



July 12, 2012

Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

RE: Comments on CCIIO's Verification of Access to Employer-Sponsored Coverage Bulletin

Dear Sir or Madam:

The Georgetown University 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. Central to our work is providing research and policy assistance to state administrators and state-based organizations on strategies for covering children and their families through public insurance affordability programs, especially Medicaid and CHIP. We conduct research and analysis to inform federal and state policymakers about issues impacting children and families in health care reform and to improve Medicaid and CHIP, particularly around streamlining enrollment and renewal systems.

Thank you for the opportunity to comment on the CCIIO Bulletin released April 26, 2012, on Verification of Access to Employer-Sponsored Coverage. While we recognize the challenges that CCIIO faces in implementing this provision given the lack of available, reliable data on access to employer-based coverage, we have significant concerns with the proposed strategies outlined in the Bulletin.

In particular, the Bulletin appears to rely heavily on the unrealistic assumption that consumers will be able to gather and provide complex data and information regarding their employer-based coverage. For example, the Bulletin indicates that consumers will need to provide information on the lowest-cost plan offered by their employer that meets "minimum value." Applicants will not know what "minimum value" means and will not be able to determine which of the plans offered by their employers meet this standard. Moreover, the lowest cost plan that meets minimum value is not necessarily the same thing as the cheapest plan offered by someone's employer, adding an additional level of confusion to the requirement that individuals provide such information. While the Bulletin indicates that HHS will encourage employers to provide such information on standardized form, they are not required to do so which may leave many consumers obligated to provide information that is not readily available to them.

We recognize that CCIIO is faced with statutory language that imposes constraints on how it implements the provision to verify employer-based coverage, however, we encourage the agency to revisit the question of whether it can identify alternatives to the strategies outlined in the Bulletin. In the face of unrealistic provisions and timeframes, other agencies have found methods for developing workable solutions and we encourage CCIIO to take a similar approach here. For example, to make it easier for employers to assess whether or not the coverage they provide will be "affordable" to their employees, the Department of the Treasury made the simplifying policy decision that employers need to take into account the cost of the coverage relative only to an employee's wages (not the employee's household income, as an initial reading of the statute might suggest). Similarly, the Department of Labor recently elected to defer implementation of the automatic enrollment requirement imposed on

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large employers for two years, citing the need to wait until it is possible to craft and issue appropriate guidance.

In the comments below, we recommend that only certain applicants should be subject to the verification policy outlined in the Bulletin. We also recommend a number of specific changes to HHS' proposed interim policy that would facilitate simple and effective pre-enrollment verification. Under certain circumstances, the Bulletin proposes to allow verification of information about the affordability and adequacy of employer coverage to be conducted after enrollment in a qualified health plan (QHP). However, this strategy could result in some people losing eligibility for advance premium tax credits (APTCs) and then being left unable to enroll in their employer coverage because the open enrollment period has ended. To avoid such situations, verification of access to affordable and adequate employer-sponsored insurance should occur at the time of application.

I. Guidance Should Clearly Identify When Applicants' Access to Employer Coverage Is Subject to Verification

The Bulletin does not specify the circumstances under which Exchanges must verify employer-sponsored coverage versus accept the attestation provided by applicants. The interim policy outlined in the Bulletin appears to require that all applicants must provide information about the availability of employer-sponsored coverage to the Exchanges and that such information must be verified using the procedures proposed in the Bulletin. However, verifying whether all applicants have an offer of coverage in this way would be burdensome for applicants and Exchanges, and is inconsistent with the statutory language of the Affordable Care Act (ACA).

Section 1411(b)(4) of the ACA sets forth the procedures that Exchanges will use in determining eligibility for premium tax credits in the situation where an offer of employer-sponsored coverage is not affordable and/or does not provide minimum value. This section states that only when an applicant with an offer of employer coverage is establishing eligibility based on this special rule, information concerning the employer and details on the coverage offered by the employer must be provided as part of the eligibility determination process. As such, the process for people who are not claiming this exemption should be handled in a different manner, as discussed below.

Applicants who are likely eligible for Medicaid should not be asked questions about the affordability and minimum value of employer-sponsored coverage available to them. An offer of employer coverage does not impact eligibility for Medicaid. As such, questions pertaining to the availability of such coverage should only be asked of applicants with income and other information that shows they are likely eligible for APTCs. Asking for information relating to employer-based coverage from applicants who are not expected to be eligible for APTCs would likely cause confusion as it is not a criteria for eligibility. It could also delay processing, as applicants will probably not have ready access to such information.

