Georgetown University Health Policy Institute
Center for Children and Families

October 31, 2011

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2349-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on CMS' Proposed Rule on Medicaid Eligibility Changes under the Affordable Care Act of 2010 -- File Code CMS-2349-P

RE: Comments on Proposed Rule on Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers – File Code CMS-9974-P

Dear Secretary Sebelius:

We appreciate the opportunity to comment on the proposed rules, cited above, issued by the Department of Health and Human Services relating to the eligibility and enrollment of individuals into health coverage under the Affordable Care Act (ACA) through Medicaid and Exchanges. As you know, these rules are critically important to ensure the successful implementation of the Affordable Care Act and they represent a significant step forwards to the goal of ensuring that all eligible persons secure coverage. We commend you and your staff for all of the hard work and good thinking that has gone into their development.

Georgetown University's Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. We have attached a lengthy set of specific comments on the proposed rules, but we would also like to share a few general thoughts at the outset and highlight some of the issues that we believe are most important from the perspective of ensuring that children and families are able to access health coverage. Because it will be so critical for exchanges to function smoothly in tandem with states' Medicaid and CHIP programs we are submitting our comments on these two rules together.

Please note that under separate cover we have submitted extensive comments on how all three proposed rules will affect immigrant and/or mixed status children and their families.

1. **Provide stronger federal oversight.** The proposed Medicaid and Exchange rules outline an ambitious vision for simple, unified eligibility determination procedures, but provide little or no detail on how HHS will ensure that states follow the proposed procedures. To make the new eligibility and enrollment systems work for families, it is critical that states actually adhere to the federal requirements. Unfortunately, it is well-known that some states may be willing to disregard the requirements in the absence of appropriate oversight. Indeed, HHS acknowledges

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as much when describing its proposed redetermination procedures, noting that it long has been required that states rely on existing data to the maximum extent feasible, but that this is not always the practice in reality.

**RECOMMENDATION:** The final Medicaid and Exchange rules should include specific details on HHS's plans for reviewing state compliance with the proposed federal requirements. We recommend that these plans include mechanisms for consumer advocates to provide information to CMS on the status of state compliance with federal requirements. We also encourage HHS to modify federal audit tools (such as PERM) to ensure states are evaluated based on the extent to which they correctly enroll eligible people in coverage, not just on whether they deny Medicaid and CHIP to people who do not qualify.

2. **Ongoing consultation with families, child advocates and policy experts.** We are aware that CMS has many existing and ongoing methods for seeking feedback from state officials as regulations and other guidance are developed to implement the ACA. We believe it is equally important for CMS to develop robust mechanisms to receive ongoing feedback from families, child advocates and other policy experts as well.

   We believe that the best outcome will be achieved if CMS conducts a transparent and inclusive process to finalize these regulations as well as future guidance and implementing regulations for the Affordable Care Act.

   **RECOMMENDATION:** CMS should convene regular working sessions with consumer advocates to obtain their feedback on proposed guidance and regulations implementing the ACA.

3. **Retain and strengthen simplifications to the application and renewal process for Medicaid and CHIP.** A key measure of the success of the ACA will be whether it promotes the enrollment of the close to two-thirds of uninsured children who already are eligible for Medicaid or CHIP. States have made considerable progress in recent years in streamlining their enrollment and renewal processes. The proposed rule builds on many of these best state practices by requiring states to use a single, streamlined application for all affordability programs that can be submitted online, over the phone, by mail, or in-person and relies on electronic verification of data to the maximum extent practicable. We strongly support the emphasis in the rule relating to streamlined renewal procedures such as the requirement for states to use a 12-month renewal period as many children lose coverage during the renewal process.

   **RECOMMENDATION:** The final Medicaid rule should retain and strengthen the simplification measures included in the proposed Medicaid rule. In particular, we encourage HHS to retain the use of 12-month renewal periods and the other proposed redetermination procedures provided for in §435.916. These policies

have a well-documented history of promoting continuity of coverage for children and should be used in all states and extended to other populations. We also recommend that the final rule explicitly indicate that face-to-face interview requirements are not allowed. While the preamble to the Medicaid rule suggests this will be case, the requirement is not actually included in text of the rule itself.

4. **Provide clearer and strong guidance on the circumstances under which states must use electronic verification of data.** Under the ACA, States must rely on electronic verification of data to the "maximum extent practicable" when evaluating eligibility. In both the Medicaid and Exchange eligibility rules, it is proposed that states must verify someone's eligibility for coverage by *first* gathering data from electronic sources. These data sources included a federal data "hub" that HHS will be establishing and state databases, such as those used to collect wage information for unemployment insurance programs. States can request additional documentation from applicants only if no electronic data are available or the data are "not reasonably compatible" with someone's stated circumstances. If implemented as intended, these provisions would mean that people will no longer will be unnecessarily required to bring in, mail, or fax copies of their pay stubs and other documents. The proposed rules, however, provide no detail on what constitutes "reasonably compatible" data, opening up the prospect that states reluctant to enroll people in coverage will adopt a state-defined standard that discourages enrollment in coverage. Also, in the proposed Medicaid rule (see §435.948), HHS appears to create a loophole in electronic verification requirements by allowing states to gather data from other agencies only to "the extent the [Medicaid] agency determines such information is useful."

   **RECOMMENDATION:** In the final Medicaid and Exchange rules, HHS should establish minimum standards for when states must collect and use data to verify eligibility electronically. For example, states should be prohibited from disregarding electronic data because it is not current as long as it reflects someone's recent circumstances as defined by the federal government with state flexibility to adopt a longer time frame (e.g., within a period of up to four months or more). They also should be required to use income data even if it deviates from someone's stated circumstances as long as it falls within a target threshold specified by CMS (with state flexibility to establish a broader target range). And, states should be prohibited from denying coverage to someone on the basis that the electronic data match is not "reasonably compatible" if the electronic data match and the person's attestation indicates eligibility. Finally, we recommend dropping the language that would give states unlimited discretion to determine it is not "useful" to check with various databases.

5. **Adopt a family-based affordability test that does not discriminate against married couples and families with children.** We are deeply concerned that the proposed Treasury rule excludes families from advance premium tax credits if they have access to employer-based coverage even when such coverage would cost more than 9.5 percent of income. We have commented on this rule under separate cover

but wish to make mention of it here since this issue is of utmost importance to children and their families.

**RECOMMENDATION:** At the very least, the rule should apply the 9.5 percent of household income threshold to the cost of "family", not "self-only," coverage.

6. **Address the issue of families facing a "double premium hit" for their children.** The proposed rules will leave many families with children facing multiple, additive obligations when it comes to paying insurance premiums if they happen to have a child eligible for CHIP (or, in some circumstances where premiums apply, Medicaid). These families must pay to purchase full family-based coverage on the Exchange *and* in 30 states CHIP premiums are required for their children. The amount they are expected to pay for their Exchange coverage is not adjusted in any way to reflect that they also have premium obligations for CHIP for their children.

   **RECOMMENDATION:** The final rules should eliminate the prospect of families facing a "double hit" when it comes to paying premiums for coverage for their children. In particular, we encourage the Treasury Department to determine if it has the discretion to take into account existing premium obligations, such as for CHIP, when evaluating the size of a family's required contribution to Exchange coverage under advance premium tax credit calculations. In addition, we encourage HHS to evaluate whether it can allow or even require states to waive the CHIP premium obligations of families whose expected contribution to Exchange coverage fails to take into account that their children already are insured through CHIP.

7. **Eliminate waiting periods in CHIP.** The proposed Medicaid rule fails to address the issue of waiting periods in CHIP (i.e., minimum lengths of time during which children must be uninsured before they can enroll in coverage). In general, waiting periods no longer make sense in a post-ACA universe in which everyone is expected to enroll in coverage and, indeed, can face penalties for failing to do so. Moreover, if states are allowed to continue to impose waiting periods, it will exacerbate the problem of families being excluded from advance premium tax credits based on a self-only test. Parents hit by this nonsensical policy not only will be unable to secure a tax credit for themselves, but they may also be forced to see their child(ren) go without coverage during a CHIP waiting period.

   **RECOMMENDATION:** We recommend that the final Medicaid rule eliminate waiting periods in CHIP. Many states already have taken this step, and it makes no sense in a post ACA world to require children to be uninsured for a specified period of time before they can secure insurance.

Thank you for your consideration of our comments. If we may provide further information, please contact Joan Alker or Jocelyn Guyer at 202/687 0880.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Parts 431, 433, 435, and 457
CMS-2349-P
RIN 0938-AQ62

**Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010**

**Part 431, Subpart A – Single State Agency**

**§431.10 – Single State Agency**
We generally support the provision that permits Medicaid agencies to enter into agreements with the Exchange to determine Medicaid eligibility with the caveat that the Medicaid agency continues to make the rules and regulations that are binding on the Exchange and other state agencies that administer the plan. There are several areas where this provision could be strengthened.

**§431.10. Stronger standards needed for "co-location of Medicaid eligibility workers.**
While not explicitly addressed in the proposed rule itself, the preamble indicates that HHS is considering giving states the option of using "co-location" of Medicaid workers to comply with the merit protection principles outlined in §431.10(d)(5). If HHS retains this as an option, we strongly encourage the agency to provide far more expansive and meaningful standards for what constitutes acceptable "co-location" options. In particular, we have found in the past that states sometimes use co-location to comply with the letter of the law, but not with its spirit. For example, some states have just one or two eligibility workers on sites where a private contractor is processing huge numbers of applications. In these situations, the co-located workers are simply token representatives.

> **RECOMMENDATION:** We encourage HHS to include a provision in the final rule that outlines specific standards for ensuring that co-located workers play a meaningful role in eligibility determinations and providing some guidelines for adequate staffing levels.

**§431.10(c)(3)(ii). Explicitly ban any fiscal incentives for contractors to take actions that discourage enrollment.**
It is somewhat unclear what role, if any, HHS is envisioning private contractors playing in the eligibility determination process. As noted above, we believe that eligibility determinations for affordability programs are inherently governmental in nature. To the extent that the final rule does allow private contractors to play some role in eligibility determinations, we strongly encourage you to add a provision that explicitly says that they cannot offer fiscal incentives to their workers or any subcontractors that discourage enrollment. §431.10(c)(3)(ii) begins to address this issue by calling for "no conflict of interest by any agency delegated the responsibility to make eligibility determinations," but does not clearly apply to any contractors that may be playing a role in eligibility determinations.

**RECOMMENDATION:** Along with expanding the scope of this provision, we encourage HHS to add a clause making it clear that a conflict of interest would include any fiscal incentives to minimize enrollment or take other actions to discourage eligible people from securing coverage.

**§431.10(c)(3)(iii). Strengthen language on need to "guard" against improper incentives/outcomes.** The proposed rule requires states to "guard" against improper incentives and outcomes.

**RECOMMENDATION:** We support stronger language that clearly establishes that such incentives and outcomes are not permitted and that requires states to monitor and promptly address such issues.

**§431.10(c)(3)(d). Strengthen oversight of states' supervision of county offices/other designees for eligibility determinations.**

The proposed rule requires states to conduct oversight of local agencies and other designees charged with conducting Medicaid determinations. This new language is very similar to language already included in §435.903, which has never been enforced. To make the new language meaningful, it is important that CMS include a review of compliance with this provision in its own oversight and audits of states. For example, compliance with this provision could be included in the performance standards that HHS has indicated it is developing for the new eligibility systems.

**RECOMMENDATION:** Strengthen oversight of state supervision of their offices/other designees for eligibility determinations.

**Part 433, Subpart E – Methodologies for Determining Federal Share of Medicaid Expenditures for Mandatory Group**

All states will receive enhanced federal financial support for the coverage of those determined "newly eligible" and enrolled under the Medicaid program expansion beginning in 2014. States are required to partner with CMS in developing a method for determining what proportion of Medicaid expenditures should be matched at the enhanced federal rate. CMS intends to evaluate proposed methods according to a strong set of principles including: that no allowable method will establish a shadow eligibility system; that no allowable method will reflect a systematic bias towards either the state or the federal government; that all allowable methods will limit administrative burden and cost; and, that all allowable methods will be applied transparently using sufficient data. We support these principles. Our specific comments below are intended to clarify the regulatory language to ensure that these principles are upheld.

In addition, we encourage you to adopt the principle that allowable methods shall not require beneficiaries to provide information during the application process that is not specifically needed to evaluate their eligibility for coverage under the new eligibility rules for Medicaid. For example, people should not be required to provide information on their assets because a state wants this information to evaluate the appropriate matching rate, including under the "threshold methodology" (see more detailed comments on this issue

below). Such a principle goes beyond "limiting" administrative burden on beneficiaries and allows them to fully benefit from the simplifications promised by the Affordable Care Act.

**§433.204. The definition of "newly eligible" in §433.204 and the "expansion state" definition in §433.10(8)(iii) should be consistent with the statutory definition of "newly eligible."**

The "newly eligible" definition included in this section of the proposed regulations is different than the statutory definition. As a result, certain states could receive less in federal matching payments for "newly eligibles" than is intended in the law. We strongly recommend that the definitions for determining federal Medicaid matching payments conform to the statutory definition.

Under the statutory definition of "newly eligible," in order to qualify for full federal funding, adults could not have been eligible for coverage under either a state plan or a waiver for full or benchmark-equivalent coverage as of December 1, 2009. Additionally, if the state had a cap or freeze in enrollment, those who were eligible, but not enrolled in coverage as a result of these policies, would be considered "newly eligible."

In §433.204 of the proposed regulations, the "newly eligible" definition does not include the reference to the benefit standards or enrollment caps. Due to this disconnect, certain states could have Medicaid enrollees who are considered "newly eligible" under the statutory definition for whom they receive only the regular Medicaid matching rate as opposed to the matching rate appropriate for "newly eligibles" – either the enhanced matching rate in the case of a non-expansion state or the transition matching rate in the case of an expansion state. For example, Utah operates a Medicaid §1115 waiver program – the Primary Care Network (PCN) – that offers limited benefits to low-income adults and parents. Although adults in Utah enrolling in the ACA Medicaid expansion would be considered "newly eligible" under statute because they were not eligible for coverage through an existing comprehensive benefit plan, under the proposed regulations the state would not receive the enhanced federal matching payment for coverage of these adults.

