



July 28, 2014

VIA ELECTRONIC SUBMISSION (www.regulations.gov)

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9941-P,
P.O. Box 8010,
Baltimore, MD 21244-8010

**Re: Notice of Proposed Rulemaking CMS-9941-P
Guidance on Annual Redeterminations for Coverage for 2015**

Dear Sir/Madam,

Thank you for the opportunity to comment on the Marketplace Renewal Proposed Regulations, CMS-9941-P, (hereinafter referred to as the “NPRM” or “proposed rule”) and *Guidance on Annual Redeterminations for Coverage for 2015* (hereinafter referred to as “2015 renewal process”).

The Center for Children and Families is based at Georgetown University’s Health Policy Institute with the mission of improving access to health care coverage among the nation’s low- and moderate-income children and families. As such, we have a long history of conducting analysis, research and advocacy on issues relating to enrollment in all insurance affordability programs, including Medicaid and CHIP, as well as qualified health plans (QHPs).

Of the 8 million individuals who gained coverage through the new health insurance marketplaces, an overwhelming 85 percent received financial assistance. Continued access to the appropriate amount of premium tax credits (PTC) and cost-sharing reductions (CSR) is critical to the affordability of coverage and the health and economic security of low- and moderate-income children, families and individuals. How the marketplace re-determines eligibility for PTC and CSR and renews coverage in QHPs will have a significant impact on maintaining the gains our country has made in providing access to affordable health insurance.

We understand that the 2015 renewal process guidance will not apply until the final rule (NPRM CMS-9941-P) is promulgated. Thus, we hope you find our comments and recommendations useful in finalizing the process for redeterminations for 2015 coverage and drafting the marketplace notices (which we hope will provide an opportunity for comment).

§155.330(b)(4) - Eligibility redetermination during a benefit year. Providing consumers with the option to report changes, renew eligibility, or take any action required by the marketplace by mail is important to many older, rural or low-income consumers who have limited access to the internet, telephone or transportation. The drafters of the ACA recognized that mail is an important avenue to coverage and required marketplaces (as well as Medicaid and CHIP agencies) to offer it as one of the four required modes of application (§ 1413).

Recommendation: Retain the regulatory requirement that marketplaces allow consumers to use mail for reporting changes as currently specified at §155.330(b)(4).

§155.335 - Annual eligibility redetermination. We appreciate the logic of phasing in functionality when deploying the kind of sophisticated information technology systems that underpin the federal and state marketplaces. We understand that the development of a robust, fully automated process for redetermination of financial assistance and QHP renewal will take time and acknowledge that not all desired system capacities will be in place for the first round of redeterminations and renewals. Thus, we generally support the additional options for redeterminations that this rule provides at §155.335(a)(2)(i) and §155.335(a)(2)(ii) as marketplaces strive to fully implement the vision of the Affordable Care Act. However, we strongly urge HHS to develop a vision for renewals that introduces more technological improvements to enhance the consumer experience, promote productivity and administrative efficiency, and facilitate retention and enrollment.

§155.335(a)(2)(ii) - Alternative procedures specified by the Secretary for the applicable plan year. The existing procedures described in §155.335 (b) through (m) should remain the ultimate goal that all marketplaces should achieve as quickly as possible. Automated redeterminations based on multiple data sources for all enrollees and individuals who completed a marketplace application will ensure that the most accurate level of financial help will be provided to consumers.

RECOMMENDATION: Amend §155.335 (a) to require the marketplace to conduct annual redeterminations in accordance with paragraphs (b) through (m) starting for the 2016 plan year.

Given that system development is not complete, we support the addition of alternative procedures until the technology is able to support the ACA's vision of a streamlined, highly automated redetermination and renewal process. Understanding that this new provision will enable the federally-facilitated marketplace (FFM) to implement its own alternative procedure for the 2015 plan year, the following comments are in direct response to the "Guidance on Annual Redeterminations for Coverage for 2015" issued by CMS on June 26, 2014, as a companion to the NPRM.

Requesting Updated Data

The proposed 2015 renewal process will collect updated income information only from the IRS, and not from other income sources available to through the federal data services hub

(hereinafter referred to as the “hub”). While IRS data is the basis for a final determination of eligibility for premium tax credits (PTCs), it is not necessarily the best source for projecting income for future eligibility or for accurately assessing cost-sharing reduction levels, which are critical to enhancing the affordability of coverage for lower income families. Considering the data lag (i.e., only 2013 tax data will be available during the renewal period) in conjunction with the proposed process, we offer these recommendations:

