March 18, 2013

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-9958-P

P.O. Box 8010

Baltimore, MD 21244-8010

**RE: Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions**

**CMS-9958-P**

Dear Sir or Madam:

The Center for Children and Families is a non-profit organization based at Georgetown University’s Health Policy Institute whose mission is to expand and improve coverage for children. We appreciate the opportunity to comment on the proposed rule relating to eligibility for exemptions and the process for designating health coverage as minimum essential coverage. Our comments follow.

Sincerely,

Jocelyn Guyer

Co-Executive Director

**General Comments**

We are extremely concerned that consumers will not have good, clear information on the exemption options during the initial open enrollment period and throughout 2014. The notion of a “shared responsibility payment” and an “exemption” will be entirely new concepts to most people. In light of the risk of significant confusion on these issues and given the complexity of verifying eligibility for exemptions, we recommend that you consider adopting a one-year transition period during which a somewhat simplified set of exemption verification procedures apply. In particular, we urge you to rely primarily on self-attestation of exemption status – accompanied by appropriate safeguards -- for this transition period. While Exchanges can and should check any data that are easily available to them on quantifiable exemptions (e.g., exemptions relating to the cost of coverage exceeding 8 percent of income on behalf of individuals who have applied to an APTC and, thus, provided detailed financial data), we otherwise think it is unlikely that HHS and SBEs will be able to apply nuanced verification policies and procedures. Self-attestation is a more realistic alternative for a transition period. To discourage people from misrepresenting their circumstances, we encourage you to design an exemption form that ensures people are signing under penalty of perjury. Moreover, HHS and/or states could plan on pulling a sample of cases for review and audit, and, moreover, they could advertise this to exemption applicants so that they are aware of the appropriate oversight steps that are being taken.

We strongly support the decision to implement the exemption for lack of lawful presence “exclusively through the tax filing process.” It would not be appropriate or effective to provide for a process under which an individual would be required to present himself or herself to an Exchange as not lawfully present.

**§155.605 Eligibility standards for exemptions**

We agree with the decision to provide an exemption to all individuals who would have been eligible for Medicaid but for their state’s decision not to expand. For some people with income between 100% and 138% of the FPL who would have been covered under Medicaid but for the Supreme Court decision, the cost of Exchange premiums and cost-sharing may be prohibitively expensive. It would be unfair to exacerbate the hardship they face as a result of the Supreme Court decision by imposing a shared responsibility payment for them if they elect not to enroll in Exchange coverage.

We strongly support providing the exemption for the entire calendar year (and potentially for more than one year if the hardship occurs over months in two calendar years). It already is going to be quite complicated to administer the exemptions, and it makes little or no sense to make the job far more complex by requiring people to make repeated requests for exemptions.

We also are concerned that people who qualify for an exemption and then lose it do not have access to a special enrollment period. We believe it would be fairer and promote a smoother implementation of the ACA if people were given a special enrollment period that allows them to enroll in Exchange coverage due to loss of an exemption.

**§155.610 Eligibility process for exemptions**

We are concerned that the rule says, “the Exchange must determine eligibility for exemptions promptly and without undue delay.” This standard is so vague as to be meaningless. We recommend that you establish a standard period during which exemptions must be determined (e.g., 15 days).

**§155.615 Verification process related to eligibility for exemptions**

Paragraph (g) is very difficult to follow and leaves unanswered the question of what happens if electronic data are not available to support someone’s application for an exemption. As discussed above, we believe an appropriate transitional solution is to allow self-attestation except in those instances in which the Exchange has data on file showing an inconsistency.

**§155.620 Eligibility redeterminations for exemptions during a calendar year**

As our colleagues at the Center on Budget and Policy Priorities have elaborated on in more details, the obligation to report changes in eligibility for an exemption is highly problematic because it could expose individuals to payment of a penalty when they have no ability to enroll in coverage. If the reporting obligations are maintained, we strongly urge you to ensure that individuals who lose their exemptions over the course of a calendar year have access to a special enrollment period.

### **§156.602 Other coverage that qualifies as minimum essential coverage**

In general, we support the goal of allowing people to remain in their current plans without having to worry about a shared responsibility payment and so are supportive of the list of coverage types that qualify individuals for an exemption. However, we are concerned that the definition of “minimum essential coverage” used to evaluate exemptions also may be used to determine APTC eligibility. It would be inappropriate to exclude people from financial help in purchasing Exchange plans simply because they have access to plans that historically have served as “patches” for those without better employer-based insurance. As a result, we encourage you to work with the Treasury to ensure that designating certain additional types of coverage as minimum essential coverage does not inadvertently prevent people who are offered such coverage from being determined eligible for subsidies.

### **§156.604 – Requirements for recognition as minimum essential coverage for types of coverage not otherwise designated minimum essential coverage in the statute or this subpart**

We are very concerned that plans might be considered to constitute minimum essential coverage if they are found to “substantially” comply (but apparently not have to fully comply) with the requirements of Title I of the Affordable Care Act. We strongly believe that HHS must not give the designation of minimum essential coverage to plans that do not meet all relevant ACA standards.