafting error in the BHP regulations, we suggest that you give states flexibility in how they fund coverage of this group in the Basic Health Program. States can currently cover children otherwise caught in the family glitch through CHIP, which is funded with a combination of federal and state funds. We suggest that 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.

- **Eligibility:** 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)).
- **Payment:** 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*

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<sup>1</sup> 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))

*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-income and moderate adults to be eligible for BHP, but does not allow federal funds to finance their coverage. We suggest that you revise the rules to give states the option – but not require them – to cover this group, since the payment methodology does not adequately compensate states for this coverage. We also suggest you 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.

***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 requires the state to redetermine their eligibility at that time.

But 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 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.<sup>2</sup> 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 common among higher income groups 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.

For these reasons we urge HHS to give states the option to institute 12-month continuous eligibility in BHP.

***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

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<sup>2</sup> Sommers, Benjamin, and Sara Rosenbaum. "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges." *Health Affairs* 30.2 (2011): 228-236. <http://content.healthaffairs.org/content/30/2/228.full.html>

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.” (“Basic Health Program; Proposed Rule,” 78 Federal Register 186, (September 25, 2013), pp. 59129). However, these elements of the preamble are not reflected in the proposed regulation text.

We suggest that you add explicit language to the regulation text that allows states to add additional benefits at state option beyond 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 should 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.”

***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.<sup>3</sup> If networks do not have sufficient available providers, enrollees’ geographic access, ability to see appropriate providers, and waiting times are compromised. DHHS, 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.<sup>4</sup> In addition, detailed network adequacy standards apply to Medicaid managed care plans, intended to assure access to care for vulnerable individuals.<sup>5</sup>

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<sup>3</sup> 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](http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf).

<sup>4</sup> 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

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 §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.

***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, 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.

In addition to the multiple plan requirement addressed below (§ 600.420), there are several other provisions in the proposed regulations which render PCCM states ineligible for the BHP. These particularly include the provisions concerning whom a state may contract with under BHP, §600.415, and the competitive bidding requirements, §600.410.

***Provide flexibility regarding contracting parties (§600.415).***

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[http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf) .

<sup>5</sup> 42 C.F.R. §§ 438-206-438.208.



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 inherently meets the contracting requirements, an alternative would be to allow any PCCM state that also contracts with a statewide administrative services organization (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 by 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

***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. Although being a PCCM provider may be demanding, 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, they 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 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.

***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 enrollees, both options should be available to states.

Limiting state options regarding choice could be detrimental to individuals and families 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 individuals and families. 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.

Section 1331 may be interpreted to allow state flexibility in offering consumer choice of either benefit package or offeror.

Section 1331(c)(3)(A) provides:  
(3) ENHANCED AVAILABILITY.—

(A) MULTIPLE PLANS.—A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

The language of the statute does not specify that the intended meaning of “standard plans” in this section is limited to multiple benefit packages – it could mean either packages or offerors of plans. And neither is it an absolute requirement as the “maximum extent feasible” clause and the word “seek” make clear.

The definition of “Standard Health Plan” in §1331(b)<sup>6</sup> is not a model of clarity. The first clause of the definition is “a health benefits plan that the State contracts with under this section,” suggesting that “plan” refers to the contracting entity – the offeror. The remainder of the definition has clauses that could be used to support either interpretation.

Similarly, “Qualified Health Plan” is sometimes referred to as a contracting entity, as in §1311(h)(1) (“a qualified health plan may contract with (A) a hospital...; or (B) a health care provider...”), but at other times as a benefit package. This is significant since §1331 draws many parallels between SHPs and QHPs.

In addition, this section of the ACA was closely modeled on an existing state-based program, the Washington Basic Health program. Section 1331 was offered as an amendment by Washington’s Senator Maria Cantwell. In Washington’s BHP, a single benefit package is offered through multiple issuers.

For these reasons, it is reasonable to interpret the “choice” requirement of 1331 as meaning a choice of either benefit packages or of plans.

Further, §1331(c)(3)(A) recognizes that a state may have challenges achieving consumer choice, and therefore includes the “maximum extent feasible” qualifier. The purpose is to offer individuals and families as much choice as possible.