Applicants should first attest to whether they have any offer of coverage and are enrolled in such coverage. Section 1411(b)(4) of the ACA refers only to individuals for whom eligibility for APTCs is being established on the basis that they have an offer of employer coverage that is either unaffordable or does not meet the minimum value standard. It does not apply to applicants who do not have any offer of coverage from their employer. We therefore recommend that applicants should first attest as to whether or not they have any offer of coverage. Self-attestation as to lack of access (or access) to an offer of employer coverage should be sufficient verification, unless the attestation is not reasonably compatible with other information available to the Exchange.

If applicants indicate that they have an offer of coverage from their employer, they should then attest to whether they are enrolled in such coverage. Footnote 3 of the Bulletin states that it “does not include a discussion of verification of actual enrollment in an eligible employer-sponsored plan. However, the basic approach detailed herein would also be an acceptable solution for verification of enrollment.” This statement conflicts with the final rule on Exchange eligibility and enrollment, which (at §155.320(d)) provides that Exchanges will verify whether an individual is enrolled in an employer-sponsored plan by “accepting an applicant’s attestation without further verification.” The Exchange should request further documentation from the individual only if it finds that the attestation is not reasonably compatible with other available information. It will be important to discern if an applicant is enrolled in employer-sponsored coverage, as the individual would therefore be ineligible for APTCs regardless of whether the offer of employer coverage is unaffordable or fails to provide minimum value.

II. Verification of Employer-Sponsored Coverage Should Follow the Framework Established by the Final Exchange Eligibility Regulations

In keeping with the strong statutory language of the ACA, the final Exchange rule outlines a vision for connecting people to coverage that harnesses the use of technology and data matching to the maximum extent possible. While we support leveraging existing data sources to verify access to affordable employer-sponsored coverage that meets minimum value standards, the use of such electronic verification will likely be very limited, at least in the initial years, as no databases exist that would allow for electronic verification of access to employer-sponsored coverage that is affordable and meets minimum value standards. Therefore, it is likely that a significant portion of premium credit applicants that claim their employer’s coverage does not meet minimum value or is unaffordable would be unable to have such information electronically verified during the application process. As such, it will be important to rely on information provided by employers and applicant attestation.

Detailed information should be required from applicants only if it is readily available. Section 1411(b)(4) requires applicants whose eligibility for APTCs is being established on the basis that their offer of employer coverage is unaffordable or inadequate to provide the following information:

- The name, address, and employer identification number of the employer (if available),
- Whether he/she is a full time employee, and
- Whether the employer provides minimum essential coverage and if it does, the lowest cost option for the enrollee and his/her required contribution.

Some applicants may be able to obtain a subset of this information on their own. For example, the name and address of the employer are typically included in employee pay stubs and the applicant should be able to provide information whether he or she is employed on a full- or part-time basis, as long as a clear definition of what constitutes “full-time” is provided. The employer identification number can be located on W-2 forms that employees receive at the beginning of each calendar year.

However, information on the nature of the coverage offered will be difficult, if not impossible, for applicants to provide without assistance from their employers. As we discuss further below, we believe HHS should encourage employers to provide an easy-to-understand document at open enrollment that shows which plans meet the minimum essential coverage requirements. If employers do so, applicants may be able to provide such information to the Exchanges. However, since employers are not required to share such information, applicants should not be required to provide it if such information is unavailable from their employers.

Inaccessible information should not delay processing. If applicants are unable to provide all the necessary information pertaining to the affordability and value of employer-based coverage, the

processing of their applications should not be delayed. In this situation, we recommend that Exchanges follow the guidelines laid out in §155.315 (f) and (g) of the final regulations that describe the approach to resolving inconsistencies. Under this approach, the Exchange would proceed with the eligibility determination as data on employer-based coverage are sought through other channels. If no such data can be found, the applicant's eligibility could be determined without it, applying the exception for special circumstances that allows the applicant to attest to information that is not available.

Strategies for collection of information on employer-sponsored coverage should focus on obtaining information from employers. We recommend the use of a standardized method to collect information about employer-sponsored coverage. HHS should develop a standard form or worksheet that employees could use to help them complete an application, with instructions on the specific information that needs to be collected and how to collect it. The form should be consumer-friendly, and to the greatest extent possible minimize the burden on applicants to collect the information.

As mentioned above, some of the information requested of applicants will need to be gathered from employers. Specifically, applicants will have to rely on their employers for information needed to determine whether available employer-sponsored coverage meets minimum value standards, along with the employee cost of such coverage. Since employers are the best, and really only, source of this information, we believe that efforts and strategies to encourage and make it easier for them to report such information to the Exchanges is likely to yield more useful information. As such, we support the Bulletin's proposal to develop standard methods for collecting information about employer-sponsored coverage directly from employers.

