



NJ For Health Care Campaign
November 25, 2013

COMMENTS to the Department of Health and Human Services and Centers for Medicare & Medicaid Services

**RE: Patient Protection and Affordable Care Act: Basic Health Program,
File Code CMS-2380-P**

New Jersey Appleseed Public Interest Law Center respectfully submits, on behalf of the NJ for Health Care Campaign, the following comments to the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) in response to the proposed regulations governing the administration, standards, funding, and implementation of the Basic Health Plan released in the Federal Register on September 25, 2013.

The NJ for Health Care Campaign is a broad-based alliance of health care, consumer, senior, student, disability, women's, labor, faith-based, civil rights and social justice organizations working to bring guaranteed, high quality, affordable health care to all New Jersey residents. Such organizations include, but are not limited to, AARP-NJ, New Jersey Policy Perspective, New Jersey Citizen Action, NJ-PIRG, Statewide Parent Advocacy Network, and Latino Action Network. See <http://njforhealthcare.org/index.html> (list of all participating organizations). We have been working over the past several years to build strong alliances with patients, providers, small and large businesses and health care and social service agencies across the State in order to ensure that the Affordable Care Act (ACA) is effectively implemented in New Jersey in accordance with our core principles: affordability, transparency, and accountability to all consumers. We were instrumental in assisting our Legislature develop a blueprint for a state-insurance exchange, which unfortunately was vetoed by our Governor, and we are committed to making sure that the ACA works for New Jersey residents.

As a general matter, we commend HHS in drafting provisions that seek to satisfy the goals of the ACA and to promote affordability for those low-income families who are not eligible for Medicaid. We believe that the Basic Health Program (BHP) has the potential to greatly benefit low-income consumers who are fiscally strapped, and to help ensure the success of the ACA by enabling more people to sign up for coverage. There is little doubt that the BHP, enabled by meaningful administrative rules, could reduce premiums and out-of-pocket expenses

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for financially limited households, improve enrollment rates, reduce barriers to needed care and support continuity of care for those enrolled, who may be in and out of Medicaid due to fluctuations in their income. This potential must be made real, and all efforts should be made to design the BHP so that states are likely to adopt such insurance option.

As a Coalition committed to the success of the ACA in our state, 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 we believe would help this program meet its potential. Specifically, our recommendations are aimed at ensuring consumer protection and input, promoting adequate and stable financing for states to enable states to opt for the BHP, facilitating continuity of care as household income changes, and encouraging delivery system innovations that improve care quality. For the past few decades, New Jersey has been in the forefront of providing public coverage for many of its low-income households. We need to continue that tradition to benefit consumers, but also to stabilize our delivery system.

From the perspective of New Jersey consumers, we submit the following comments:

As a preliminary matter, we support several provisions in the proposed rule that we want to highlight, and ensure remain unchanged. They are as follows:

§600.145 Requiring State to operate the program statewide. Pursuant to §600.145, “the state would not be permitted to limit enrollment to a lower income level than prescribed in the statute, cap enrollment or impose waiting list.” We support the notion that benefits must be consistent statewide, and that caps or waiting lists would deny access to care.

§600.310 Requiring single, streamlined application. Although the regulations propose to codify a single, simple application by adopting reference to regulations at “§431.907(b) and 45 CFR 155.405(z) and (b),” we caution that individuals with disabilities may be eligible for multiple plans and there must be coordination of benefits to meet the needs of such individuals. This concern also applies to §600.330, which discusses standards of coordination between the BHP and other insurance affordability programs. The regulations should highlight a requirement that any special needs of the disabled in the application process must be satisfied.

§600.320(d) Allowing BHP to adopt Medicaid’s continuous open enrollment policy. There is little doubt that 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. In addition, we would prefer that eligibility be determined by a governmental entity that determines eligibility for Medicaid or the Exchange, rather than the BHPs directly. In this way, any potential for conflict of interest disappears.

§600.335(b) Requiring Basic Health Programs to use the Medicaid appeals process. 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, some of whom will now be eligible for the BHP.

