California Comments

PROPOSED RULES FOR EXCHANGE FUNCTIONS IN THE INDIVIDUAL MARKET; ELIGIBILITY DETERMINATIONS; AND EXCHANGE STANDARDS FOR EMPLOYERS

45 CFR PARTS 155 & 157
CMS-9974-P
RIN 0938-AR25

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51204	**Part 155: Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act**	
51204-51205	**1.Subpart D: Exchange Functions in the Individual Market; Eligibility Determinations for Exchange Participation and Insurance Affordability Programs**	
51205-51206	**a. Definitions and General Standards for Eligibility Determinations (155.300)** This section includes definitions used in the proposed rule as well as general standards for eligibility determinations. Pg 51229 (c): An attestation may be made by the applicant, an application filer, or, if the individual cannot attest, the attestation of a parent, caretaker, or someone acting responsibly on behalf of the individual.	Application filer: The proposed definition of application filer includes "any individual" completing an application and responding to questions about the application. The proposed Medicaid eligibility rule, 435.907 (a), requires applications to be completed by "the applicant, an authorized representative, or someone acting responsibly for the applicant." This inconsistency should be resolved by changing the definition of an application filer to incorporate the same clarifying language as in 435.907. Presumably states will have the ability to establish additional requirements to ensure that only persons authorized by an applicant are submitting applications in

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	Attestations related to determining a person's eligibility for a premium tax credit must be provided by a primary taxpayer.	their behalf. Federal Poverty Level -- This proposed rule applies a different point in time definition of the Federal Poverty Level (FPL) to be used for exchange programs (premium tax credits and cost-sharing reductions) than what is used in Medicaid and CHIP, depending on the time period of application and program requirements. The FPL standard used by Medicaid and CHIP will be the same as those used by the exchange during open enrollment, but not during any special enrollment periods of the exchange. California recommends that exchange programs, Medicaid and CHIP use the same FPL standards at all times to facilitate enrollment simplification and coordination. Reasonably compatible -- California proposes to develop a state definition of reasonably compatible to be included in the exchange, Medicaid and CHIP state plans and to implement the identified definitions and processes as approved in the state plans.
51206-51209	**b. Eligibility Standards (155.305)** Pg 51229 (a)(1): In order to be eligible for enrollment in a QHP, an individual must be a citizen, national, or non-citizen lawfully present, and be reasonably expected to remain so for the entire period for which enrollment is sought.	Expectation of lawful presence -- Comments requested on the language that a person be "reasonably expected" to remain lawfully present during the period of coverage. California should be able to identify in the exchange state plan a specific time period during which applicants agree that they will continue to be lawfully present for purposes of meeting this requirement.

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51209-51210	**c. Eligibility Determination Process (155.310)** Pg 51230 (a): Application. The Exchange must accept an application from individual as prescribed in 45 CFR 155.405. May not require an individual not seeking coverage for himself or herself to provide information regarding citizenship or immigration status. Pg 51231 (b): An individual may decline screening for insurance affordability programs, but must forego advance payments of premium tax credits if so. (c): The Exchange must accept an application and make an eligibility determination for an applicant at any point during a benefit year; does not supersede enrollment periods. (d): Determination of eligibility. After collecting necessary data, perform determination under 155.305. The Exchange may allow an applicant to accept less than the expected annual amount of advance payments authorized. Exchange may provide advance payments for a primary taxpayer only if the primary taxpayer attests that he or she will meet the tax-related provisions discussed in the definition of primary taxpayer. If the Exchange determines an applicant is eligible for Medicaid or CHIP, must notify relevant agencies and transmit information.	Streamlined application -- California recommends that HHS work closely with states, including state exchanges, to develop the single, streamlined application proposed in 155.405. California acknowledges and agrees with the ability of states to develop and propose an alternative single application for the state. Enrollment of family members living outside the service area of the Exchange -- 155.305 (a) (2) (iv) allows a dependent or spouse living outside of the service area of the exchange to enroll in the exchange where they live or the exchange where the primary taxpayer lives. California is concerned that this provision is unworkable for network plans, such as HMOs , where the plan only covers emergency services out of the HMO's service area, and for PPOs, where the contracted preferred provider network might not include providers in other states. The majority of individuals with public and private coverage in California are enrolled in either an HMO or a PPO. At a minimum, individuals should be notified of the coverage limitations and potential for higher out-of-pocket costs if they select a network plan and live in another state. Qualified Health Plans participating in the exchange should not be required to cover out-of-area services not generally covered, or to pay for services at in-network rates, in conflict with the applicable terms of the HMO / PPO contract or policy. Screenings declined -- California requests that the rules clarify that exchanges will