Of additional concern, the "newly eligible" definition in this section when viewed alongside the definition of an "expansion state" at §433.10(8)(iii) creates the potential for certain expansion states to receive only the regular matching rate for all those determined "newly eligible" under statute. At §433.10(8)(iii), the criteria defined for an "expansion state" include that the state offer a benefit meeting the benchmark benefit standard. A state such as Utah that has expanded coverage for adults, but with a lesser benefit would not qualify as an expansion state, but the adults eligible for the limited benefit program also would not be deemed "newly eligible" for the purposes of the matching rate. Thus, the state would receive neither the transitional matching rate appropriate to an expansion state nor the enhanced matching rate appropriate to "newly-eligible" coverage, but instead would receive only the regular matching rate for their expansion population.

Neither definition (§433.204 and §433.10(8)(iii)) includes the reference to enrollment caps or freezes. Therefore, in states like Utah where the PCN programs is closed and not

accepting applications, those excluded from coverage as a result of such policies would not be considered "newly eligible" as specified in the statute, and their coverage would only be matched at the regular rate.

> **RECOMMENDATION:** We recommend that both the "newly eligible" definition in §433.204 and the "expansion state" definition in §433.10(8)(iii) conform to the statutory definition of "newly eligible" at § 2001 (a)(3)(B) of the Affordable Care Act. Namely, the definitions should take into account adult status (age over 18), should require the benefit package of an existing expansion program to at least meet the benchmark benefit standard, and should require that applicants are not excluded from coverage due to capped or limited enrollment.

**§433.206(a). Apply a single "hybrid" methodology to be used by states in apportioning the appropriate FMAP.**

The regulations envision permitting each state to choose from multiple, federally-approved methods for determining what proportion of their Medicaid expenditures is for "newly-eligible" individuals and thus should be matched at an enhanced rate. We are concerned this creates unnecessary complexity for both states and the federal agency.

We recommend a hybrid method for the "newly eligible" determination that would be used by each state. In the first three years of the Medicaid expansion – 2014 through 2016, states would use the proposed "threshold method" (incorporating our recommendations below) to determine those "newly eligible." Then, in 2017 and years thereafter, the federal government would coordinate the "proportions methods" (also incorporating our recommendations below) using the data gathered from a state's unique experience in the previous three years. This hybrid model would allow each state to establish high-quality benchmark data based on its own application of former and current Medicaid eligibility standards, while then establishing an ongoing process coordinated by the federal government that would reduce the administrative burden on the state. Acknowledging that there may be demand among the states for flexibility in choosing their methodology, we also will comment on each of the individual methods suggested in the regulations.

> **RECOMMENDATION:** We suggest that a single method (a hybrid approach based on two of the methods – the "threshold method relying on MAGI" and the "proportions method" – suggested in the regulations) be used for all states.

If the final rules, however, allow a choice of methodologies, it is important that states be required to use alternative ways to obtain information rather than requiring applicants to supply additional information for the purpose of the matching rate determination. Doing so would complicate the application process in direct conflict with the principles articulated in the preamble. While the regulations do speak to this issue at §433.206(d), we recommend that this language be strengthened to ensure that applicants are not unduly burdened, cross-referencing the standards of a streamlined application at §435.907(b). Instead of requesting any documentation, electronic data matching should be used to the fullest extent possible in acquiring necessary information, as specified under §435.949. Beneficiaries should not be asked to submit additional documentation for the purposes of determining the matching rate that is not required for an eligibility determination.

**RECOMMENDATION:** Strengthen §433.206(d) by reinforcing the requirements to not unduly burden applicants with a cross-reference to §435.907(b) and to rely on data matching as required under §435.949. Regardless of which method a state uses, applicants should not be asked to submit any additional documentation for the purpose of determining the matching rate.

**§433.206. Define a more specific timeline for approval of the methodology and ensure a public and transparent process that seeks stakeholder input.**

The regulations envision that CMS will coordinate and communicate with each state to arrive at an acceptable "newly-eligible" determination method. If CMS allows states to choose among methodologies, we are concerned that timelines for this process are undefined, or otherwise inappropriate. For example, at §433.206(b) the regulations require a state to submit for approval the "newly-eligible" determination method it will use at least two years prior to the method's implementation. This seems reasonable and allows time for communication between CMS and the state over the details of the method, and time for the state to develop the administrative structure necessary to implement the method. However, the regulations do not establish a timeframe for CMS' approval of the method.

**RECOMMENDATION:** We recommend an adjusted and better-defined timeframe for communication between CMS and the states with regard to the "newly-eligible" determination method. If permitted a choice of methods, a state should report to CMS its method choice at least two years prior to the date it would be implemented as required under the proposed regulations. CMS should be then responsible for approving or denying that choice within a 90-day period. If CMS requires more details on the methodology to assess its feasibility and validity or adjustments to the proposed methodology, a state should be required to submit that information one year prior to the method's implementation to allow for negotiation between the state and federal government. CMS and the state should arrive at agreement no later than six months prior to the implementation of the method to allow time for the state to develop the administrative structure necessary for implementation.

**RECOMMENDATION:** Given the significant budgetary and beneficiary implications, the negotiations between states and CMS on the proposed methodological approach should be public (including any documents submitted by the state and any questions posed by CMS in response). In addition, the process should allow for input from beneficiaries and consumer advocates to ensure that the proposals do not unduly burden applicants.

If CMS were to establish an effective method for evaluating, negotiating, and approving a state's "newly-eligible" determination method in a timely manner, then we support the policy in §433.206(b) that states must use an approved method for a minimum of three years. This will create stability and reduce the administrative complexity of the "newly-eligible" determination process, as well as allow adequate time for the full evaluation and approval of a new approach, if a state so chooses.

**§433.208. Revise the threshold methodology.**
Should the final regulations permit states to use the "threshold method," either independently or in conjunction with the "proportions method" in a hybrid form as we recommend, we support several revisions to the regulatory language that describes the standards a state must meet in gathering information.

We recommend the regulations grant states the explicit option to use MAGI-equivalent standards in evaluating eligibility under the "threshold method." The preamble language suggests this as an option, but the regulatory language does not. While not fully defined, the MAGI-equivalent standard should appropriately take into account disregards and deductions that states use in determining Medicaid eligibility currently. Those with MAGI between the MAGI-equivalent standard for current eligibility and the Medicaid expansion eligibility standard would be deemed "newly eligible," assuming that they met the assets and disability status standards. States using this option would accomplish the stated goal of providing a simplified eligibility assessment using available data.

> **RECOMMENDATION:** States should have the explicit option to use MAGI-equivalent standards in evaluating eligibility under the "threshold method."

> **RECOMMENDATION:** As mentioned in our comments on §433.206, should another "threshold" (instead of the MAGI-equivalent standard) be proposed by the states, we recommend that the language in this section explicitly require states to gather all necessary supplemental information through electronic data matching or other processes that require no additional information from the applicant or applicant filer. Beneficiaries should not be asked any additional questions for the purpose of determining the matching rate that are not required for an eligibility determination.

The preamble language indicates that states should not consider their medically needy coverage category in the "newly-eligible" determination. However, the regulations at §433.208(a)(1) are not clear in this regard, instead requiring states to "incorporate state eligibility standards, including disregards and other adjustments that were in place in the State on December 1, 2009." We are concerned that without explicit direction to the contrary states may interpret this language to require that they evaluate eligibility under the medically needy coverage category for the purpose of the "newly-eligible" determination.

> **RECOMMENDATION:** We recommend that the regulatory language explicitly indicate that an evaluation of eligibility under the medically needy category is unnecessary.

The regulations request comment on whether or not asset holdings should be considered under the "threshold method" for "newly-eligible" determination. We would suggest that only income eligibility and not asset information be considered in comparing individuals' eligibility against the December 2009 criteria. While not considering assets may make someone who would otherwise be "newly eligible," eligible under the pre-reform levels, doing so would simplify the process for both states and beneficiaries. States are not allowed to take assets into account under §2002(a)(14)(C) in determining eligibility;

therefore they will no longer be requesting such information or verification from the families as a regular step in the eligibility determination process. As such, requiring it for determining the matching rate would place an undue burden on families and states, especially as a significant portion of low-income individuals likely do not have assets in excess of those thresholds.

> **RECOMMENDATION:** We recommend that when comparing individuals' eligibility against the December 2009 criteria, only income eligibility and not asset information be considered.

The regulations request comment on whether or not disability status should be considered under the "threshold method" for "newly-eligible" determination.

> **RECOMMENDATION:** First, we recommend that the language explicitly require the state to inform an applicant of his or her right to ask for a full-eligibility determination, as opposed to the standard streamlined process, if they feel they might be eligible for a more comprehensive set of benefits if determined eligible under a disability category. We also recommend that, for the general purpose of the "newly-eligible" determination, applicants not have to provide any additional information on disability status but rather that the state pull from existing data.

Finally, CMS would require a state choosing the "threshold method" to receive CMS approval of the detailed methodology of its plan prior to implementation. However, we are concerned that CMS does not define a timeline by which states must submit the plan, nor by which CMS must grant approval. Please see our earlier comments on §433.206(b) for recommendations on the overall timeline.

**§433.210. Eliminate the statistically-valid sampling methodology as an option.**
The "sampling method" suggested in the regulations is unworkable. It threatens to create a scenario under which a state operates a "shadow eligibility system" thereby violating several of the core principles suggested in the preamble language. We strongly oppose the inclusion of the "sampling method" among the options available to a state for its "newly-eligible" determination method.

The "sampling method" would require states to complete, for a sample of the Medicaid enrolled population, a full-eligibility determination under both the former and current Medicaid eligibility standards in the state. We are concerned this would require the state (either during the application process or during a later "sampling period") to ask a more detailed set of questions of those enrolled under the new adult eligibility group in order to have the information necessary to complete both eligibility determinations. In addition, such an approach would likely require states to maintain their legacy eligibility systems in order to determine eligibility under their old rules or, at minimum, require additional rules in the upgraded system to make such a determination. Either approach would result in the state operating a "shadow eligibility system" and goes against the intent laid out in the preamble.

> **RECOMMENDATION:** Remove the statistically-valid sampling methodology as an option in apportioning FMAP in the final rule.

**§433.212. Clarify that the CMS established FMAP proportion methodology is based on expenditures not enrollment.**

The "proportions method" suggested in the regulations provides states a consistent and administratively simple means for their "newly-eligible" determination. Provided that CMS does solicit guidance from agencies and organizations with experience operating eligibility simulation models as suggested in the regulations at §433.212(c), we believe this is a feasible method. We encourage CMS to consider the Congressional Budget Office, the Urban Institute, and the Agency for Healthcare Research and Quality at HHS as credible sources of information on effective modeling techniques. Despite its potential feasibility, we have a concern related to the implementation of this method.

The "proportion" determined under this method for each state should be the health care expenditures for those identified in the modeling process as "newly-eligible" enrollees in Medicaid as a proportion of total health care expenditures for all those in the new adult Medicaid eligibility group. Although the regulatory language makes clear that the proportion will be based on expenditures (§433.212(c)(2)), the language in the preamble suggests that instead the proportion would be based on enrollment. We support a proportion based on expenditures and not enrollment because it is quite possible that Medicaid expenditures for the "newly-eligible" group will be different than for those adults eligible for Medicaid under current standards.

> **RECOMMENDATION:** If retained as an option, the final regulation should clarify that the proportion attributable to the "newly-eligible" will be based on expenditures, not enrollment.

While we support the use of MEPS, MSIS, and CPS data as the foundation for the implementation of the "proportions method," there are some serious concerns regarding sample size, especially for smaller states, in MEPS and CPS data. As a result, some of the modeling may be considered invalid by some states if based solely upon these data. So that the results are not rejected on the basis of insufficient data, CMS should work with experts to continue to investigate other potential national data sources (e.g., ACS) or state-specific data (e.g., enrollment and expenditure data following several years of implementation of the ACA) as suggested in the hybrid model described above.

> **RECOMMENDATION:** CMS should continue to explore other national data sources in applying the CMS-established FMAP methodology or the hybrid methodology recommended in these comments.

**Part 435 – Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa**

**§435.4. Definitions and use of terms supported.**

Caretaker relative - We support the codification of the definition of a *caretaker relative*. We also believe the specification that a relative does not have to claim a child as a tax dependent to be considered a *caretaker relative* is an important addition because it reflects the reality for many families.

Dependent child - We also support the codification of the definition of a *dependent child*. We welcome that HHS has codified the state option to: 1) eliminate the "deprivation" requirement altogether, and 2) reiterated that states can establish a higher number of working hours as the threshold for determining unemployment (if deprivation is considered).

Pregnant woman - We support the explicit inclusion of the "post-partum" period in the definition of *pregnant woman*. While this eligibility category exists in the statute, it was not previously mentioned in the regulations describing the mandatory categories of eligibility and is a welcome clarification.

**Subpart B – Mandatory Coverage**

**§§435.110, 435.116, 435.118. In consolidating eligibility groups, income standards for all groups should be converted to MAGI-equivalent standards, consistent with 435.603.**

We support the consolidation of existing mandatory and optional eligibility groups into three categories in 2014: parents and other caretaker relatives (§435.110), pregnant women (§435.116), and infants and children under age 19 (§435.118). However, states should be required to convert their minimum eligibility standard to a MAGI-equivalent standard to account for disregards and exclusions currently used by the state.

For each of the new eligibility categories, states are required to establish income standards in state plans using the minimum and maximum income tests set out in these regulations. Yet HHS is not requiring states to convert their minimum eligibility standards to a MAGI-equivalent standard. This means that states will not have to account for disregards that are currently employed in the state when determining the minimum income standard for MAGI-based Medicaid. As a result, individuals currently eligible under some of the mandatory categories will lose eligibility.