Employers already provide information about the cost of various plans to their employees (usually before the start of an open enrollment period), although this information may not be provided in a consistent way. Many open enrollment periods occur during the same time period as the open enrollment period for coverage through the Exchanges (October through December). At this time, employees evaluate their health insurance choices, and to facilitate this, employers provide information about the cost to employees of each available plan. HHS should take advantage of this existing opportunity and encourage employers to disseminate the additional information that is needed to determine the affordability and adequacy of the coverage it offers to its employees and report the information to the Exchange during this time. We believe that large employers in particular will have an incentive to report such information in order to avoid having workers request the information from them on an individual basis.

Affordability and minimum value information provided by an employer should be considered "verified". Any information on the affordability and minimum value of coverage provided by employers — either furnished directly to the Exchange or indirectly through the applicant — should be considered sufficient to verify whether the offer is affordable and provides minimum value for purposes of determining eligibility for the APTCs. As noted above, we support the use of standard forms that employees and employers can use to voluntarily collect and provide information about employer-sponsored coverage. These forms could then be used as documentation to verify information about an applicant's employer coverage. For example, if an employer provides a standard, HHS-approved form during open enrollment that details the affordability and adequacy of the coverage it offers to its employees, that form should be able to serve as sufficient documentation of such coverage. Similarly, applicants could ask their employers to fill out and certify information about employer coverage on an HHS-approved form, which should then serve as sufficient documentation for the Exchanges to verify access to employer-sponsored coverage that is affordable and has minimum value.

Post-enrollment verification should be avoided as it could pose significant financial burdens to some consumers. HHS proposes to conduct post-enrollment verification as an interim strategy until a reliable data source is established. While we support the intent behind HHS' proposal, which is aimed at ensuring that eligibility decisions do not get delayed, we believe that if information is obtained from the employer during the application process as laid out above, such post-enrollment verification is unnecessary and duplicative. Additionally, if the required information is simply unavailable to the applicant, the Exchange should proceed with the eligibility determination based on the applicant's attestation, consistent with §155.315 (f) and (g) of the final regulations. Post-enrollment verification would only increase the burden on the Exchanges, employers, and applicants.

We are also concerned that this review may produce some unintended consequences that could pose significant financial burdens on some consumers. Consider a scenario in which the Exchange determines, based on information provided in the application, that an individual's offer of employer coverage is unaffordable and therefore the individual is eligible for the APTC. However, when the Exchange conducts post-enrollment verification, it receives information indicating that the employer offer of coverage meets the affordability test. In such a scenario, would the individual then be determined ineligible for the premium credit?

We are particularly concerned that at this point, individuals who were told by the Exchange that they were eligible for APTCs would have already declined participation in their employer-sponsored coverage and as a result be locked out of such coverage until the next open enrollment period. If these individuals are subsequently determined ineligible for the premium credit, they would have little choice but to purchase unsubsidized Exchange coverage that would likely be much more expensive than the coverage originally offered by the employer or remain uninsured.

The best way to avoid such an outcome is for HHS to have robust information about employer coverage that would facilitate verification at the time of application. Thus, HHS should strengthen efforts, such as the strategies mentioned above, to obtain upfront, timely and accurate information directly from employers. In addition to pursuing such strategies, HHS should ensure that consumers are not be financially burdened by the Exchange's inability to verify access to affordable employer-sponsored coverage that meets minimum value standards during the application process. Thus, if post-enrollment verification is retained as an option, we recommend allowing consumers to maintain their eligibility for APTCs until they are able to enroll in employer-sponsored coverage either through a special enrollment period or during the next open enrollment period.

Any federal verification system should be made available to the states through the federal data hub. HHS has suggested that access to minimum essential employer-sponsored coverage can be verified through the development of a database populated with relevant information from employers. As noted above, we support a standardized way to collect these data and encourage employers to submit them to the Exchange. Such a strategy would streamline the eligibility determination process and ease the burden on both applicants and employers (who would only have to supply the data once, as opposed to responding to each employee inquiry). HHS also suggests that such a database could be part of the data hub that Exchanges will access to verify applicants' information. We strongly support that the data collection, storage, and dissemination be housed within the centralized federal data hub and made available to all state Exchanges. Consolidating this function will ease the burden on employers, especially large, multi-state employers, as well as on states and individuals.

Thank you for your consideration of our comments. If we may provide further information, please contact Martha Heberlein at 202-687-4929.