- **Provide consumers with details of the income on which their eligibility determination is based.** It is not possible for a consumer to assess the accuracy of the information that the marketplace is using as the basis of financial assistance eligibility without additional information. All notices, whether in response to a new at application, at renewal and when changes are reported, should provide a clear summary of the income source and amount that is being used to determine eligibility going forward. This is particularly important in 2015 since the first tax reconciliation process will not have occurred, which is critical to giving consumers and administrators an opportunity to assess the extent that discrepancies in income have occurred and take corrective action to assure a greater level of accuracy in the future.
- **Advise enrollees that they should not include pre-tax contributions when reporting income.** MAGI-based income differs, in some cases considerably, from gross income. Individuals and families make pre-tax contributions that reduce their taxable income, on which MAGI-eligibility is based. Reminding consumers of this fact (and what those deductions are) will make reporting of any changes in income more accurate and assure that consumers receive the maximum PTC and CSR available to them.
- **Implement future system upgrades so that additional and more current income data sources are used for the basis of redetermining eligibility for financial assistance.** HHS should strive to use all income-related hub data sources, such as SSA, for redetermining eligibility for financial assistance. Additionally, HHS should work toward integrating key state sources of income information, including state wage and unemployment data, that are often more timely.
- **Develop a path to a fully automated renewal process that redetermines eligibility for financial assistance based on routine changes within the marketplace, including updated federal poverty level (FPL) thresholds and benchmark plans.** The vision for highly automated renewals should not require consumers to contact the marketplace unless they need to report a change. In future years, HHS should strive for a higher functioning, automated process that takes into account the move to the new FPL and the calculation of the premium subsidy based on the new benchmark plan.

Standard Notices

- **Start renewal notices for a marketplace QHP with an emphatic message that directs enrollees to return to the marketplace to update their information.** The

draft issuer notices inappropriately placed an emphasis on ‘no action required.’ We believe that it is vitally important for all consumers to update their information, particularly given that only IRS data is being used for the initial assessment of ongoing eligibility. Regardless of whether the 2013 tax data is reflective of the consumer’s current income, the fact that the redetermination is not based on the new FPL thresholds and 2015 benchmark plan means that consumers who do nothing will almost inevitably experience discrepancies between their advanced premium tax credits and the actual premium tax credit, as well as the correct cost-sharing level.

- **Coordinate the timing and content of the marketplace and issuer notices.** How the marketplace re-determines financial assistance eligibility and renews coverage as well as the substance of marketplace notices, significantly influences the content and timing of issuer notices. We strongly urge HHS to release drafts of the marketplace notices for comments, and to delay finalizing the issuer notices until the process and marketplace notices can be better coordinated. While we appreciate that the regulations require issuers to provide 90 days advance notice in the case of a plan discontinuation, it will be more confusing to consumers to receive notices regarding their eligibility for financial assistance weeks after they have received notices of renewal from the issuer. This will trigger additional demand on limited consumer assistance resources just as enrollment is opening for the 2015 plan year. If true coordination is not possible, HHS should, at minimum, send an advance notice to enrollees receiving PTC and/or CSR, prior to the issuer notice, that they will be getting more information about their ongoing eligibility for financial assistance.

Notices to all enrollees (except those over 500% FPL and those who did not authorize the use of tax data) should clearly articulate that no action means that their premium tax credit and cost-sharing levels will NOT be changed for 2015. We strongly support informing all enrollees of the importance of contacting the marketplace to trigger the most up-to-date and accurate eligibility determination. Those receiving PTC may be entitled to a larger credit that would make purchasing coverage more affordable; conversely, if their income increased, they may owe more at reconciliation if an accurate determination is not made. Additionally, a surprisingly large number of individuals and families with income just over the cusp of each cost sharing level will not receive the appropriate cost-sharing reduction without contacting the marketplace so that eligibility can be updated for the new FPL levels and benchmark.

Income-Based Outreach Notices

- **Clarify whether the outreach notice will target enrollees with an increase or decrease in income of 50% or 50 percentage points of the FPL.** We have heard different interpretations of the information contained in the 2015 renewal process guidance.
- **Use the option in the guidance to send income-based outreach notices to additional populations, including:**

- ***Enrollees with income below 250% FPL based on the updated FPL thresholds (2014) who are not enrolled in a Silver plan.*** There was considerable confusion among consumers as they shopped for coverage regarding eligibility for cost-sharing reductions. While the majority of consumers did choose Silver plans, some opted for lower cost bronze plans or higher cost Gold plans. In order for these consumers to get the greatest value from the financial assistance available to them, it is important to target them with additional outreach. Additionally, we recommend that as individuals contact the marketplace to update their eligibility for 2015, the marketplace should alert enrollees if they are newly eligible for CSRs due to a change in income and/or the updated FPL thresholds.
- ***Enrollees who appear eligible for Medicaid/CHIP based on their respective state eligibility.*** In addition to enrollees who may be newly eligible for Medicaid/CHIP based on income changes or updating of the FPL, other individuals who are eligible for Medicaid/CHIP may be enrolled in QHPs because there was an inconsistency or a child may have been subjected to a CHIP waiting period. These individuals should get a notice encouraging them to return to the marketplace for an updated eligibility determination.
- ***Clarify that marketplace will send this notice to all enrollees with income above 350% FPL up to 500% FPL.*** While this may be implied, it would be helpful to be explicit.

