National
Family Planning
& Reproductive Health Association

October 29, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9995-IFC2
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-9995-IFC2
Comments on the Centers for Medicare & Medicaid Services' Interim Final Rule
Changes to Definition of "Lawfully Present" in the Affordable Care Act of 2010

Dear Sir/Madam:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the Centers for Medicare & Medicaid Services (CMS) Interim Final Rule changes to the definition of "lawfully present" in the Affordable Care Act (ACA).

NFPRHA is a national membership organization representing the nation's family planning providers — nurse practitioners, nurses, administrators and other key health care professionals. NFPRHA's members operate or fund a network of more than 3,700 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 49 states and the District of Columbia.

For the reasons discussed below, NFPRHA opposes the prohibition of health care coverage eligibility for individuals living and working in the US under the Deferred Action for Childhood Arrivals (DACA) policy. The change in the definition of "lawfully present" in the Pre-Existing Condition Insurance Plan (PCIP) program and the use of this definition in other provisions of the ACA (including the health insurance exchanges, the health insurance premium tax credits, Medicaid, and the Children's Health Insurance Program (CHIP)) is discriminatory and will result in reduced access to family planning and other vital preventive health services for young immigrant women and men. Moreover, the decision lacks policy justification and undermines the goals of the ACA. NFPRHA urges you to reconsider the decision and allow those immigrants granted deferred action under DACA to participate in the coverage options available under the ACA.

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1) <u>The Interim Final Rule will significantly limit immigrants' access to sexual and reproductive health care.</u>

NFPRHA believes that a person's immigration status or ability to provide citizenship documentation should not have any impact on their ability to access affordable, confidential, high-quality family planning and other health care services. Currently, immigrant women and men face significant health care access challenges that adversely impact their health. According to the Kaiser Family Foundation, "Of the 11 million low-income non-citizens, 60 percent had no health insurance in 2001 and only 13 percent received Medicaid."[1]

The administration's decision will significantly limit immigrants' access to comprehensive, quality, and affordable preventive health care. Under the ACA, every insured individual is guaranteed access to a basic set of preventive health services designed to reduce health care costs and improve public health. The ACA makes tremendous advances in women's health, including requiring coverage of maternal and newborn care in health plans offered in the exchanges and access to preventive care, like contraception, cervical cancer screenings, and sexually transmitted disease (STD) screenings, at no additional cost to the patient. The decision to deny those eligible for DACA access to the ACA's health coverage will present a significant barrier to health care. Other coverage options currently available to immigrant women, including the "unborn child" option under CHIP and Emergency Medicaid, do not provide comprehensive insurance coverage for a full range of health care services.

Currently, a majority of female immigrants do not have health care coverage and are less likely than their US-born counterparts to receive adequate reproductive health care, including cervical and breast cancer screening and treatment, family planning services, and HIV/AIDS testing and treatment. Current obstacles take a toll on the health of immigrant women and widen health disparities. For example, while cervical cancer has been on the decline for US-born women, it has been on the rise for immigrant women.[2] Research indicates that the disease can be prevented through routine gynecological care and is highly treatable when caught early. The decision to deny DACA-eligible women coverage could exacerbate this costly health disparity.

Lack of health insurance and high out-of-pocket costs are cited as the main factors limiting immigrant women's access to preventive health care, including reproductive and sexual health care.[3] The Interim Final Rule reinforces barriers to health care for immigrants and their families, which could have damaging consequences on their health and overall quality of life.

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[1] Kaiser Commission on Medicaid and the Uninsured, *Immigrant's Health Care Coverage and Access*, accessed October 2012, http://www.kff.org/uninsured/upload/Immigrants-Health-Care-Coverage-and-Access-PDF.pdf.

[2] American Congress of Obstetricians and Gynecologists, *Health Care for Undocumented Women*, accessed October 2012, http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co425.pdf?dmc=1&ts=20121018T1458085508.

[3] Ellen Schleicher, MHS, *Immigrant Women and Cervical Cancer Prevention in the United States*, Women's and Children's Health Policy Center, Johns Hopkins Bloomberg School of Public Health, accessed October 2012,

2) The Interim Final Rule contradicts the goals of the ACA.