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	(e): Effective dates. The Exchange must implement eligibility determinations in accordance with Subpart E. (f): Notification of eligibility determination. The Exchange must provide an applicant with a timely, written notice of the eligibility determination. (g): Notice to employer of employee's eligibility. Codifies reporting rules under ACA for employer responsibility provisions. (h): To the extent an applicant who is eligible for enrollment in a QHP but does not select a QHP within the enrollment period seeks a new enrollment period before he or she would have been subject to annual redetermination, the Exchange must receive an attestation about whether information affecting eligibility has changed. To the extent an applicant who is eligible for enrollment in a QHP does not select a QHP within the enrollment period, the Exchange will conduct an annual redetermination in accordance with 155.335 before determining the applicant's eligibility for an enrollment period.	not bear future fiscal risk related to an individual's choice to decline screening for insurance affordability programs, providing the exchange documents the person's declination and informs them of the consequences of that choice. States should not be subject to financial penalties or audit exceptions in these cases. <u>Effective dates of coverage</u> -- California proposes to work with the state Department of Health Care Services (Medicaid) and the Managed Risk Medical Insurance Board (CHIP) to propose in the respective state plans effective dates of coverage across health insurance affordability programs with the goal of minimizing gaps in coverage for individuals with fluctuating incomes, including individuals losing employer-sponsored coverage, as they move between programs. <u>Applications pending enrollment</u> -- California generally agrees with the ability to accept an attestation from an applicant whose eligibility was determined outside of open enrollment periods as to whether any information affecting eligibility has changed, for up to one year. California requests the flexibility to determine and propose in the exchange state plan circumstances when an application process should begin anew which might include changes to marital status and dependents for simplicity and consistency across programs.

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51210-51213	**d. Verification Process Related to Eligibility for Enrollment in a QHP (155.315)** Pgs 51231-32 The Exchange must take steps to verify citizenship, residency, immigration, and incarceration status. Includes verification with SSA and DHS. Pg 51232 (f): HHS may approve an Exchange plan or a significant change to modify the methods for the collection and verification of information as described in this subpart, as well as the specific information to be collected, based on a finding by HHS that the requested modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that any applicable requirements under this subpart and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of information will be met.	Federal data sources -- States will need information about federal electronic data sources and the robustness of the proposed federal data HUB at the earliest possible date to facilitate development of state systems and eligibility rules for all health insurance affordability programs.
51213-51218	**e. Verification Process Related to Eligibility for Insurance Affordability Programs (155.320)** Pg 51232 (a): General Requirements. This process will be performed only for individuals requesting an eligibility determination for insurance affordability programs. (b)(1): The Exchange must verify whether an individual is eligible for minimum essential coverage other	

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	than employer-sponsored coverage or Medicaid, CHIP, or BHP. (b)(2): The Exchange must verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or a Basic Health Program, if applicable, within the state in which the Exchange operates. Pgs 51232-34 (c): The Exchange is required to verify both annual household income information and current household income information. Medicaid proposed rule contains variations from methodology of premium tax credit and cost-sharing reductions for both income and household size. For all individuals whose income is counted in calculating a primary taxpayer's household income, the Exchange must request tax return data from the Secretary of the Treasury by submitting identifying information to HHS, which will submit the information to the Secretary of the Treasury. Pg 51233 (c)(2)(ii): The Exchange must verify MAGI-based income for purposes of determining eligibility for Medicaid and CHIP by following the procedures described in 42 CFR 435.948 and 42 CFR 435.952. Pgs 51233-34 (c)(3)(iv): Codifies minimum requirements of ACA Section 1412(b)(2) regarding circumstances	Verification of existing eligibility for Medicaid and CHIP -- California agrees that it would be helpful to states to have a centralized electronic resource to identify individuals who may be eligible or enrolled in exchange, Medicaid or CHIP programs in other states. Streamlined eligibility -- HHS seeks comment on how best to streamline eligibility across health insurance affordability programs given differences in the income and other eligibility standards proposed. California recommends that federal standards across programs be consistent unless precluded by the ACA. In addition, states should have the flexibility to propose in the program state plans strategies to align programs at the state level. For example, states should be able to propose how the exchange and other state agencies will treat income, whether current monthly or annualized incomes, across health insurance affordability programs, for specific applicants and beneficiaries. Coordination of coverage effective dates among all health insurance affordability programs would maximize consistency among programs, minimize coverage gaps for individuals moving between programs and reduce disruptive enrollment churning between programs. Consistent federal standards and state flexibility to align program standards and requirements, timelines and processes across all health insurance affordability programs are effective strategies to ensure that states can achieve streamlined and efficient eligibility and enrollment systems.