Consolidated Notices and Providing Reminders

- **We strongly support the consolidation of notices.** Receiving multiple notices can be confusing for consumers.
- **We strongly support additional follow-up by notice or phone, but emphasize that such follow-up should ONLY target those who have NOT contacted the marketplace or for whom additional information is needed.** Experience in Medicaid and CHIP has proven that consumers may need to be contacted multiple times to encourage them to take action. However, the marketplace should filter out enrollees who have already acted before conducting any follow-up. This is important to avoid confusing consumers and to prevent repeating what occurred in the processing of inconsistencies, where multiple notices were sent to individuals, including to individuals who already sent in the requested information.

§155.335(a)(2)(iii) - Alternative procedures approved by the Secretary. We support alternative procedures that facilitate continued enrollment. However, we strongly urge HHS to ensure that any alternative processes approved for state-based exchanges meet all minimum federal standards, are clear improvements from the process that the FFM will use in terms of coordinating between Marketplaces and issuers, are no more burdensome for consumers, and will produce an eligibility determination that is accurate and timely. HHS should require states to post the details of their plans for public comment before federal approval is granted to assure transparency and public input.

§155.335(e) - Changes reported by qualified individuals. It is important to note that this provision applies to the annual eligibility renewal process. In the renewal procedures outlined in §155.335(b) through (m), the Marketplace must send a notice which includes individuals' projected eligibility based on updated information that the marketplace has obtained through electronic data sources, along with information that the marketplace used to project individuals' eligibility for PTCs and CSRs. Individuals can then evaluate whether information provided by the Marketplace accurately reflects what they believe their circumstances will be for the next calendar year — the year for which their PTC and CSR eligibility is being redetermined. Paragraph (e) would then require individuals to report any changes to the information contained in the notice within 30 days of receiving the notice.

Changes in circumstances during the year should be reported when they occur as required by §155.330(b). However, when the Marketplace is redetermining eligibility for the upcoming plan year, it should not ask an individual if there are changes based on the standards of eligibility. It should ask how the individual's situation *in 2015* will be different. The language and requirements in paragraph (e) should be specific to changes in the information contained in the notice as they relate to individuals' anticipated circumstances for the upcoming calendar year.

§155.335(e)(2) - As noted in our comment at 155.330(b)(4) we believe the option to report changes by mail is important to many older, rural or low-income consumers who may have limited access to or ability to use other modes of submission, therefore we do not support this change.

RECOMMENDATION: Retain the regulatory requirement that marketplaces allow consumers to use mail to transact marketplace business at renewal as currently specified at §155.335(e)(2).

§155.335(j) - Re-enrollment. While we appreciate the importance of making it as easy for consumers to retain coverage, there are a number of challenges not only due to this being the inaugural round of renewals but also due to the lack of robust technological processes and consumer assistance resources to support the effort. However, we are not in full agreement with the hierarchy for automatic re-enrollment in a QHP because there are substantial differences in plans at different metal levels and in different product lines. We do support re-enrollment as described in §155.335(j)(1)(i) and §155.335(j)(1)(ii), which would re-enroll an enrollee in the same plan or a plan in the same product line at the same metal level. Ultimately, we believe it should be a marketplace, not issuer, function to determine comparability of plans for auto-enrollment to ensure that such determinations are objective and in the best interests of consumers.

We do not support the hierarchy as described in §155.335(j)(1)(iii) through (iv) or in §155.335(j)(2)(i) through §155.335(j)(1)(iv). There are two specific circumstances under which the hierarchy is not acceptable and we strongly oppose any re-enrollment that would result in the loss of cost-sharing reductions or premium tax credits.

RECOMMENDATION: No individual or family who qualifies for cost-sharing reductions should be auto-reenrolled in any plan other than a silver plan.

RECOMMENDATION: No individual or family who qualifies for premium tax credits should be enrolled in a QHP outside the marketplace.

In all cases, issuers must be required to disclose the full differences in plan benefits, benefit limitations and exclusions, cost-sharing, provider networks, drug formularies and any other details. If the hierarchy is retained, such notices should clearly articulate when the enrollee is at risk for losing cost-sharing reductions or premium tax credits and emphatically refer enrollees back to the marketplace.

§156.1255 - Renewal and re-enrollment notices. The exchange should provide boilerplate language that all issuers are required to use to convey the information required under this section. In addition to the information included in this section, issuers should be required to provide detailed information about how the plan selected for re-enrollment differs from the enrollee's current plan as described in the paragraph above. We believe that the draft standard issuer notices should clearly emphasize the importance of individuals contacting the marketplace to update their eligibility. More detailed comments on the proposed notices were provided directly to CMS at a previous date.

Thank you for consideration of these comments and recommendations. If you have questions, please contact Tricia Brooks, at pab62@georgetown.edu or 202-365-9148.

Respectfully submitted,
Georgetown University Children for Children and Families