In some states or regions of states, a state may only be able to contract with one offeror, but could offer a choice of benefit packages. In others, the state may contract with multiple offerors and determine that the trust funds could be better spent on a single benefit package. For example, a state may be able to contract with multiple offerors to offer a zero-premium, comprehensive benefit package with minimal or no cost-sharing that is aligned with the Medicaid package. It would be unfeasible in this situation to justify coming up with another, lesser benefit package with higher cost-sharing, just to meet the choice requirement. Moreover, this could disadvantage all BHP enrollees by

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<sup>6</sup> (b) STANDARD HEALTH PLAN.—In this section, the term “standard health plan” means a health benefits plan that the State contracts with under this section—

(1) under which the only individuals eligible to enroll are eligible individuals;  
(2) that provides at least the essential health benefits described in section 1302(b); and  
(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

adding administrative costs. Such a state should have the option of offering a choice of companies/entities rather than a choice of package.

However, another state may best serve individuals and families by creating an efficient BHP that maximizes continuity of care. In the case of PCCM in conjunction with an ASO specifically, the state does not contract with risk-bearing entities so there are not multiple offerors of plans to enrollees. Rather, it contracts on a non-risk basis with individual practices throughout the state to coordinate care for enrollees, while administering the program through a single statewide system that includes a contract with a single ASO to conduct some administrative functions. Requiring multiple plans in this situation would be confusing and inefficient. As such, it is not feasible for a state to offer multiple "plans" under its PCCM program extended to BHP enrollees.

Some states are fixing their fragmented health care systems by extensively coordinating care through local community-based coordinating organizations operating within global Medicaid budgets. Not all enrollees in such states have multiple coordinated care plan options, in some cases because the local health system and participant pool are not large enough to support multiple plans. Allowing them to continue these delivery system innovations within BHP would be appropriate when it is beneficial to low-income enrollees, especially considering the “maximum extent feasible” clause, and in light of the ACA’s interest in pursuing these kinds of approaches. Perhaps high standards for network adequacy and other consumer safeguards could be used to meet the consumer interests that would otherwise be met through multiple plan options.

Circumstances will vary from state to state as to what type of “choice” is most meaningful to individuals and families. The statutory language contains the flexibility to allow states to make this determination in light of what is most desirable given the local healthcare and financing landscape.

The proposed rule should be clarified to allow state flexibility.

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 individuals and families “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 individuals and families to the maximum extent feasible. This authority should serve as a check on a state that might be overly restrictive in its offerings to individuals and families.

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.

***Require the BHP blueprint to specifically address pregnant women in their strategies on churn mitigation (§600.425)***

We applaud the requirement in Section 600.425 that a state's BHP blueprint must include a description of how the program will ensure coordination with other insurance affordability programs to help mitigate the negative impact of churn. However, we urge CMS to require the BHP blueprint to specifically address women in their strategies on churn mitigation. Low-income pregnant women are especially vulnerable to disruptions in care due to the time-limited nature of their Medicaid coverage (i.e., they are eligible only when pregnant and 60 days post-partum), the complexity of their eligibility requirements, and frequent income fluctuations. Seamless coverage and continuity of care ensures that women receive the necessary services to be healthy before conceiving and to have a healthy pregnancy outcome.

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

We appreciate your responsiveness to consumer concerns regarding cost-sharing administration, by requiring in §600.520(c)(3) that states ensure that individuals and families 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.

***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 who has paid most of the premium due.

***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<sup>7</sup>. 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 QHP premium in a state’s exchange is \$500. An enrollee’s subsidy is \$400, and their 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 person receives an \$80 cost-sharing reduction, so \$4 is allocated from the \$380 tax credit for this purpose. \$376 remains to subsidize a silver-equivalent plan, which is 94% of the premium tax credit.

Based on the above analysis, it seems clear that in order to avoid effectively reducing premium tax credits below 95%--and potentially passing these reductions on to very low-wage individuals and families--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:

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<sup>7</sup> We estimate this amount to be in the range of \$3-6 per member per month.

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 [...].

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 individuals and families 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).

***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 provides 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, as will be proposed in the forthcoming Payment Notice.

Thank you for the opportunity to provide comments on this proposed rule, and for keeping low-income individuals and families a priority as you continue your important work implementing the Affordable Care Act. If you have any questions regarding our comments, please contact Sonya Schwartz at Georgetown University Center for Children and Families at 202-784-4077 or [ss3361@georgetown.edu](mailto:ss3361@georgetown.edu).

Sincerely,

Sonya Schwartz  
Georgetown University Center for Children and Families