In the preamble discussion of these new eligibility categories, HHS indicates it considered whether or not states should convert the federal minimum income standards prescribed in statute to a MAGI-equivalent standard. HHS admits that doing so would maintain eligibility for individuals who may otherwise lose Medicaid due to the elimination of income exclusion and disregards under MAGI. But this would result in different minimum income eligibility standards applied across states and reduce eligibility simplification, and therefore HHS decided not to require conversion to MAGI-equivalent standards.

Yet in the preamble under Proposed Methods for Counting Income Based on MAGI, §435.603(e), HHS indicates that "to account for the general elimination of income disregards and to ensure continued coverage at pre-Affordable Care Act levels, per §2002(a), States will convert current income standards for eligibility groups under which financial eligibility will be based on MAGI to a 'MAGI-equivalent' income standard."

Therefore the proposed rules are inconsistent and contradictory. In one section, HHS requires states to convert income standards for eligibility to a MAGI-equivalent standard, while in another section it does not.

In addition, the "net equivalency" section of the ACA clearly requires states and the Secretary of HHS to establish an income equivalent test that ensures children eligible for Medicaid do not lose coverage. Despite this, HHS made a policy decision not to require states to convert their minimum eligibility standard to a MAGI-equivalent standard and does not believe the impact on eligibility will be significant. We do not agree with this and below we list the implications of HHS' decision on different eligibility groups.

> §435.110. Parents and other caretaker relatives - For parents and other caretaker relatives, HHS says if individuals in this category lose eligibility under section 1931 (if a state reduces coverage to the minimum permitted under the statute), these individuals will still retain eligibility under the new adult group. Yet we do not know what scope of benefits individuals in the new adult group will receive, making it difficult to assess the impact of this change. Important benefits may be lost for these individuals in states that choose to provide more restrictive benchmark plans to the new adult group.
>
> §435.116. Pregnant women - HHS notes that pregnant women would be affected if a state were to decrease its income standard to the statutory minimum level because the MOE for pregnant women ends in 2014 and there is no other coverage group to which affected pregnant women can be transferred. Therefore, HHS indicates a woman in this situation would "likely become eligible for advanced payments of the premium tax credit for enrollment through the Exchange." This will most likely mean a less generous benefit package and considerably more cost-sharing for low-income pregnant women. This is a serious concern which could result in pregnant women not being able to access needed care.
>
> §435.118. Infants and children under age 19 - HHS states that the impact to children will not be significant because eligibility standards for children must be maintained through September 2019, in accordance with MOE provisions. HHS adds that when the MOE expires, eligibility for "only a small number of children would be affected if a State were to drop coverage to the minimum level permitted." It is unclear what data HHS relied on to make this assumption.

Plus, as mentioned above, the ACA explicitly requires the Secretary of HHS to ensure that the income eligibility thresholds established using modified adjusted gross income and household income "will not result in children who would have been eligible for medical assistance on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance." Unlike the MOE provision which expires in 2019, this provision is not time limited. Therefore children are protected beyond the MOE and the proposed regulation is in conflict with the statute.

**RECOMMENDATION**: For all MAGI-based Medicaid categories, we recommend that HHS require states to convert their minimum eligibility standard to a MAGI-equivalent standard to account for disregards and exclusions currently used by the state. The ACA requires such a conversion for children. For uniformity purposes, and to ensure consistent results, the same should apply to all categories in this section. People who are eligible for Medicaid now should not be made worse off upon the implementation of health reform. This conversion should not be burdensome for the states, and some states may already be planning on a MAGI conversion for the purpose of determining the federal matching rate.

**§435.116(d). The option to provide a limited benefit package that only covers "pregnancy related services" should be eliminated.**

States will have the option of offering some pregnant women a limited benefit package that only covers "pregnancy related services." States are only required to cover full-scope Medicaid for women with income below the AFDC income standard in effect as of May 1, 1988, which is significantly less than 133% FPL. This authorizes states to provide fewer services to pregnant women than to adults in the 133% adult expansion group who are not pregnant.

This is problematic because pregnant women will not qualify for the new adult expansion category because they are excluded by statute. And, those who are under 133% FPL cannot qualify for coverage through the Exchange. Thus, there is a segment of low-income women who may not have full-scope health insurance under any of the ACA's options. HHS should modify this regulation to prevent this since Congress did not intend to make low-income pregnant women eligible for a more limited scope of benefits than other adults with the same income.

**RECOMMENDATION:** HHS should eliminate the state option in §435.116(d)(1) to provide limited benefits to pregnant women. However, the option to provide enhanced pregnancy-related services as set in §440.250(p) should remain. *Pregnancy-related services* should be broadly defined since almost any medical condition can impact or complicate a pregnancy. Most states have recognized that all health services provided to pregnant women are pregnancy-related. Therefore HHS should accept the policy of most states as its own. Ultimately, HHS must align coverage for pregnant women with the coverage provided to all other adults.

**Subpart C—Options for Coverage**

**§435.218. Retain the provision for future expansions of children's eligibility within this category and that existing CHIP coverage must transition to Medicaid follow such expansion.**

We support the creation of this new eligibility group, which provides a mechanism for states at their option to cover individuals whose income exceeds the state's income standard for mandatory coverage. HHS describes this as an alternative to income disregards which were used to expand eligibility but will no longer be available in 2014.

We support the inclusion of children, if they are not already eligible for Medicaid, in this new optional group. HHS mentions that if a state currently covers children with incomes above 133% FPL in a separate CHIP program, but decides to adopt coverage under this new option, the state must shift the children from CHIP to Medicaid. States will still be able to claim enhanced FMAP under title XXI for such children but as is the case today must adopt Medicaid rules if it chooses the Medicaid option. This is a positive result because it will enable children to receive full Medicaid coverage, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits, enhanced appeal rights and possibly lower cost-sharing.

**Part 435, Subpart G — General Financial Eligibility Requirements and Options**

**§435.603 – Application of Modified Adjusted Gross Income (MAGI)**

**§435.603(a)(3). Allow states to convert all current enrollees to MAGI-based eligibility at their next regularly-scheduled renewal.**

The regulation states at §435.603(a)(3) that for determining ongoing eligibility for those deemed eligible before December 31, 2013 and receiving Medicaid as of January 1, 2014, the use of the MAGI methodology will not be applied until the next regularly-scheduled redetermination or March 31, 2014, whichever is later, if that individual would lose eligibility as a result of the shift to MAGI. Allowing for such a grace period will ensure that individuals are able to maintain their coverage during the initial transition to the MAGI methodology.

It does, however, require states to review eligibility for all those currently enrolled in the program on January 1, 2014 (and subject to the new MAGI methodology). As is required under the regulation for redeterminations (§435.916), states should conduct these reviews based on information already available to the state and without any additional burden on the beneficiaries. Because of the enormous workloads facing states in advance of January 2014, CMS should consider allowing states to maintain regularly scheduled redetermination schedules for their current caseloads.

> **RECOMMENDATION:** CMS should allow states to continue with the redetermination of current beneficiaries as scheduled. This would ensure that beneficiaries maintain their coverage during the transition to MAGI and would ease the burden on states as they implement reform.
>
> **RECOMMENDATION:** The grace period in §435.603(a)(3) is not carried over to children in the Children's Health Insurance Program (CHIP). In order to consistently apply the new MAGI-based income levels across programs, as well as to ensure that children in CHIP are afforded the same protections as those in Medicaid, §457.315 should also incorporate §435.603(a)(3).

**ADDITIONAL RECOMMENDATIONS**

Conversion to MAGI - To account for the elimination of income disregards and ensure continued coverage at pre-ACA levels, states must convert their current income standards to a "MAGI-equivalent" standard for all groups for which eligibility will be determined using MAGI. The preamble indicates that separate guidance will be issued outlining the methodologies states may use to arrive at these equivalent standards. In addition, HHS has issued an RFP requesting assistance in developing the methodologies for arriving at the MAGI-equivalent standard. While the methodology and process for doing the MAGI conversion is not laid out in this proposed regulation, we strongly recommend that the approach taken to develop such methods and standards be a public and transparent one, both at the national and the state level, as the stakes are incredibly high for current and future Medicaid beneficiaries.

The preamble also discusses allowing states to convert to MAGI prior to 2014 using a section 1115 waiver. As with the conversion process itself, the application and approval process for such waivers should be a public one. While the proposed regulations outlining the transparency requirements for section1115 waivers have not been finalized, the public notice and comment requirements in those proposed regulations were strong and should, at a minimum, be followed in such cases where a state is seeking a waiver to implement the MAGI conversion prior to 2014. Given that maintenance of eligibility requirements will remain in place for adults until 2014 and children until 2019, it is especially important that states converting to MAGI in advance of 2014 use a methodology that does not result in the loss of eligibility for current beneficiaries.

> **RECOMMENDATION:** Given the high stakes for current and future beneficiaries, the development of the MAGI conversion process should be transparent and involve input from stakeholders (including advocates).

Converting Minimum Eligibility Thresholds - §2002(a) requires states to develop thresholds that are not less than the effective income levels in place at the time of enactment. In proposing a simplified approach to eligibility based on the new MAGI methodology, the intent is that eligibility will not change for any of the populations. However, as discussed above, the conversion to MAGI is only required for the maximum effective income levels, not the minimum standards. The preamble states that HHS considered converting the minimums to protect eligibility for those who would lose coverage if a state reduced eligibility to the minimum standards, but chose not to as it would result in different minimum eligibility standards across states and reduce simplification.

However, the minimums, especially as they apply to §1931 coverage for parents (one of the groups most likely to be impacted by such an exclusion), are already disparate in states throughout the country. Additionally, it is unclear what simplification is lost as a result of such a conversion. The ACA clearly states that a conversion to MAGI is required not only for the purpose of determining income eligibility, but also for "any other purpose applicable under the plan or waiver for which a determination of income is required." As those parents who are covered under §1931 are entitled to a different benefit package than those found to be newly-eligible, it is important to maintain the minimum standards and

convert them to MAGI so that these parents continue to receive the benefits they are currently afforded.

Additionally, failing to convert minimum standards to MAGI would also adversely impact pregnant women. If a state were to decrease its income standard to the statutory minimum level (after the maintenance-of-effort requirements end in 2014), there is no other coverage group to which affected pregnant women can be transferred. As a result, a woman in this situation would likely become eligible for advanced payments of the premium tax credit for enrollment through the Exchange. This will most likely mean a less generous benefit package for pregnant women, greater cost-sharing, and a violation of the intent of the statute.

> **RECOMMENDATION:** To maintain the benefits that current beneficiaries are receiving, minimum eligibility levels should also be converted to a MAGI-equivalent.

**§ 435.603(b). Require states to count a pregnant woman as two people in determining household size for all members of the family.**

We support the proposed rule requiring states to count a pregnant woman as two persons in determining her household size. We agree that this method of counting pregnant women, which anticipates the change in household size that will occur after the birth, would promote continuity of coverage for the pregnant woman.

However, we recommend that states be required to always count pregnant women as two persons, whether in determining their own eligibility or in determining the eligibility of their family members. We see significant problems in the proposed rule, which makes it a state option to count the pregnant woman as one or two persons when determining the household size of other family members. In such cases, if a state counts pregnant women as only one person, members of the same household could end up in different coverage programs. It would be difficult to explain and administer a policy that requires family members who live together and have the same income available to enroll in different coverage. Moreover, this policy would lead to disruptions in coverage for the non-pregnant members of the household. If, on the other hand, the pregnant woman is always counted as two persons in determining the household size of her family members, the entire family would be covered together under Medicaid when they apply. And no changes in coverage would be necessary for any of the family members when the child is born.

> **RECOMMENDATION:** CMS should require states to always count a pregnant woman as two people in determining household size to minimize disruptions in coverage and split coverage within families.

**§ 435.603(d). We support provisions related to household income as detailed below with the recommendations as noted.**

<u>Not Counting Income of Non-Filers in Determining Household Income -</u> Under (d)(2), the income of an individual who is included in the household of his or her parents, but is not required to file a tax return, is not included in the household income. This is the case whether or not he or she chooses to file a return. In order to be exempt from filing a tax return, these dependents would be earning relatively little. In the 2010 tax year, for

example, they could not earn more than $5,700 annually (the threshold to file taxes as a single individual under age 65 who is claimed as a dependent). As their income is minimal and would not likely be available for the purchase of health insurance coverage, excluding it from the calculation of household income in determining Medicaid eligibility is appropriate.

Counting "Actually Available Cash Support" as Income - We recommend removing (d)(3) which would require the states to count actually available cash support in certain instances. In determining eligibility for individuals who are claimed as tax dependents, but are not the spouse or child of the taxpayer (e.g., children claimed by their grandparents, or a niece claimed by her aunt), the proposed rules would require states to count actually available cash support provided by the taxpayer who is claiming the individual as a tax dependent. We believe this requirement is unnecessary, as well as difficult to implement and enforce.

> **RECOMMENDATION:** Remove the requirement under §435.603(d) to require states to count available cash support as income.

**§ 435.603(f). Provide a safe harbor of Medicaid coverage for individuals who would be considered ineligible for both Medicaid or premium tax credits due to differences in determining household size.**

In developing the rules around household composition for Medicaid, we recognize the tension between aligning Medicaid rules with the premium tax credit rules and ensuring that individuals now eligible for Medicaid do not lose eligibility as a result of the new rules. We believe that in attempting to strike the proper balance, the proposed rule has become too complex. It may be difficult for families to understand the proposed household rules and in some instances the proposed rule would split them up, with different members of the family receiving coverage from different sources.

The proposed rules would apply a different method for determining the household of an individual based whether the individual is: (1) a taxpayer; (2) a taxpayer's dependent; or (3) a non-filer or someone who is not claimed as a tax dependent. And in some cases the same family will be treated differently depending on how they file their taxes.

There are some specific situations for which the outcome of the proposed rules is extremely problematic and we provide recommendations on how to address them. However, as we may not have accounted for all the complicated situations, we urge HHS to revisit the proposed rules and examine various scenarios to identify problematic outcomes, so that they can be addressed in the final rule.

In addition, based on the situations we have identified, we are particularly concerned that because of the different treatment for Medicaid and premium credits, some people might be deemed ineligible for both programs.