§600.405 Providing flexibility for states when setting up their BHP programs in 2015.

Flexibility is of course good, and therefore, we appreciate that the proposed rule provides states with an exemption from certain contracting requirements for the first year. States must be given flexibility in the contracting process so that it will not be a barrier to 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 may render a BHP difficult and under some circumstances impossible (in most, if not all, Primary Care Case Management states, which does not include New Jersey).

§600.415 Allowing states to contract with non-licensed HMOs that participate in Medicaid or CHIP.

Here in New Jersey, we believe that 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 consumers, 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 between the BHP and Medicaid.

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

§600.615 Providing states with reasonable financial certainty through quarterly payments. 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 (and that retrospective adjustments will be required 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). 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 Exchange – in the prospective payment formula. This method of calculation 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 decision to institute a method of prospective payments to states that would substantially reduce 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: First, the payment

methodology in the Notice for Proposed Rulemaking (NPRM) misconstrues the plain meaning of the statute which authorizes 100 percent federal financing to support the consumer's cost-sharing reductions; and secondly, it fails to provide guidance on permissible ways for states to finance the administrative costs of a BHP, given that trust funds may not be used for these costs. Any financial barriers that may cause a state not to pursue a BHP should be avoided. For without a BHP, the most vulnerable low-income consumers may have to opt for a low-value Bronze plan or incur gaps in coverage because they are unable to maintain consistent premium payments for silver or higher level plans. These two financing issues are further discussed below.

We now want to turn our attention to provisions for which we suggest changes. They are as follow:

§600.115(c) Development and Submission of BHP Blueprint. We suggest that CMS develop specific transparency and public input requirements for states submitting a BHP blueprint. Specifically, we recommend that the public notice opportunity suggested at 42 CFR § 600.115(c) be expanded 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 simpleive 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 that Blueprint. Such a process would 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 that have been effective in permitting 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>

Further, we suggest transparency and specific timeframes for input as the state develops the BHP blueprint as follows:

- 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; and,
- 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 are:

- 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; and,
- To ensure that the public has adequate time to provide input at 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.

§600.125(a). Revisions to a certified BHP Blueprint. We request CMS to define the type of "significant change(s)" that would require a state to revise its BHP blueprint to capture a broad range of changes. A definition is required since what might be considered a small change in some programs could be much more significant in BHP. 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; and the contracting process. 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)).

§600.305(a)(3)(ii). Eligible Individuals. We suggest that regulations give states the option to provide the BHP to low-income adults when an offer of employer-sponsored insurance is unaffordable and to provide flexibility on how to fund coverage of this group. Now known as “the family glitch,” a drafting error in the Affordable Care Act leaves hundreds of thousands of children and spouses, who could have received premiums for coverage in the Exchange, without an affordable coverage option. While we know one cannot fix the drafting error through the regulatory process, we suggest that you give states flexibility in how they fund coverage of this group in the BHP. 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 finance such option.

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

Accordingly, as currently drafted the rules require 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 funds to cover this group.

§600.340. Periodic re-determination and renewal of BHP eligibility. We recommend that the states be permitted to provide 12-month continuous eligibility. 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 re-determine their eligibility at that time. However, 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.¹ 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.

Therefore, we believe that 12-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.

§600.405 Standard Health Plan coverage. Pursuant to the proposed regulation, the BHP is required to include, at a minimum, essential health benefits and to use as a reference plan one of

¹ 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>

the commercial insurance benchmark plan options. In addition to this provision, 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 also states that when the standard health plan is subject to state insurance mandates requiring additional benefits (which is “not the same as a state choosing to add additional benefits only to its standard health plan(s)), “Payment for these benefits would come from either state funds or trust fund surplus.” (“BHP; 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.

Accordingly, we suggest that you add explicit language to the regulation text that allows states to add additional benefits 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 mimic the benefits and delivery system of the commercial market, while others would build on the Medicaid delivery system in order to make it work best. In either case, states 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.”