The Interim Final Rule runs counter to one of the primary goals of the ACA – to expand access to affordable health coverage to millions of currently uninsured individuals. The decision to prohibit ACA coverage for individuals granted deferred action under DACA could result in poor health outcomes for vulnerable immigrant communities that already experience significant health disparities.

Non-citizen immigrants have much more limited access to private health insurance compared to their US-born counterparts. In 2010, only 39% of non-citizen immigrants had access to private coverage compared to 64% of naturalized citizens and 64% of US born citizens.[4] Moreover, non-citizen immigrants traditionally lack employer-sponsored coverage, which contributes to their high uninsured rates.[5] In 2011, the uninsured rate for US-born citizens was 12.4% compared to 47.4% for non-citizens.[6]

Immigrants who will gain DACA status will be between the ages of 15 and 30, a key demographic in need of the full range of preventive reproductive and sexual health services in order to be productive and healthy. Expanding access to health coverage will help DACA-eligible individuals avoid negative health consequences (like cervical cancer, STDs, and unplanned pregnancies), establish healthy habits, and experience long-term positive health outcomes.

3) The Interim Final Rule will lead to higher health care costs and burden the health care delivery system.

Excluding individuals granted deferred action under DACA from the coverage options under the ACA does not eliminate their health care needs. The rule serves only to ensure that those young adults attending school, working, and contributing to society will remain without a regular source of care. Instead of being able to access services they need to maintain good health, those granted deferred action under DACA will be forced to go without affordable care. They will seek health services in high-cost hospital emergency rooms, potentially shifting the costs of their care to health care providers and local and state governments. Others may have to

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http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/ImmigrantWomenCerCancerPrevUS.pdf.

[4]Kaiser Commission on Medicaid and the Uninsured, *Connecting Eligible Immigrant Families to Health Coverage and Care: Key lessons from Outreach and Enrollment Workers*, accessed October 2012, http://www.kff.org/medicaid/8249.cfm.

[5] Thomas C Buchmueller, et al., "Immigrants and Employer-Sponsored Health Insurance," *Health Services Research* 42 (February 2007): 286-310. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955235/.

[6] U.S. Census Bureau, *Health Insurance Coverage Status and Type by Citizenship Status*, accessed October 2012, http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_B27020&prodType=table

unfairly pay out-of-pocket for services or even go without care. Ultimately, health care costs for these individuals, as well as costs to the overall health care system, will remain high and could lead to poor health outcomes and increased health disparities.

Instead of creating a more streamlined eligibility and enrollment system under the ACA, the Interim Final Rule will also introduce additional complexity in eligibility rules and confusion for state agencies, eligibility workers, and patient navigators. Excluding DACA-eligible individuals from aspects of the ACA will exacerbate the confusion as states reach out to immigrant communities to encourage them to enroll. States already working to implement outreach and enrollment systems for the coverage expansions will be forced to waste resources enforcing a policy that unnecessarily places a distinction between those granted deferred action under the DACA process and those granted deferred action on other grounds who may be eligible to access benefits under the ACA.

The Interim Final Rule creates a patchwork of maternity coverage options for immigrant women across the states and places further strain on an already-stressed safety net. Currently, only 15 states offer immigrant women coverage under the "unborn child" option in CHIP.[7] Access to safety-net programs or state-based health care options for immigrants varies widely from state to state, and these programs have been greatly strained due to budgetary cuts and increased demand.

The decision to prohibit access to coverage for immigrants living in the US under DACA makes little economic or public health sense. The passage of the ACA was an important step toward ensuring health care access for all and reducing health disparities. CMS should reverse course and allow individuals residing in the US under DACA to participate fully in the coverage benefits under the ACA.

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NFPRHA appreciates the opportunity to comment on CMS' Interim Final Rule. If you require additional information about the issues raised in this letter, please contact Nicolette Paterson at npaterson@nfprha.org or 202-293-3114.

Sincerely,

Robin Summers,
Senior Policy Director

[7] Families USA, *Covering Pregnant Women: CHIPRA Offers a New Option*, accessed October 2012, http://familiesusa2.org/assets/pdfs/chipra/Covering-Pregnant-Women.pdf.