> **RECOMMENDATION:** We recommend the creation of a "safe harbor" for such individuals, which would make them eligible for Medicaid when application of the rules yields a decision of ineligibility for both Medicaid and premium credits.

**§§435.603(f)(2)(iii) and (f)(3). Allow for children claimed by their non-custodial parent to be considered in the same household as the custodial parent for the purposes of Medicaid eligibility.**

Under §435.603(f)(2)(iii) and (f)(3), children who are claimed as tax dependents by their non-custodial parent would be considered in the same household as the custodial parent for the purposes of Medicaid eligibility. We strongly support HHS's decision to not require the child to obtain coverage with the non-custodial parent who claims the child as a tax dependent. It is typically the custodial parent who makes most of the health care decisions for the child; therefore, it is often most appropriate for the child to obtain coverage with the custodial parent, and the rules should support this.

In the preamble, HHS discusses an alternative for the child to enroll through the Exchange in which the child lives and be eligible for a premium credit as a member of the non-custodial parent's household. As such a choice raises a number of potential issues around coordination between states, we do not support allowing such a choice. Additionally, allowing such a choice goes against the statute and the proposed regulations in §1.36B-2(c)(2), which state that in order to be eligible for subsidized coverage in the exchange, an individual cannot be eligible for Medicaid. It is not clear why an exception should be made in cases such as these.

> **RECOMMENDATION:** Do not adopt an alternative for a child to enroll through the Exchange in which the child lives and be eligible for a premium credit as a member of the non-custodial parent's household.

**§435.603(f)(4). Treat all married couples as filing jointly regardless of how their taxes are filed and apply consistent rules for unmarried couples for premium tax credits.**

We support retaining current Medicaid rules that limits the inclusion of spouses in each other's household to those who are living together. We also support HHS's decision not to adopt the rule applied to eligibility for premium credits and require married couples to file a joint return in order to be eligible for Medicaid.

In most cases, applying the proposed rules yields the appropriate outcome in families where the parents are married and file a joint return. However, the outcome is vastly different and very complicated when the parents file separate returns, and we recommend that HHS revise its income counting methodology in such cases. Under the proposed methodology, each spouse is included in the household of the other spouse despite their filing status. However, the spouse filing a separate return and not claiming the child does not get included in the household of the child.

> **RECOMMENDATION:** In the case of married couples who live together, we recommend always treating them as filing jointly — and using the rules that apply to married couples filing jointly — regardless of how they file. This approach would attribute the same income and household size to the different members of the family, ensuring that they are able to get coverage together as a family.

In addition, we recommend that Medicaid follow the same rule as for premium credits for unmarried parents who have a child in common and who live together but cannot file a joint return. Because the income of both parents is counted in determining eligibility of the child, but each parent's income is considered independently when determining their eligibility, application of the proposed rules would split the child's coverage from the parents' coverage, despite the fact that they live together and have the same income available to them.

Alternatively, if Medicaid follows premium credit rules for determining the household in this situation, only the income of the parent claiming the child would be considered and the child would generally get coverage with that parent. While we understand the proposed rule is based on current Medicaid practice, the availability of premium credits and the use of a tax-based approach require a change in current rules to avoid the potential that children receive less comprehensive coverage than their parents.

> **RECOMMENDATION:** The proposed Medicaid rules for determining household size for unmarried parents should follow the rules established in the Exchange, counting only the income of the parent who claims the child.

**§§ 435.603(h)(1) and (h)(2). Use of projected annual income should align with 12-month annual renewal periods and states should be given the option to apply this provision to applicants and new enrollees.**

HHS is proposing to allow states to use projected annual income for the current calendar year, but only for current beneficiaries. Using projected annual income means a beneficiary would be able to maintain eligibility as long as annual income remains at or below the Medicaid threshold even if monthly income exceeded the threshold for certain months in the year. The rationale for such an approach is to promote the continuity of coverage by minimizing churn on and off and between sources of coverage because of relatively small changes in income or the receipt of a lump sum during the year. Additionally, while the regulation states that such a projection can be made for a calendar year, it should be adjusted to state that the projection should be made for the 12-month period following an eligibility determination to align with the proposed 12-month redetermination period in §435.916. It also should not be limited to those who are current beneficiaries, but should be used for those initially applying for coverage, so as not to create a disparity between groups.

> **RECOMMENDATION:** Align the annual projected income with the 12-month renewal period. Projections of income should be made for the 12-month period following an eligibility determination.

Section (h)(1) of the proposed rule states that financial eligibility for applicants and new enrollees are based on current monthly income. For those already enrolled, section (h)(2) allows states to elect to use monthly income or projected annual income for the current calendar year.

> **RECOMMENDATION:** We strongly support using projected annual income and believe states should be able to do so for both new applicants and current enrollees.

In addition, HHS should clarify that this rule does not mean that states will evaluate Medicaid eligibility based on an individual's average income for the calendar year, as the exchange would do. Rather, that states should be able to take into account an individual's current situation and fluctuations in income to project his or her *future* average monthly income. For example, in the case of an individual with lump sum income at the time he applies for Medicaid, a state should be required to take into account that the lump sum income will not be available to the applicant in the eligibility determination process. This distinction is especially important for families whose income declines dramatically in one month, for example due to the loss of a job. If the family is screened using current monthly income, they could be determined eligible for Medicaid; however, if the state used annual income taking into account past earnings, they may be found ineligible.

> **RECOMMENDATION:** HHS should clarify that projected annual income does not mean projected annual income for the calendar year, as the exchange would do. Rather, the state should use current income and fluctuations in income to project his or her future average monthly income until the end of the current 12-month eligibility period.

**§435.603(h)(3). States should be required to take predictable changes in income into account.**

States are currently afforded the flexibility to take into account future changes in income that can be reasonably anticipated. The proposed regulation retains this option, under (h)(3). Section (h)(3), which applies to both applicants and new enrollees and current beneficiaries, allows states to choose to adopt a reasonable method to include "a prorated portion of reasonably predictable future income" when determining monthly or projected annual income. Additionally, we believe states should be required to take predictable changes in income into account.

The regulation suggests the use of a "prorated portion" of this predictable future income, in determining eligibility. This would, in effect, spread out the increase or decrease in income over the entire year and by doing so eligibility determinations would be more reflective of the individual or family situation over the course of the year. Such an approach would go hand-in-hand with using projected annual average monthly income in reducing churn and maximizing continuity of coverage. For example, an individual employed as a landscaper would have income that fluctuates seasonally. Such an individual would be able to reasonably anticipate that his income would be higher in the summer months and lower in the winter months. Taking into account those fluctuations would ensure continuity of coverage and should be a requirement for states.

However, such an approach should not alter the treatment of lump sum income, which the regulation requires be taken into account in the month it was received. States should be required to take into account the fact that such income would not be available in the future in the eligibility determination process. Treating lump sums differently makes sense, because they are one-time events.

Taking into account a predictable change in income would not negate the requirement under §435.916(c) that beneficiaries make timely and accurate reporting of changes in circumstances. It would however, allow states to factor in, at the time of application and renewal, knowable changes in income and therefore make a more accurate assessment of eligibility for the entire year.

**RECOMMENDATION:** Require states to take predictable changes in income into account for both applicants and current beneficiaries.

The verification requirements for such predictable changes in income should be no more cumbersome than those required for other income as specified in §435.948. As mentioned in the preamble to section (h)(3), individuals should be able to provide verification through such means as a signed employment contract or a history of fluctuations (for example, past small-business revenue statements). In addition, self-attestation of changes should also be accepted by states, but it will be important to clearly define "reasonably compatible" so that its application is consistent both within and across states. We address this concern in our comments related to §435.948.

**§435.905. Expand the list of types of program information that must be available for consumers.**

In 2014, the need for information about Medicaid and other health coverage programs will be even greater than it is now due to the requirement that all individuals obtain coverage. We support many aspects of the proposed rule on availability of program information and offer recommendations to make it stronger.

As proposed, the rule requires states to make program information available to "…all applicants and other individuals who request it" but we believe that it should be required that program information be made publicly available so that consumers will be able to learn about the program without having to formally request information from the agency.

We support the requirement that agencies make program information available in an electronic format. Because people are increasingly turning to the Internet to learn about products and services, it is vital that program information be accessible electronically.

**RECOMMENDATION:** The final rule should expand the list of program information listed in (a) to provide consumers with the following information:

- how the application and renewal processes work;
- how to obtain assistance with applying for and renewing coverage;
- details on covered benefits, including details on benchmark benefit packages or benchmark equivalent benefit packages for newly eligible adults;
- agency responsibilities; and
- consumer appeals (which was previously required to be available in bulletins and pamphlets but was eliminated by the replacement of the current §435.905(b)).

**RECOMMENDATION:** Agencies should be required to make program information publicly available so that consumers can learn about the program without having to

request information from the agency. The final rule should clarify that the program information must be available through the state and/or agency website and that it should provide a link to the state's online application and a link to the Exchange website required by § 155.205(b).

**§435.905(b). All program materials should be in simple, plain language and meet meaningful access standards.**

We support the requirement that program information be made accessible to persons with disabilities and those who have limited English proficiency. Please see our comments submitted under separate cover by Dinah Wiley for more on this topic.

**§435.907. Retain the requirement that states use a single, streamlined application to determine eligibility for all insurance affordability programs. Explicitly codify that states cannot require face-to-face interview requirements at application.**

In 2014, a single, streamlined application that is a pathway to all health insurance affordability programs will be vital to ensure that eligible individuals get enrolled in the correct program without the burden and potential confusion of having to complete multiple forms to determine eligibility for subsidies. We strongly support this provision of the proposed rule, which codifies §1413 (b)(1)(A)(i) of the ACA and requires agencies to use a single, streamlined application to determine eligibility for Medicaid, CHIP, Basic Health (if applicable), premium credits, cost-sharing reductions.

**RECOMMENDATION:** We recommend that the final rule explicitly indicate that face-to-face interview requirements are not allowed. While the preamble to the Medicaid rule suggests this will be case, the requirement is not actually included in text of the rule itself.

**§435.907(a). The final rule should directly permit the use of express lane eligibility in lieu of an application.**

The rule states that state Medicaid agencies must require an application for insurance affordability programs. We are concerned that the requirement could be interpreted to negate the automatic enrollment option allowed by section 203 (a)(1)(D) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This option allows agencies to automatically enroll children in Medicaid and CHIP based on data already available on hand through other agencies without necessarily requiring a new application. To complete an eligibility determination using this option, states must have sufficient information about children from express lane agencies or other data sources. The express lane option requires states to provide families with information about services provided through Medicaid (or CHIP), cost sharing responsibilities, renewal requirements, and other program requirements. Families must affirmatively consent to the enrollment of children but they are not required to complete an application. This option has allowed states such as Louisiana to increase enrollment of eligible children by using data from other state agencies like SNAP.

**RECOMMENDATION:** The final rule should directly address that the express lane option is still allowable.[1]

**§435.907(a). The final rule should define the role of authorized representatives and persons acting responsibly for the applicant.**
Additionally, authorized representatives and persons acting responsibly for the applicant should be clearly defined and consumers should be informed of this and be allowed to terminate the authority of these individuals at any time.

**§435.907(b). The final rule should clarify that multi-benefit applications can be used in addition to a state's single, streamlined application.**
While we strongly support the single, streamlined application envisioned in the proposed rule, we are concerned that some states may misunderstand the rule to mean that multi-benefit applications are no longer allowed. If states stop using multi-benefit applications, consumers who wish to apply for multiple assistance programs will have to complete separate applications that require many of the same data elements to obtain health coverage, Supplemental Nutrition Assistance Program or Child Care Subsidies, and/or other benefits and make the process too burdensome.

**RECOMMENDATION:** It should be clarified that nothing in the rule should be interpreted to prevent states from having multi-benefit applications in addition to their single, streamlined application for insurance affordability programs. States should also be able to create alternative applications that allow consumers to choose to apply for other programs.

**§435.907(d). Retain the requirement that Medicaid agencies allow consumers to use multiple methods to submit applications.**
We support the requirement that Medicaid agencies establish procedures to allow consumers to submit applications via the Internet, telephone, mail, in person and fax**.**

**§435.908 – Assistance with Application and Redetermination**

**§435.908(a). Support allowing applicants and beneficiaries to obtain assistance from a person of their choice.**
We support the continued requirement that Medicaid agencies allow applicants and beneficiaries to obtain assistance from their choice of individuals through the application and redetermination process. Such assistance should be clearly defined as recommended under §435.907(a).

**§435.908(b). HHS should establish and monitor standards to ensure access to adequate assistance.**
We commend HHS for including an explicit requirement that Medicaid agencies provide assistance to individuals seeking help with the application or redetermination process as

[1] While CHIPRA imposed a sunset on Express Lane eligibility, Congress subsequently adopted the Affordable Care Act and in it assumed continuation of the option.

many individuals and families will need assistance to understand the coverage available to them and how to access and maintain the coverage. We strongly support the provision requiring Medicaid agencies to make such assistance available to individuals in person, over the phone, and online. We support giving consumers options for obtaining assistance to ensure individuals have choices that meet their schedules, capacity and need. However, this provision needs to further specify standards for Medicaid agencies to ensure that assistance is truly accessible.

> **RECOMMENDATION:** We recommend that HHS should add standards that will ensure adequate access to assistance by measuring agency performance looking at: call abandonment, call wait times, number of days to wait for an in-person assistance appointment, waiting time for online assistance, and other measures should be measured to examine agency performance on assistance.

**§435.916 – Periodic Redeterminations of Medicaid Eligibility.**
We strongly support the overall approach of this section as the rules will reduce the administrative burden on states and improve retention among eligible beneficiaries. The proposed changes build on state practices that have had documented success in reducing staff time, decreasing churn, and improving program integrity.

**§435.916(a)(1). Twelve-month renewals will improve state efficiency and promote continuity in coverage.**
We commend HHS for requiring that redetermination be completed once every 12 months unless the state has information about changes in circumstances. Although states currently have the flexibility to require redeterminations more frequently, few have chosen to do so for children and parents in Medicaid. However, the proposed rule only applies to beneficiaries found eligible for Medicaid based on MAGI. The final rule should retain this requirement and it should be extended to Medicaid beneficiaries that are found eligible for Medicaid on a non-MAGI basis.