§600.410(d). Competitive contracting process. Missing from the competitive contracting process is a requirement that a state adopts Medicaid or Exchange standards for network adequacy and essential community providers. Network adequacy has been identified as a critical issue in the new health insurance marketplaces, and has long been a concern in Medicaid managed care plans.² If networks do not have sufficient available providers, enrollees’ geographic access, ability to see appropriate providers and waiting times are compromised. DHHS has recognized the seriousness of this issue in the Exchange, and issued guidelines that require QHPs to meeting minimum network adequacy standards³ when implementing the federal regulation, which requires sufficiency in number and type of providers, including “essential

² 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.

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

community providers.” In addition, detailed network adequacy standards apply to Medicaid managed care plans, intended to assure access to care for vulnerable individuals.⁴

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.” However, 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. Therefore, 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.

§§ 600.410 and 600.415. Contracting process and contracting qualifications. More generally, we in New Jersey, join our consumer advocates in other states to request that the regulations be amended to provide flexibility for states that administer Medicaid through the PCCM to participate in the BHP (even though New Jersey does not do so at this time). As proposed, the regulations would make it impossible for those states that administer Medicaid through 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, this provision would still severely undermine the basic BHP goal of encouraging continuity of care with the Medicaid program, ACA §1331(c)(4). This is the case, 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 for low-income consumers. In addition, to ensure access to a broad range of providers, the HHS must strengthen contracting standards and incorporate a nondiscrimination provision to prevent any attempts to unfairly exclude or restrict specific providers from the BHP.

Specifically, **pursuant to §600.415**, the only choices for an “offeror,” which a state may contract with, are insurers, licensed and unlicensed HMOs, and a “network of health care providers.” Under PCCM, states contract individually with medical practices to coordinate care for their Medicaid patients; they do not contract with an entire network of providers pursuant to one large contract. While the proposed regulations should be revised to provide that contracting with individual practices that meet stringent medical home requirements under a PCCM system

⁴ 42 C.F.R. §§ 438-206-438.208.

inherently meet 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.

If some detail as to the activities of a contracted ASO to render them qualified as an offeror in a PCCM state is deemed necessary, we recommend that the ASO 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; and
- Assisting practitioners with intensive care management for more complex patients; or
- Providing disease management to enrollees; or
- Conducting utilization reviews when submitted by the PCCM providers or others; or
- Providing customer service to enrollees.

A second problem with §600.415, as currently drafted, is that it does not provide adequate protections for providers and will allow states to adopt laws or policies to ban certain providers from contracting with standard health plans. It appears that the proposed rule will allow states to disregard an important nondiscrimination provision that applies to QHPs; such nondiscrimination clause is critical to ensuring robust provider networks and patient access to trusted safety-net providers. Accordingly, in addition to the Essential Community Provider (ECP) standards and network adequacy provisions included in the proposed rule, we strongly urge the Department to require standard health plans to meet the nondiscrimination standard embodied in 45 CFR §155.1050(c). This important protection prevents states or Exchanges from adopting laws or policies that would prohibit an issuer from contracting with an ECP, and is specifically designed to prevent attempts to unfairly exclude or restrict certain providers – including women’s health providers and family planning providers – from plans offered in the Exchange. This provision is equally applicable to BHPs and equally essential to ensuring reasonable and timely access to a broad range of providers. Unfortunately, without a nondiscrimination provision, states may believe themselves free to impose restrictive policies as well as any BHP.

In addition, 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 do not submit sealed bids and do not engage in price competition. Nonetheless, since they are required to satisfy 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, which assists the PCCM practices and contracts with the state through a competitive bidding process, to meet this requirement, especially if such contract was previously in place under Medicaid.

More generally, we suggest broadly defining what constitutes competitive contracting to encourage development of innovative models of care delivery. Specifically, we recommend initially dropping the “two responsible bidders serving a local health care market” standard to enable states to pursue innovative delivery system reform. Under community-based coordinated care-global budget models and other kinds of ambitious efforts, it may take time for several competitors to emerge. Many providers are still standing on the sideline, hoping to let others take the risks. 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.