**§435.916(a)(2). Use of data available to automatically renew coverage is highly recommended.**
We strongly support that the proposed rule requires agencies to evaluate already available information first, either from the client file or other third party data sources, to the maximum extent possible in making eligibility redeterminations. This is consistent with the intent of the law and the verification requirements laid out in §435.945. Requiring states to use data that is available, timely, and accurate will reduce administrative burdens and costs for agencies, be far less onerous for applicants and beneficiaries, and significantly increase the number of eligible individuals who retain coverage.

Under the proposed redetermination process, if states find beneficiaries are still eligible based on available information, beneficiaries are notified that they remain eligible and are not required to take any action unless the information used in the determination is inaccurate. This, too, will significantly increase the number of eligible individuals who remain eligible. We also strongly support this proposed approach.

**§435.916(a)(3). Redeterminations of eligibility based on streamlined methods are administratively efficient and will ensure that eligible persons stay enrolled.**
For cases when the agency is not able to renew eligibility based on available data, §435.916(a)(3) requires that the state provide beneficiaries with pre-populated forms, which should contain the available information that is "needed" (as specified by the Secretary) for renewal.

> **RECOMMENDATION:** The final rule should be clarified that states should only "need" what is explicitly required to make an eligibility determination, namely income; they should not be asking for additional information that is unnecessary for making such a determination or information on eligibility criteria that do not change, such as citizenship. Strong federal oversight should ensure that the burdens placed on beneficiaries at renewal are minimal.

Recognizing that the available data sources should have been exhausted in implementing the process outlined in §435.916(a)(2), the final regulation should require that beneficiaries be able to provide reasonable alternative documentation to verify their statements and when such documentation is not accessible, allow for self-attestation.

Beneficiaries are given 30 days to respond and provide further information (if necessary) through the same avenues (online, over the phone, via the mail, in person, as specified in §435.907(d)). We strongly support that if coverage for a beneficiary is terminated because they fail to complete the renewal processes within 30 days, there is an opportunity to be reconsidered without the need to file a new application if the individual responds to the agency within a reasonable period. The final rule should retain this policy.

> **RECOMMENDATION:** The final regulation should set a standard of 90 days, as suggested in the preamble, for what is considered to be "timely" period to renew without filing a new application.

**§435.916(a)(4). The final rule should include clear provisions that require the Medicaid agency to screen and enroll individuals not eligible for Medicaid in other insurance affordability programs.**
§2201 of the Affordable Care Act requires Medicaid agencies to screen for eligibility in CHIP and the QHPs and to ensure that individuals are, "if eligible, enrolled in such a plan without having to submit an additional or separate application." We also strongly support the provision requiring the Medicaid agency to assess eligibility for other insurance affordability programs when an individual is determined to be no longer eligible for Medicaid, and to send the pertinent data to the appropriate program. This policy will help promote continuous coverage and should be retained in the final rule. A simple electronic referral system is not sufficient to "ensure enrollment." We believe stronger and clearer language is needed to ensure compliance with this section of the law.

> **RECOMMENDATION:** Clarify in §435.916(a)(4) that it is the responsibility of the Medicaid agency to screen and ensure enrollment in other insurance affordability programs. We also recommend that HHS monitor compliance with this requirement.

**§435.916(b). Adopting the MAGI renewal process for all Medicaid beneficiaries is strongly supported.**

In the preamble HHS seeks comment on whether to extend the MAGI renewal rules and processes to non-MAGI beneficiaries. We strongly support the principles set out in §435.916(a) and would support extending them to all beneficiaries.

**§435.916(c) and (d). Requirements to report changes in income should be limited to those that impact ongoing eligibility.**

The proposed regulation requires agencies to ensure that beneficiaries make timely and accurate reports of any changes in circumstances that may affect their eligibility and to review eligibility in response. While we agree that beneficiaries should report changes such as loss or gain of household members, loss or gain of employment or change in state residency, we do not believe that the final rule should require beneficiaries to report income fluctuations that will not impact their eligibility throughout the 12-month eligibility period. Nor do we believe that the final rule should require agencies to act on fluctuations in income that do not impact eligibility during 12-month eligibility periods.

Fluctuation in income is common among low-income families and individuals, and we believe that it will be administratively burdensome and costly to require agencies to act on fluctuations that may temporarily change eligibility. Additionally, such an approach is consistent with the budget periods proposed under §435.603(h) that allow states to consider projected annual income.

At the very least, the final rule should limit the burden on beneficiaries and agencies by only requiring that changes that are likely to impact eligibility be reported and acted on. This alternative would still require beneficiaries to report changes in household size, loss or gain of employment, and change of state residency and agencies would be required to act on those changes. However, beneficiaries should not be required to report income decreases (unless doing so would lower their premiums and/or cost-sharing). Beneficiaries should only be required to report income increases that would have the effect of putting them above the Medicaid income threshold and agencies would only be required to act on such changes. This alternative approach would require that enrollment agencies to notify beneficiaries of a monthly dollar amount that would put them above the income threshold.

Establishing a percentage increase in income that enrollees would be required to report, such as 5%, is recommended. In addition, beneficiaries would be required to report if their income goes above that threshold and is reasonably expected to stay above that threshold consistently going forward.

> **RECOMMENDATION:** Beneficiaries should be required to report changes in household size, employment, or state residency. Reports of income fluctuations should not be required unless an increase puts families above the income threshold. Medicaid should calculate this threshold and inform enrollees of the amount that they would be required to report. Alternatively, the state should have the option to establish benchmarks for reporting income, such as if a permanent increase in income of more than 5% is anticipated.

**ADDITIONAL RECOMMENDATIONS**

**§435.916. Explicitly codify that states cannot require face-to-face interview requirements at renewal.**

In 2014, automatic renewals will be vital to ensure that eligible individuals stay enrolled without the burden and potential confusion of having to complete multiple forms to determine eligibility for subsidies.

> **RECOMMENDATION:** We recommend that the final rule explicitly indicate that face-to-face interview requirements are not allowed at renewal. While the preamble to the Medicaid rule suggests this will be case, the requirement is not actually included in text of the rule itself.

**§435.945 – General Requirements**

**§435.945(a). This subpart should be removed as program integrity is clearly dealt with in part 455.**

The proposed rule indicates that nothing in the subpart (which includes §435.948, §435.949 or §435.956) should be considered to limit state program integrity efforts. Restating the objective of program integrity in such broad terms serves little practical purpose in the regulation, and instead weakens the regulation by allowing a broad, vague exception to all provisions of the regulation if any program integrity interest can be identified. We are concerned that if states wish to continue relying on processes that heavily depend on the collection of paper documentation, they can do so under the banner of program integrity. The net effect could be simply to make it difficult for all eligible children and families to enroll.

> **RECOMMENDATION:** Program integrity is clearly dealt with under §455 and is best addressed through those specific regulations, thus the removal of subpart (a) is recommended.
>
> **ALTERNATIVE RECOMMENDATION:** We believe that the final rule in §435.945(a) should require that if states choose to not implement provisions in this subpart in order to maintain program integrity, they should be required to document how the alternative process will improve program integrity and get approval from the Secretary.

**§435.945(b) The final rule should narrow the broad language and eliminate preamble references to strict §1137 compliance.**

We commend the proposed authority for states to accept attestations for most verification purposes. However, we recommend that the regulation be strengthened to require states to accept attestation for these purposes unless there is a clear reason not to use attestation under specific circumstances. The benefits of the administrative simplicity for states and the reduced barriers for families far outweigh any potential problems from making attestation the default position. Numerous state programs, particularly the Children's Health Insurance Program, use attestation successfully today, and this success should be built on.

**RECOMMENDATION:** To the extent that the regulation truly seeks to enable acceptance of attestation, the regulation should narrow the broad language ("subject to the verification requirements set forth in this subpart") and preamble references to strict §1137 compliance.

**§435.948. The final rule should define reasonable compatibility as information that is relatively consistent and does not vary in a way that is meaningful for Medicaid or CHIP eligibility.**

CMS staff has described a definition of "reasonable compatibility" standard to exist when an individual's attestation and the available electronic data are relatively consistent and do not vary in a way that is meaningful for eligibility. For example, if an individual's attestation of income and the income information available through IRS or other databases differ, but both are below the Medicaid eligibility threshold, the individual should be considered eligible and enrolled without delay. In other words, the two sources of data need not match one another if both lead to the same eligibility determination. However, this crucial definition is absent from the regulations.

**RECOMMENDATION:** CMS should define reasonable compatibility as information that is relatively consistent and does not vary in a way that is meaningful for Medicaid or CHIP eligibility.

We also believe that states should be prohibited from disregarding electronic data because it is not current as long as it reflects someone's recent circumstances as defined by the federal government with state flexibility to adopt a longer time frame (e.g., within a period of up to four months or more). States also should be required to use income data even if it deviates from someone's stated circumstances as long as it falls within a target threshold specified by CMS (with state flexibility to establish a broader target range).

**RECOMMENDATION:** CMS should define what constitutes reasonable "current" income (e.g. up to four months, or more at state option).

**§435.948(a). The final rule should replace the word "useful" with "available, accurate and timely."**

Paragraph (a) states that the agency must request information from state, federal, and other databases to the extent that the information is "useful" to verify financial information. The term useful is quite subjective, and could result in some states defining it in such a way that either overuses other data sources or fails to access needed data. Replacing this subjective term with more specific language—available, accurate, and timely—will ensure that states are not required to tap databases that are out of date or not known to provide pertinent information, but that they are required to make full use of reliable data sources available to them, rather than requiring individuals and families to provide paper verification.

**RECOMMENDATION:** Replace the word "useful" in paragraph (a) with "available, accurate, and timely."

**§435.948(b). The federal data services hub will promote efficient access to data needed to verify eligibility.**
We commend the requirement that the agency "must" obtain data available from the federal electronic data services established in §435.949.

**§435.948(c)(1). Require states to access data from other sources before asking applicants to provide documentation.**
States should be required to develop a state data services hub that provides the Medicaid and other state agencies with access to relevant, useful data to verify eligibility. With the availability of enhanced federal financial support for systems development, state costs will be minimal and quickly offset by administrative savings.

> **RECOMMENDATION:** Change the proposed rule to reflect that the agency "must" obtain the information directly from the appropriate agency or program consistent with the requirements in §435.945 of this subpart.

**ADDITIONAL RECOMMENDATIONS**

The regulation text does not appear to suggest the same process for presenting the individual with known financial information and allowing them to affirm or deny it, as is the suggested procedure for exchanges making Medicaid determinations in 155.320(c). The regulation should more explicitly require Medicaid agencies to follow this process, to ensure individuals experience the same eligibility process whether they apply through the Medicaid/CHIP agency or the exchange.

> **RECOMMENDATION:** Require the Medicaid agency to provide individuals with the known financial information and allow them to affirm or deny it.

**§ 435.949 – Verification of Information through an Electronic Service**

**§435.949(a). HHS should continually improve and expand the sources of eligibility information available through the hub.**
We commend the creation of the federal electronic service through which States may verify eligibility-related information available through the "hub". We recommend that HHS explore the feasibility of providing additional linkages to state or other databases that contain reliable, relevant eligibility data. For example, the Utah e-Find data brokering system provides access to a large number of federal and state data sources through a single system. In particular, it is a priority for HHS to develop an electronic source that will assist states in determining whether an individual has access to minimum essential coverage, as well as reliable sources of current income.

> **RECOMMENDATION:** HHS should seek to provide as robust a data service hub as possible and continually improve and expand the sources of information available through it to aid states in verifying eligibility electronically, in real-time.

**§435.952 – Use of Information and Requests of Additional Information from Individuals**

**§435.952(a). The final rule should set timeliness standards for acting on applications, redeterminations and reported changes.**

The rule should clarify the Medicaid agency's responsibility to "promptly evaluate information received or obtained by it in accordance with regulations under §435.940 through §435.960 of this subpart to determine whether such information may affect the eligibility…" The final rule should specify timeliness standards for Medicaid agencies to act on information during the initial application, at the annual redetermination and when changes are reported that impact eligibility.

> **RECOMMENDATION:** We propose that Medicaid agencies be required to complete such determinations as quickly as possible but under no circumstances should it take more than 30 days. Timeliness standards should differ for different situations. When electronic data is available to support real-time or near real-time decisions, the timeliness standard should be shorter. In turn, timeliness standards ideally should provide extra time in situations when individuals and families must provide additional information.

**§435.952(b). Reviewing eligibility on a continual basis is neither administratively efficient nor effective in promoting continuity of coverage.**

The ability of states to verify eligibility by accessing relevant data electronically will revolutionize the application process for children and families. It will ease administration for states and simplify enrollment for consumers. Data matching for verification should occur upon application, redetermination, and at other appropriate eligibility review junctures, but it should not be an affirmative on-going and real time responsibility for states with regard to Medicaid. If states are required to conduct behind-the-scenes verification on a continual basis, many individuals will likely move back and forth between Medicaid and coverage through the Exchange with premium tax credits throughout the year. This movement between programs would be burdensome to consumers, disrupt continuity of care and be costly to Medicaid agencies, Exchanges, health plans and medical providers. The final rule should only require Medicaid agencies to act on changes in household size, state residency and loss or gain of employment that impact eligibility.

> **RECOMMENDATION:** We recommend that the regulation should be clear in requiring the use of data sharing for the purposes of appropriate verifications at application and redetermination, and as individuals report changes, but not as an on-going real time Medicaid responsibility. Agencies should only be required to act on income fluctuations that would likely have the affect of putting beneficiaries over the Medicaid income threshold.

**§435.952(c)(2). A reasonable period to provide proof should be defined as no less than 30 days.**

We strongly support allowing applicant or beneficiary statements time to submit statements to explain discrepancies. This provision should be retained in the final rule. We also support that agencies must provide consumers with a reasonable period to provide proof.

> **RECOMMENDATION:** The final provision should define a "reasonable period" of no less than 30 days and states should extend the time if needed.