§600.420 Enhanced availability of Standard Health Plans. We suggest that the regulations be amended to explicitly provide flexibility for states to develop either a single benefit package offered by different carriers or a single offeror of coverage providing different plans. We are concerned that the proposed language of §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 authorizing statute is inclusive and permits the latter. In the interest of state flexibility to create choice that is most beneficial to BHP consumers, we recommend that both options be available.

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. We believe that such a position is consistent with Section 1331 of the ACA. Specifically, 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 in contrast to multiple offerors of the same plan. The definition of “Standard Health Plan” in §1331(b)⁵ also leaves the same ambiguity. The first clause of the definition is “a health

⁵ (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.

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 includes phrases 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 consumers 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 adding administrative costs. On the other hand, another state may best serve consumers by creating an efficient BHP that maximizes continuity of care. For example, 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 were it to be extended to BHP enrollees.

In addition, some states, like New Jersey, are trying to fix 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 consumers. The statutory language must contain the flexibility to allow states to make this

determination in light of what is most desirable given the local healthcare and financing landscape. 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.

§600.520(c)(3). Cost-sharing protections. As a policy matter, we suggest that the regulation be amended to clarify that cost-sharing subsidies are to be administered in a manner that is invisible to the consumer. We appreciate the government’s sensitivity to consumer concerns regarding the administration of cost-sharing by requiring that states ensure that consumers are not held responsible for monitoring cost-sharing reductions. However, 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 only then be required to seek reimbursement of the subsidy. We know that all BHP enrollees will qualify for these reductions; accordingly, there should be no reason to administer the cost-sharing in such a complicated manner.

§600.525. Disenrollment and Consequences for Nonpayment of Premiums. We emphatically urge that the regulations specify that states are not permitted to terminate coverage of BHP enrollees who fail to pay a *de minimis* part of their premium payment. 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 and would be counterproductive.

§600.605. BHP Payment Methodology. For the following reasons, we believe that the federal BHP payment should be 100 percent of the cost-sharing reduction for which the eligible individual would have qualified in the Exchange. 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 cost-sharing reductions *to the enrollee* (sometimes referred to as “actuarial boost”) at least equivalent to what they would have received in an Exchange silver plan. States have no discretion (nor should they) to negotiate or bargain with enrollees to lower these reductions; they must provide 100% of them to enrollees.

Under the proposed rule, states receive only 95% of these funds from the federal government and are thus left to finance the other 5% from the BHP trust fund.⁶ However, the only other money in the BHP Trust Fund derives from the 95% premium tax credits. The inescapable conclusion is that states must use some of its tax credit money to compensate for insufficient cost-sharing dollars. So, the tax credits available to a state to purchase standard health plans would be *less than* 95% of the tax credits, possibly making a Basic Health program prohibitive. For 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 consumers --- states need to receive 100 percent of the cost-sharing reductions for which BHP enrollees would have been eligible 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 [...].

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, receive 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).

§600.705(d). BHP Trust Fund. We understand that BHP funds may not be used for administrative costs, but we would appreciate regulations and/or guidance that provides states with explicit options for paying the administrative costs of a 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. Assisting states in

⁶ Advocates estimate this amount to be in the range of \$3-6 per member per month.

identifying 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.

In sum, while the proposed regulations are a positive step toward implementing the ACA, there are some provisions that should be strengthened and/or clarified in order to sufficiently protect low-income consumers. In specific, NJ for Health Care Campaign approves all steps that give maximum flexibility to states so as to design its BHP to accommodate local circumstances, especially its current administration of Medicaid and its efforts to reform the delivery of health care received by such enrollees. The explicit purpose of the ACA is to improve insurance coverage, affordability and quality of services. The BHP may be the only real alternative for low wage workers who are not eligible for Medicaid, and the federal government must take all steps necessary to facilitate state adoption of the program.

On behalf of New Jersey consumers, we look forward to regulations that provide access to affordable coverage for New Jerseyans and facilitate New Jersey adopting the BHP.

Respectfully submitted,

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