**§435.952(d). Beneficiaries must be given an opportunity to provide additional information in cases when data matches are inaccurate.**

We strongly support the provision prohibiting the agency from denying, terminating or reducing benefits based on information received through data matching unless the agency has sought additional information from the individual.

**RECOMMENDATION:** The final rule should add the term "suspend" in addition to deny, terminate or reduce benefits. Consistent with rules on application and renewal, the final rule should:

- provide reasonable and multiple methods for consumers to provide documentation such as in-person, by mail, over the telephone, via fax, and online;
- provide assistance to individuals and families who may need to obtain documentation;
- include a list of the types of acceptable documentation such as paper documentation provided by applicant/beneficiary, letters from employers, and telephone contact with reliable third party sources (if approved by applicant/beneficiary);
- clarify that Medicaid agencies may not require consumers to produce a specific document, for example, the agency cannot say "the alternative must be a pay stub."

**§435.956 Verification of Other Non-Financial Information**

**§435.956(c) States should be required to accept self-attestation.**

We strongly support that the Medicaid agency may accept an applicant's attestation of residency to determine eligibility unless the state has information that is not reasonably compatible. We prefer that states be required to accept self-attestation (as is allowed in the Exchange) to support consistency of verification among all affordability programs.

**RECOMMENDATION:** To support consistency among all affordability programs, states should be required to accept self-attestation of residency unless there is a clear reason not to do so.

**§435.956(e). Self-attestation of pregnancy and household size will facilitate enrollment.**

We strongly support the proposed requirement that the Medicaid agency must accept attestation of pregnancy and household size, unless the state has information that is not reasonably compatible. Allowing for self-attestation will greatly reduce the administrative burden of applying for coverage for applicants and states.

**§435.956(f). Self-attestation of age and date of birth should be required.**

We support that the Medicaid agency may accept an applicant's attestation of age and date of birth to determine eligibility. However, we urge CMS to require that Medicaid agencies "must" accept self-attestation of age and date of birth, unless there is a clear reason to not

use self-attestation in a particular circumstance. This will further streamline and simplify the application process for consumers and states.

**RECOMMENDATION:** The final rule should require Medicaid agencies to accept an applicant's attestation of age and date of birth to determine eligibility unless there is a clear reason to not accept self-attestation in a particular circumstance.

**Part 435, Subpart M – Coordination of Eligibility and Enrollment Between Medicaid, CHIP, Exchanges and Other Insurance Affordability Programs**

**§435.1200 Medicaid Agency Responsibilities.**

We support the overall approach of this section, which provides for coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other programs. However, we believe there is a need for more specific standards regarding the timeliness of actions, how consumers will be informed and notified, and how issues that will arise between the various coverage programs will be resolved.

**§435.1200(c). Retain the requirement for interagency agreements and provide model agreements to states.**

We support the requirement that the Medicaid agency enter into agreements with the Exchange and other agencies administering affordability programs to ensure coordination. This should be retained in the final rule, and we suggest that HHS provide model agreements for this purpose.

**RECOMMENDATION:** Retain the requirement for interagency agreements and provide model agreements to states.

**§435.1200(d). Retain the requirement for an accessible website that includes the capability to submit application and renewal information.**

We support the requirement to maintain a web site that provides information on the various insurance affordability programs, as well a mechanism through which people can apply for and renew coverage. We also support the specific requirement that the website be accessible to people with disabilities and people with limited English proficiency.

**RECOMMENDATION:** Retain the requirement for an accessible website that includes the capability to submit application and renewal information.

**§435.1200(e). Establish a timeliness standard of 30 days.**

We support the requirement that the Medicaid agency furnish Medicaid "promptly and without undue delay" to applicants found eligible by the Exchange to the same extent as if they were found eligible by the Medicaid agency. While the timeliness standards in the current rule §435.911 (proposed to be re-designated §435.912) maintains the 45 days (90 days for a determination of disability) standard, we propose revising and shortening this standard to 30 days, to make it consistent with the new vision of "real time" eligibility in 2014.

**RECOMMENDATION:** At §435.912, establish a timeliness standard of 30 days to reflect the use of real time or near-real time eligibility systems.

**§435.1200(f). Retain the prohibition that states cannot request information available to them.**

We are pleased that the proposed regulations prohibit the State Medicaid agency from requesting information or documentation from the applicant that is already contained in the transferred application. Similarly, as required in §435.945(f), we ask that State Medicaid agencies consider verifying information already known to other State entities or utilizing data sharing technologies such as asset verification systems before requesting additional information from the applicant.

> **RECOMMENDATION:** Retain the prohibition on requesting information from applicants that is already available to the agency and the requirement for electronic transfer of information on those determined not eligible.

**§435.1200(g)(1). The final rule should include clear provisions that require the Medicaid agency to screen and enroll individuals not eligible for Medicaid in other insurance affordability programs.**

We also support the requirement that the Medicaid agency electronically transfer applications of individuals determined not eligible for Medicaid to other insurance affordability programs. However, 1943(b)(1)(C) requires Medicaid agencies to screen for eligibility in CHIP and the QHPs and to ensure that individuals are, "if eligible, enrolled in such a plan without having to submit an additional or separate application." We also strongly support the provision requiring the Medicaid agency to assess eligibility for other insurance affordability programs when an individual is determined to be no longer eligible for Medicaid, and to send the pertinent data to the appropriate program. This rule will help promote continuous coverage and should be retained in the final rule. A simple electronic referral system is not sufficient to "ensure enrollment." We believe stronger and clearer language is needed to ensure compliance with this section of the law.

> **RECOMMENDATION:** Clarify in §435.1200(g)(1) that it is the responsibility of the Medicaid agency to screen and ensure enrollment in other insurance affordability programs. We also recommend that HHS monitor compliance with this requirement.

**§435.1200(g)(2). Retain the ability to enroll individuals in other insurance affordability programs while reviewing a determination of blindness or disability.**

We support allowing individuals who are eligible for other insurance affordability program to immediately enroll into these programs while a Medicaid determination regarding eligibility on the basis of being blind or disabled is pending.

> **RECOMMENDATION:** Retain the ability to enroll individuals in other programs while pending a determination of blindness or disability.

**ADDITIONAL RECOMMENDATIONS**

The challenge of ensuring effective coordination among the various insurance affordability programs is compounded by a number of factors including the lack of alignment of eligibility rules on household composition, timing of income, different treatment of employer coverage, as well as different income standards based on age and disability. Added to this is the fact that exchanges can determine eligibility for Medicaid and CHIP, but

unless a state chooses to allow it, Medicaid agencies cannot determine eligibility for premium credits.

We make the following specific suggestions for the regulation and future guidance:

> **RECOMMENDATION: Timeliness standards.** The proposed rule creates numerous requirements for conducting various activities in a prompt manner without "undue delay." We recommend including specific timeliness standards for electronic transfers, which should take no longer than one business day once the need for a transfer is identified, in the final rule.
>
> **RECOMMENDATION: Monitoring and enforcement.** To ensure effective coordination of the application process, there should be ongoing oversight by HHS based on meaningful performance measures. HHS should outline plans for actively reviewing states' compliance with the application and renewal procedures included in the final review, as well as provide beneficiaries and advocates with clear and well-defined avenues for alerting HHS to potential issues. Finally, HHS should ensure that consumers have adequate means to have their complaints addressed in addition to a formal appeal process.
>
> **RECOMMENDATION: Need for clear standards on dispute resolution and "safe harbors."** Despite efforts to clearly delineate eligibility for the different programs, it is very likely that disputes will arise as to which program should cover an individual or family. In some instances, an individual or family may be found ineligible for all coverage programs even though their income is below 400 percent of the poverty line. HHS should outline clear standards for resolving these cases without delaying benefits and without disadvantage to beneficiaries. The need for these standards will be especially acute in states with a federal exchange in which the state is opposed to implementing health reform. Medicaid coverage should be provided as interim coverage if a final determination cannot be made within 30 days.

**PART 457 – Allotments and Grants to States**

**§457.330. Retain the requirement that CHIP use the single, streamlined application.** The rule states that the state shall use the single, streamlined application required by proposed rule §435.907(b) and should also comply with most provisions in §435.907 except for those related to non-MAGI applicants. We commend HHS for applying the relevant requirements in this and preceding sections equally to CHIP and Medicaid. Comments we have made for §435.907 that are applicable to CHIP are as follows:

In 2014, a single, streamlined application that is a pathway to all health insurance affordability programs will be vital to ensure that eligible individuals get enrolled in the correct program without the burden and potential confusion of having to complete multiple forms to determine eligibility for subsidies. We strongly support this provision of the proposed rule, which codifies §1413(b)(1)(A)(i) of the ACA and requires agencies to

use a single, streamlined application to determine eligibility for Medicaid, CHIP, Basic Health (if applicable), premium credits, cost-sharing reductions.

**RECOMMENDATION:** Support the rule codifying §1413(b)(1)(A)(i) of the ACA to require the use of a single, streamlined application, ensuring "no wrong door" for consumers when determining their eligibility for insurance affordability programs, including CHIP.

In regard to 435.907(a) as applied to CHIP, the rule states that state Medicaid agencies must require an application for insurance affordability programs. We are concerned that the requirement could be interpreted to negate the automatic enrollment option allowed by §203(a)(1)(D) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This option allows agencies to automatically enroll children in Medicaid and CHIP based on data already available on hand through other agencies without necessarily requiring a new application. To complete an eligibility determination using this option, states must have sufficient information about children from express lane agencies or other data sources. The express lane option requires states to provide families with information about services provided through Medicaid (or CHIP), cost sharing responsibilities, renewal requirements, and other program requirements. Families must affirmatively consent to the enrollment of children but they are not required to complete an application. This option has allowed states such as Louisiana to increase enrollment of eligible children by using data from other state agencies like SNAP.

**RECOMMENDATION:** The final rule should directly address that the express lane option is still allowable.[2]

**RECOMMENDATION:** Additionally, authorized representatives and persons acting responsibly for the applicant should be clearly defined and consumers should be informed of this and be allowed to terminate the authority of these individuals at any time.

In regard to how §435.907(b) is applied to CHIP, while we strongly support the single, streamlined application envisioned in the proposed rule, we are concerned that some states may misunderstand the rule to mean that multi-benefit applications are no longer allowed. If states stop using multi-benefit applications, consumers who wish to apply for multiple assistance programs will have to complete separate applications that require many of the same data elements, to obtain health coverage, Supplemental Nutrition Assistance Program or Child Care Subsidies, and/or other benefits and make the process too burdensome.

**RECOMMENDATION:** It should be clarified that nothing in the rule should be interpreted to prevent states from having multi-benefit applications in addition to their single, streamlined application for insurance affordability programs. States should also be able to create alternative applications that allow consumers to choose to apply for other programs.

[2] While CHIPRA imposed a sunset on Express Lane eligibility, Congress subsequently adopted the Affordable Care Act and in it assumed continuation of the option.

In regard to how §435.907(d) is applied to CHIP, we support the requirement that Medicaid agencies establish procedures to allow consumers to submit applications via the Internet, telephone, mail, in person and fax.

**§457.335. Comments made at §435.905 and §435.1200(d) apply to availability of program information and Internet website in CHIP.**
The rule states that the provisions in §435.905 and §435.1200(d) apply to states that administer CHIP separate from Medicaid. We commend HHS for applying these requirements equally to CHIP and Medicaid. Comments we have made for §435.905 and §435.1200(d) that are applicable to CHIP are as follows:

In 2014, the need for information about Medicaid and other health coverage programs will be even greater than it is now due to the requirement that all individuals obtain coverage. We support many aspects of the proposed rule on availability of program information and offer recommendations to make it stronger.

As proposed, the rule requires states to make program information available to "…all applicants and other individuals who request it" but we believe that it should be required that program information be made publicly available so that consumers will be able to learn about the program without having to formally request information from the agency.

We support the requirement that agencies make program information available in an electronic format. Because American adults are increasingly turning to the Internet to learn about products and services, it is vital that program information be accessible electronically.

> **RECOMMENDATION:** The final rule should expand the list of program information listed in (a) to provide consumers with the following information:
> - the application and renewal processes;
> - the availability of assistance with applying for and renewing coverage;
> - details on covered benefits, including details on benchmark benefit packages or benchmark equivalent benefit packages for newly eligible adults;
> - agency responsibilities; and
> - consumer appeals (which was previously required to be available in bulletins and pamphlets was eliminated by the replacement of the current §435.905(b)).
>
> **RECOMMENDATION:** Agencies should be required to make program information publicly available so that consumers can learn about the program without having to request information from the agency. The final rule should clarify that the program information must be available through the state and/or agency website and that it should provide a link to the state's online application and a link to the Exchange website required by §155.205(b).

In regard to how §435.905(b) is applied to CHIP, we support the requirement that program information be made accessible to persons with disabilities and those who have limited English proficiency.

**Apply to CHIP the recommendation at §435.603(a)(3) that would allow states to convert all current enrollees to MAGI basis on their next regularly-scheduled renewal.**

The regulation states in §435.603(a)(3) that for determining ongoing eligibility for those deemed eligible before December 31, 2013 and receiving Medicaid as of January 1, 2014, the use of the MAGI methodology will not be applied until the next regularly-scheduled redetermination or March 31, 2014, whichever is later, if that individual would lose eligibility as a result of the shift to MAGI. Allowing for such a grace period will ensure that individuals are able to maintain their coverage during the initial transition to the MAGI methodology.

It does, however, require states to review eligibility for all those currently enrolled in the program on January 1, 2014 (and subject to the new MAGI methodology). As is required under the regulation for redeterminations (§435.916), states should conduct these reviews based on information already available to the state and without any additional burden on the beneficiaries. Because of the enormous workloads facing states in advance of January 2014, CMS should consider allowing states to maintain regularly scheduled redetermination schedules for their current caseloads.

> **RECOMMENDATION:** CMS should allow states to continue with the redetermination of current beneficiaries as scheduled. This would ensure that beneficiaries maintain their coverage during the transition to MAGI and would ease the burden on states as they implement reform.
>
> **RECOMMENDATION:** The grace period in §435.603(a)(3) is not carried over to children in the Children's Health Insurance Program (CHIP). In order to consistently apply the new MAGI-based income levels across programs, as well as to ensure that children in CHIP are afforded the same protections as those in Medicaid, §457.315 should also incorporate §435.603(a)(3).

**ADDITIONAL RECOMMENDATIONS**

**Address the issue of families facing a "double premium hit" for their children.** The proposed rules will leave many families with children facing multiple, additive obligations when it comes to paying insurance premiums if they happen to have a child eligible for CHIP (or, in some circumstances where premiums apply, Medicaid). These families must pay to purchase full family-based coverage on the Exchange *and* in 30 states CHIP premiums are required for their children. The amount they are expected to pay for their Exchange coverage is not adjusted in any way to reflect that they also have premium obligations in CHIP for their children.

> **RECOMMENDATION:** The final rules should eliminate the prospect of families facing a "double hit" when it comes to paying premiums for coverage for their

children. In particular, we encourage the Treasury Department to determine if it has the discretion to take into account existing premium obligations, such as for CHIP, when evaluating the size of a family's required contribution to Exchange coverage under advance premium tax credit calculations. In addition, we encourage HHS to evaluate whether it can allow or even require states to waive the CHIP premium obligations of families whose expected contribution to Exchange coverage fails to take into account that their children already are insured through CHIP.

**Eliminate waiting periods in CHIP.** The proposed Medicaid rule fails to address the issue of waiting periods in CHIP (i.e., minimum lengths of time during which children must be uninsured before they can enroll in coverage). In general, waiting periods no longer make sense in a post-ACA universe in which everyone is expected to enroll in coverage and, indeed, can face penalties for failing to do so. Moreover, if states are allowed to continue to impose waiting periods, it will exacerbate the problem of families being excluded from advance premium tax credits based on a self-only test. Parents hit by this nonsensical policy not only will be unable to secure a tax credit for themselves, but they may also be forced to see their child(ren) go without coverage during a CHIP waiting period.

**RECOMMENDATION:** We recommend that the final Medicaid rule eliminate waiting periods in CHIP. Many states already have taken this step, and it makes no sense in a post ACA world to require children to be uninsured for a specified period of time before they can secure insurance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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**Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers**

**PART 155—Exchange Establishment Standards And Other Related Standards Under The Affordable Care Act**

**§155.310 – Eligibility determination process**

**§155.310(a)(2). Retain the provision that disallows an Exchange from requiring non-applicants to provide information about themselves not needed for determinations.**
We strongly support inclusion of the language in 155.310(a)(2) to not require non-applicants to provide information about themselves unless such information is necessary for another family member's eligibility determination. This provision is consistent both with the statute, which specifies that people can only be required to provide the minimum information needed to conduct an eligibility determination, and with the public policy goal of increasing enrollment of eligible individuals in coverage. In the absence of such a protection, many people may find the process of applying for coverage unnecessarily intrusive and be discouraged from enrolling.

**§155.310(b). Retain the provision to allow an applicant to bypass a determination of eligibility for financial assistance in the insurance affordability programs.**
We support the provision in §155.310(b) that prevents people from picking and choosing the affordability program to which they want to apply. States have enormous incentives to encourage individuals to seek federally-funded tax credits rather than Medicaid or CHIP, which are partially state funded. We believe §155.310(b) is an important backstop against potential state efforts to steer enrollment away from Medicaid and CHIP and should be retained.

**§155.310(d)(2). Allow consumers to take less than the full premium credit if they desire but ensure that there is sufficient consumer assistance to help applicants fully understand the impact of attesting to future income.**
Given the fiscal problems that people may face if they are hit with a repayment obligation, we support allowing people to take less than the full premium credit for which they qualify. However, we think this measure needs to be accompanied by stronger requirements that Exchanges play a more active role in educating consumers about not only the credit and the risk of reconciliation payments, but also the potential to pay higher cost-sharing, which is not reconciled. In addition, we note that this provision highlights the importance of Navigators having the capacity to help people decide whether to take advantage of this option. Educating consumers regarding the interplay between premium credits, cost-

sharing reductions and the annual reconciliation process should be specifically included in the responsibilities of Navigators.

In addition, we believe that Exchanges should be required to provide more consumer assistance when people are obligated to attest to their future tax status and we are somewhat concerned that 155.310(d)(2)(ii) does not acknowledge the complexity created by the requirement that people attest to their future status.

**RECOMMENDATION:** Exchanges should be required to provide information on how the credit works, the nature of the reconciliation process, and the pros and cons of taking less than a full credit, including the impact on cost-sharing.

**RECOMMENDATION:** We recommend that Exchanges be required to provide people with information on why they are obligated to attest to their future tax status and on how they can and why they should report changes over time.

**RECOMMENDATION:** In outlining procedures for reporting changes over time, we recommend that you consider requiring people to report changes in their circumstances only if the changes make them eligible for a larger tax credit. In circumstances where people experience an improvement in their circumstances, they should be given a "safe harbor" from reconciliation obligations if they accurately described their circumstances to the best of their ability at the time of application. It is simply unrealistic to imagine that people can accurately predict their future income and household composition in many circumstances.

**RECOMMENDATION:** We recommend that you strengthen 155.310(d)(3) to require Exchanges to transfer a finding of eligibility for Medicaid and CHIP (not just to provide "notice," as is currently proposed) to the State Medicaid or CHIP agency promptly and without undue delay, but within no more than 1 business day.

**§155.310(g). Provide stronger protections for consumers against employer retaliation when an employee is approved for a premium tax credit in the Exchange.**
We are concerned that §155.310(g) is dangerously broad and could expose workers to retaliatory action by employers who face employer responsibility payments.

**RECOMMENDATION:** We recommend that you clarify in the provision that employers should be notified of an employee's receipt of an advance payment of the premium tax credit or cost-sharing reduction only if it has direct implications for the size of an employer's responsibility payment. Moreover, the employer should be provided only with the minimal information required to evaluate its liability for employer responsibility payments. Finally, we recommend that the rule should require that the notice to the employer specify that employers may not retaliate against employees receiving subsidies.

**§155.315 – Verification process related to eligibility to enroll in a QHP through the Exchange**

**§155.315(b). Strengthen the requirement for Exchanges to access citizenship and immigration data by specifically referencing the electronic data service established in 42 CFR §435.949.**

We support that Exchanges must access data through HHS to verify citizenship and immigration status provided by other federal agencies.

> **RECOMMENDATION:** We recommend that a specific reference be made to the electronic data service established in 42 CFR §435.949.

**§155.315(c). Require self-attestation of verification of residency.**

In our comments on the Medicaid NPRM at 42 CFR §435.956(c) and §457.380(c), we recommended that states be required to accept self-attestation of residency.

> **RECOMMENDATION:** Similarly, we propose that the Exchange be required to accept self-attestation of residency.

**§155.315(g). HHS should monitor compliance of Exchanges in not requiring information from applicants and enrollees that is not necessary.**

We support that Exchanges are prohibited from requiring an applicant to provide information beyond the minimum necessary to support eligibility and enrollment in the insurance affordability programs.

> **RECOMMENDAITON:** We recommend that HHS implement a review of this policy to ensure compliance.

**§155.320 – Verification process related to eligibility for insurance affordability programs.**

**§155.320(c). Further clarification of the sequencing process in evaluating current monthly income versus future projected income and what is expected of applicants is needed.**

This provision of the proposed rule is complicated and needs significant clarification. It is difficult to see how the process would work for many individuals and families applying for coverage.

In general, the process must look at eligibility based on two different sets of rules, one for Medicaid based on current monthly income and the other for premium tax credits and cost-sharing reductions in the Exchange based on projected annual income. It is not clear whether this would be sequenced in some way or require the family to understand the program rules in order to attest to their income. Section (c)(3) is especially problematic because it could limit advance payments for families in a way that makes coverage unaffordable.

As we have noted in our comments on the Medicaid rule, the "reasonably compatible" standard is not well defined. For Medicaid, we recommend that it be defined as a difference that would change the outcome of the eligibility determination. However, for advance payments almost any difference in income could result in a greater or lesser advance payment, which has financial implications for low-income families. Thus, it is not clear

when an attestation would be considered reasonably compatible with the prior tax return. Moreover, if it is reasonably compatible, it is not clear what income information would be used to determine the advance payment— the amount in the prior year tax return or the amount the applicant attests to.

We are especially concerned that the proposed rule would only consider substantial decreases in income in determining the amount of the advance credit and the level of cost-sharing reductions. In providing examples of what types of income changes can trigger the use of more recent information to determine eligibility, the statute provides an example of a decrease in income of more than 20 percent. The statutory language makes it clear, however, that the Secretary is not limited by the examples and can take into account "other significant changes in eligibility." We recommend that HHS use this flexibility to adopt a lower threshold, since a 20 percent change in income is not sensitive enough to respond to the needs of low- and moderate-income families.

For example, for a family of four with income of just over 200 percent of the poverty line ($44,700 in 2011), a 20 percent change in income amounts to $8,940 — quite a substantial sum. If this family's annual income drops by $8,000, but it is not allowed to use more recent income information during open enrollment because the decrease is less than 20 percent, then — based on information from the most recent tax year — the family would have to pay 6.3 percent of its income toward premiums and be enrolled in a plan with a 73 percent actuarial value. If more recent income information were used, the family would instead pay 4.6 percent of income toward premiums and be enrolled in a plan with an 87 percent actuarial value, which means the family's deductibles and cost-sharing would be considerably less.

In this case, the use of a lower threshold would result in a much more accurate calculation of premium credits and cost-sharing reductions. As illustrated by this example, if people cannot have their eligibility determined on the basis of more recent information unless they experience a decrease in income of at least 20 percent, then a family whose income falls significantly may fail to receive the cost-sharing assistance for which it should qualify. And since there is no year-end reconciliation for the cost-sharing reductions, there would be no way for the family to recover the additional money it spent on higher deductibles and co-payment amounts.

> **RECOMMENDATION:** We recommend that individuals and families be allowed to report more current information on income without a percentage or dollar limit being placed on what they may report, but the Exchanges only be required to use the newer information in determining eligibility and the amount of the credit when there has been a change that 1) either exceeds a specified threshold, 2) would result in the family being eligible for a lower cost-sharing category , or 3) would make a family eligible or ineligible for the credit. While we are not making a specific recommendation here on the exact level at which to set the threshold, we note that it should be sufficiently low so that it is sensitive to people's needs — i.e., it should be set well below 20 percent. At the same time, it should not be so low that it would apply to almost everyone and be overly burdensome to administer. The threshold

could be set just as a modest percentage of income, or as the higher of a modest percentage of income or a flat dollar amount. Under any scenario, states that want to adopt a lower threshold should be given the option to do so.

**§155.320(e). The Exchange, not applicants, should be responsible for determining if an applicant's employer-sponsored coverage is affordable and meets minimum value standards.**

We support the general approach of this provision, which would allow applicants to attest whether they are eligible for employer-sponsored coverage. The preamble suggests that Exchanges would be responsible for determining whether such coverage is affordable and whether it meets minimum value standards based on other information sources.

**RECOMMENDATION:** We are hopeful that HHS or the Exchange will implement an alternative means for confirming enrollment in or eligibility for minimum essential coverage. Alternatively, we support standard templates for the information needed to make this determination as suggested in the preamble. Employees should not be expected to provide information regarding minimum value, for example, as this would not be readily accessible to them.

**§155.330 – Eligibility redetermination during a benefit year**

**§155.330(b). Different reporting requirements should be established for the various changes potentially impacting eligibility that enrollees might encounter.**

Paragraph (b)(1) requires that all Exchange enrollees report changes related to the eligibility standards specified in §155.305 within 30 days of such change. These changes could include, but are not limited to, changes in residency, immigration status, household income, and eligibility for employer-sponsored coverage.

**RECOMMENDATION:** We recommend a requirement to report changes in household size and eligibility for minimum essential coverage within 30 days of such a change.

Reporting Changes in Income - We believe that the proposed rule, which requires all individuals to report any changes in income (regardless of the magnitude), is overly broad, and unnecessarily goes further than what the statute requires. While it can benefit consumers to report income changes to reduce their potential liability during reconciliation, requiring consumers to report all income changes is too cumbersome for both consumers and the Exchange. Because the premium credits are linear, any change in income, no matter how small, would affect the amount of the premium credits that an individual or family is entitled to receive. Accordingly, we recommend that HHS and the Exchanges encourage, but not require, premium credit recipients to report income changes.

In addition, under the proposed rules, changes in income reported will be subject to the verification procedures described in §155.320. Under §155.320, decreases in income reported by the enrollee will be considered and used only if the income drops more than 20 percent from the income reported in the enrollee's most recent tax return or if a member of the household has filed an application for unemployment benefits. As explained in our

comments on §155.320, we believe that the 20 percent threshold for acting on decreases in income is too restrictive. Households should have the option to report decreases in income, and significant changes should be acted on by the Exchange to ensure that advance payments are sufficient for the family to afford coverage and that families are not unfairly paying additional cost-sharing.

For increases in income, the reconciliation process should be sufficient to ensure that premium credits people receive in the end are accurate. As any excess credits received would have to be reconciled and repaid when they file taxes, households will have an incentive to report changes to avoid repayment at tax time. We recognize that it is important to limit consumers' risk of having to pay back excess credits during the reconciliation process. Accordingly, we recommend that the Exchanges be required to educate consumers about the risks of reconciliation, and encourage consumers to report significant increases in income.

In addition, families should be encouraged to report income changes at certain thresholds that may make them eligible or ineligible for assistance, including for cost-sharing subsidies. Exchanges should provide families with information on the dollar amounts that correspond to monthly income 138 percent (eligibility for Medicaid), 250 percent (eligibility for cost-sharing subsidies), and 400 percent (no longer eligible for premium credits) of FPL in order to encourage reporting when such thresholds are crossed.

> **RECOMMENDATION:** We recommend that HHS and the Exchanges encourage, but not require, premium credit recipients to report income changes. Families should always have the option to report changes, and Exchanges should be required to act on decreases in income, particularly those that affect access to affordability programs, and on significant increases.
>
> **RECOMMENDATION:** Exchanges should be required to educate consumers about the risks of reconciliation, and encourage consumers to report significant increases in income, as well as changes that may put them over or under specific thresholds for assistance.

**§155.330(c). Reviewing eligibility on a continual basis is neither administratively efficient nor effective in promoting continuity of coverage.**

§155.330(c)(1) requires Exchanges to periodically examine available data sources to identify cases in which an individual has become eligible for Medicare, Medicaid, CHIP, or Basic Health. We recommend striking this for two reasons. First under 24 CFR §435.916(a)(4), the Medicaid agency is required to assess eligibility for other insurance affordability programs when an individual is determined to be no longer eligible for Medicaid and to send the pertinent data to the appropriate program to which he or she is eligible. Secondly, individuals are required to report changes to eligibility in accordance with this section of the proposed rules. Thus, continual review of other data sources is redundant and represents an unnecessary administrative burden to the Exchange. This is consistent with our recommendation at §435.945(b).

> **RECOMMENDATION:** Eliminate §155.330(c)(1) in the final rule.

**§155.330(e). HHS should coordinate coverage start and end dates between the insurance affordability programs to eliminate possible gaps in coverage.**
The proposed rule requires that changes from a redetermination conducted during the benefit year are effective on the first day of the month following the date of the notice. Such a redetermination should trigger a special enrollment period. For example, an individual who is receiving premium credits experiences a decrease in income, such that the individual becomes eligible for a cost-sharing reduction. Alternatively, a family gains a dependent, which changes their household size. These changes not only result in a change in eligibility for premium credits and cost-sharing reductions, they also entitle an enrollee to change plans through a special enrollment period. Consequently, the effective dates for changes that result from a mid-year redetermination should coincide with the effective dates for coverage through a special enrollment period.

However, there is concern that an individual or family determined eligible for Medicaid could experience a gap in coverage if the Medicaid agency is unable to process their enrollment in a timely matter. HHS should coordinate coverage start and end dates between the insurance affordability programs to eliminate the possibility of gaps in coverage.

> **RECOMMENDATION:** HHS should coordinate coverage start and end dates between the insurance affordability programs to eliminate possible gaps in coverage.

**§155.335 – Annual eligibility redetermination**

**§155.335(a). Coordinate annual renewal with annual open enrollment.**
§155.335(a) requires the Exchange to redetermine eligibility on an annual basis, but does not indicate a timeframe for when the redetermination must occur.

> **RECOMMENDATION:** We recommend that HHS clarify in the final rule that annual eligibility redeterminations must be conducted in concert with the annual open enrollment period.

**§155.335(b). Explicitly clarify that enrollees are not required to submit a new application to have their eligibility redetermined.**
The process of updating such enrollees' income and family size information described in paragraph (b) should be automatic through the verification process outlined in §155.320. Moreover, there should be no need to verify eligibility factors that do not generally change from year to year such as age, citizenship, or legal immigration status.

> **RECOMMENDATION:** We recommend that HHS clarify in the final rule that enrollees receiving premium credits need not submit a new application in order to have their eligibility redetermined.

**§155.335(c). Retain and strengthen the automatic renewal notice, which provides enrollees with updated information and indicates their eligibility status going forward.**
We support the requirement for Exchanges to provide enrollees with an annual

redetermination notice that includes updated income and family size information obtained from a recent data match, the information used for the most recent eligibility determination, and the projected eligibility determination for the following calendar year after considering the updated information from the data match. It will be important for individuals and families to know what their likely eligibility for insurance affordability programs will be for the next calendar year, so that they can make informed decisions during the open enrollment period.

**RECOMMENDATION:** We recommend that these notices be automatically sent to enrollees who are receiving advanced payments of the premium tax credits, and that such individuals' eligibility be automatically reevaluated without requiring them to submit an application.

**RECOMMENDATION:** Under §155.410(d), Exchanges are required to provide a notice about the annual open enrollment period. It is unclear whether this is the same notice about the eligibility redetermination that is referenced in this section. We recommend that these two notices be merged into one and that the following information be included in the notice:

- The date that open enrollment begins and ends;
- An explanation that open enrollment is the only opportunity to enroll in new coverage or change coverage, unless there is an event that triggers a special enrollment period;
- The availability of premium credits and cost-sharing reductions;
- An explanation that open enrollment is the time for redetermining eligibility for premium credits and cost-sharing reductions;
- For individuals receiving premium credits and cost-sharing subsidies, updated income and family size information as verified by the Exchange through the data hub, the level of premium credits and cost-sharing subsidies that the individual is receiving, and the projected level of premium credits and cost-sharing subsidies based on the updated information;
- Where to obtain information about QHPs and premium credits and cost-sharing reductions, including the website, toll free call center, and through Navigator and other consumer assistance programs; and
- The penalty for being uninsured.

**RECOMMENDATION:** In addition, such notices should be written to assure communication with Limited English Proficiency individuals and to persons with disabilities, in accordance with the standards in §155.230.

**RECOMMENDATION:** Assuming that this notice is combined with the notice of open enrollment proposed in §155.410(d), we recommend that Exchanges be required to send the notice no later than 45 days before the beginning of the annual open enrollment period. This would give people the opportunity to provide updated or corrected information, or inform the Exchange that the information obtained from the data match is accurate and have their eligibility redetermined prior to the

beginning of annual open enrollment when they will need this information in order to select a plan for the coming year.

**§155.335(d). Specify that enrollees can report changes via various methods that are available at application, and for reporting changes throughout the benefit year.**

**RECOMMENDATION:** We recommend clarifying this provision to ensure that enrollees can report any changes using a variety of modes (telephone, online, in person, fax, mail).

**§155.335(e). Specify that the Exchange must act on reported changes on a timely basis and that HHS establish timeliness standards as part of the performance metrics that will be developed in future rulemaking or subregulatory guidance.**

We recognize the need to verify information reported by enrollees before Exchanges can use such information to redetermine eligibility. However, to ensure timely redeterminations, we recommend requiring Exchanges to complete necessary verifications in a timely manner, and that the consumer receives eligibility confirmation prior to the end of the open enrollment period.

**RECOMMENDATION:** Specify that Exchanges must complete necessary verifications on a timely basis and that HHS set timeliness standards.

**§155.335(f). Eliminate the requirement for signature and return of the renewal form.**

Paragraph (f)(1) directs Exchanges to require an enrollee to sign and return the redetermination notice described in paragraph (c). However, paragraph (f)(2) requires the Exchanges to proceed with the eligibility redetermination even if the enrollee fails to sign and return the redetermination notice. Thus, it is unclear why enrollees for whom the information in the notice is current and correct must sign and return the notice in the first place.

**RECOMMENDATION:** We recommend deleting (f)(1). However, the requirement to report changes and make corrections to any erroneous or outdated information contained in the notice within 30 days should still apply, which is consistent with the proposed rule for Medicaid.

**§155.335(g). Notices of eligibility at redetermination should be timely and include information about the consumer's rights to appeal the decision.**

**RECOMMENDATION:** To ensure timely redeterminations, we recommend requiring Exchanges to complete necessary verifications within a specified timeframe (10 days) so that the consumer receives eligibility confirmation prior to the end of the open enrollment period to allow for plan selection.

**RECOMMENDATION:** Consistent with our comments to paragraph §155.335(d), we recommend that notices on the outcome of the redetermination include information about consumers' rights to appeal the decision.

**§155.335(h). Effective dates of coverage or ineligibility at annual renewal should coincide with the end of the benefit year.**

We do not believe it is appropriate to use the effective dates specified in §155.330(e) for changes that result from an annual redetermination of eligibility. As noted in our comments to paragraph (a) of this section, the annual redetermination of eligibility should be conducted in concert with the annual October to December open enrollment period.

> **RECOMMENDATION:** Accordingly, we recommend coordinating effective dates as outlined for the annual enrollment periods in §155.410(f).

One exception to this rule, however, involves people who become Medicaid eligible. In those cases, we recommend that Medicaid eligibility and coverage be effective on the first day of the month the eligibility determination is made. However, following the rules outlined in §1.36-B2(c)(B) of the proposed IRS regulations, individuals who move from premium credit to Medicaid eligibility would not be treated as eligible for minimum essential coverage under Medicaid earlier than the first day of the first calendar month after the eligibility determination has been made.

> **RECOMMENDATION:** An individual or family should not be treated as eligible for other minimum coverage until the first day of the first calendar month after the eligibility determination has been made. Additionally, HHS should ensure coordination with Medicaid coverage to eliminate potential gaps in coverage.

**§155.335(i) Retain the provision that an individual or family remains enrolled in their current plan at renewal if they do not choose a new plan as part of the open enrollment process.**

We support the proposed rule to keep an eligible enrollee enrolled in the QHP he or she selected the previous year unless the enrollee terminates coverage from that plan.

**§155.340 – Administration of advance payments of the premium tax credit and cost-sharing reductions**

**§155.340(a). Strengthen the requirement that Exchanges must transmit information to facilitate the premium tax credits and cost-sharing subsidies.**

We support that the provision requires the Exchange to simultaneously transmit information to facilitate the administration of advanced payments of the premium tax credit and cost sharing subsidies to the applicable QHP and HHS. Exchanges are expected to build modern information technology systems and should have the capability to transmit data instantly in "real time." The final rule should include a timeliness standard for the transmission of these data.

> **RECOMMENDATION:** We recommend the timeliness standard to reflect the "real time" expectation that HHS has articulated, but also to provide for instances when systems are not functioning properly. We suggest the following language: "the Exchange must transmit data as quickly as possible and under no circumstances ake more than one business day."

**§155.340(b). The final rule should clarify that Exchanges must transmit minimal data and the rule should replace references to social security number with taxpayer identification number.**

We are concerned that this provision will be burdensome for Exchanges and it raises privacy concerns for employees. We recognize that the transmission of information described in this provision is required by sections 1311(d)(4)(I)-(J) of the Affordable Care Act. However, the final rule should clarify that the Exchange will only transmit a minimum amount of information required by law (employee name and taxpayer identification number).

> **RECOMMENDATION:** We recommend that the final rule clarify that the Exchange only transmit a minimum amount of information required by law (employee name and taxpayer identification number) and should replace all references to "social security number" with "taxpayer identification number" as specified in the ACA.

**§155.340(c). The final rules should specify that notices be written in plain, easy to understand language that meets meaningful access standards.**

This provision does not provide enough detail concerning what information will be provided to consumers about reconciliation or when the information will be provided. We understand that the Secretary of the Treasury will prescribe the content and timing of the notice required under this subsection, but the final rule should clarify that notifications provided by the Exchanges to consumers should be written in plain, easy to understand language that meets meaningful access standards required throughout the eligibility process.

> **RECOMMENDATION:** We recommend that the notifications be written in plain, easy to understand language that meets meaningful access standards required throughout the eligibility process so that consumers are well informed and understand the reconciliation process.

**§155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Condition Insurance Program.**

In general, §155.345 should include a provision that explicitly prohibits Exchanges from requiring individuals to resubmit or reverify any information that already has been gathered and verified after being submitted to a Medicaid or CHIP agency. On a related note, §155.345(d)(1) should make it clear that Exchanges are not allowed (not simply "not required) to duplicate an eligibility and verification finding made by a Medicaid or CHIP agency.

> **RECOMMENDATION:** Clarify that Exchanges may not require individuals to resubmit verified information.

**§155.345(b). Final rules should better define screening for non-MAGI categories.**

We recommend stronger language on screening obligations. The existing language calls for a "basic screening," but fails to provide any meaningful detail on what that entails. The language should be stronger, more specific, and make it clear how applicants and enrollees will know they can ask for more screening, particularly if there are implications for the benefit package that the applicant or enrollee would receive.

**RECOMMENDATION:** Provide greater detail on what constitutes a basic screening. We encourage you to include more stringent requirements for screening in circumstances where a state varies benefit packages for people found eligible under MAGI versus non-MAGI categories.

**§155.345(c). Require clear notice of the opportunity to request full Medicaid determinations.**

Individuals should be informed they can request a full determination of Medicaid eligibility without being required to resubmit or reverify information. Individuals who make such a request should be eligible for enrollment in a qualified health plan and receipt of premium tax credits and cost-sharing reductions while the Medicaid determination is pending.

**RECOMMENDATION:** Require clear notice of the opportunity to request a full determination, specifying that individuals will not be required to resubmit or re-verify any information that already has been provided to the Exchange. Allow individuals to enroll in subsidized coverage while their full Medicaid determinations are pending.

**§155.345(d). Identify responsibility for enrollment into Medicaid and CHIP.**

The language addressing the requirement for Medicaid and CHIP agencies to evaluate eligibility for Exchange coverage is vague, saying only that procedures must be in place to ensure a determination "is performed" without specifying which agency is required to perform the determination.

**RECOMMENDATION:** The final rule should make it clear that Medicaid and CHIP agencies must screen applicants for Medicaid eligibility and, if they are found eligible, to enroll them in coverage. We believe that this more robust requirement is clearly envisioned in the statute, which calls on Medicaid and CHIP agencies to screen applicants for coverage and, "enroll" those found eligible.

**§155.355 Future rulemaking on appeals should ensure that all information is provided in a meaningful and accessible manner.**

We support the requirement that Exchanges include information about the right to appeal and how to appeal in notifications provided to consumers when any determination regarding eligibility or the amount of advance payments and cost-sharing subsidies are made. We note that this provision refers to three separate sections regarding eligibility determinations— the eligibility determination process at §155.310, eligibility redetermination during the benefit year at §155.330, and the annual redetermination process at §155.335.

The preamble states that the details of the individual eligibility appeals process and standards for federal appeals will be in future rulemaking. We look forward to commenting on these rules.

**RECOMMENDATION:** Future rulemaking on appeals should require that Exchanges ensure that notices and information on the right to appeal be provided in an accessible and readable manner and that it should meet the

meaningful access standards for persons with limited English proficiency and conform to rules ensuring equal access to persons with disabilities.