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	under which an application filer who is attesting to a decrease in income for a primary taxpayer, or is attesting to income because tax return data is unavailable, may utilize an alternate income process. Pg 51234 (c)(4): The Exchange must provide education and assistance to an application filer about the verification process. Pg 51234 (d): The Exchange must verify whether an applicant is enrolled in an eligible employer-sponsored plan by accepting the applicant's attestation without further verification, unless the information is not reasonably compatible with other data. Pg 51234 (e): The Exchange must require an applicant to attest to his or her eligibility for qualifying coverage in an eligible employer-sponsored plan for the purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions. The Exchange must verify whether an applicant is eligible for qualifying coverage in an eligible employer-sponsored plan for eligibility for advance payments of the premium tax credit and cost-sharing reductions. (f) Additional verification related to immigration status for Medicaid and CHIP. The Exchange must verify whether an applicant requesting eligibility for insurance affordability programs who is not a citizen or national meets the five-year waiting	<u>Assistance for application filers</u> -- California is concerned about the requirement that the exchange provide education and assistance to application filers regarding issues affecting tax-based definitions of household and income, such as whether available tax information is representative of a primary taxpayer's likely situation for the year. California strongly recommends the development of federal materials, including an online calculator, and real-time resources (e.g., toll-free hotline) to assist application filers, navigators, brokers and program staff in answering these types of tax-related questions. Exchanges should be required to educate filers about the availability of federal resources and assistance but should not have to assume primary responsibility for providing and tax-related information and advice. Given the potential liability of applicant taxpayers related to repayment of advanceable credits, it is critical that the appropriate federal agencies assume primary responsibility in this area. <u>Eligible employer-sponsored coverage</u> -- The proposed rule assumes that an applicant generally knows whether or not he or she is enrolled in an eligible employer-sponsored plan for purposes of tax credit eligibility. This assumption may not be correct. Given the complexities of understanding what constitutes minimum essential coverage and eligible employer coverage, employers and health insurance issuers should have a responsibility to notify employees as to whether the plan

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	period. Eligibility for emergency Medicaid coverage does not qualify an individual as eligible for Medicaid.	they offer is eligible for premium tax credits and cost sharing. California agrees with the provision in the proposed rule relating to the Summary of Benefits and Coverage (SBC) requiring the SBC to disclose whether the coverage is minimum essential coverage and recommends that employers, employer plans and health insurance issuers be required to provide similar disclosures to employees about the eligibility of the plan they offer for tax credit purposes. Exchanges and applicants should be able to rely on the employer notice to employees as evidence that an employee is enrolled in coverage eligible for tax credits and cost sharing reductions. Exchanges should not be responsible for determining whether an employee has eligible employer-sponsored coverage. A centralized database for employers to provide information about the coverage they offer for this purpose would be helpful but exchanges and employees should be able to rely on the data provided to determine eligibility. A template for employers to use to notify employees of the nature of the coverage they offer for tax credit purposes would also be helpful. <u>Reliance on attestations</u> -- California is concerned about the potential for future liability of the state related to eligibility decisions based on attestations made by applicants and applicant filers. States should not bear any future financial liability related to eligibility

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		determinations later found to be inaccurate if the state relies on attestations and follows the verification procedures using available federal and state data sources as outlined in the state plans for the exchange, Medicaid and CHIP. California's enabling legislation for California prohibits the expenditure of any state General Fund resources for California. States should not be subject to financial penalties or audit exceptions in these cases.
51218-51219	**f. Eligibility Redetermination During a Benefit Year (155.330)** Redetermination process relies on the individual to provide updated information during the benefit year. This eliminates the administrative burden associated with electronic data matching. But there is a provision for state flexibility. Pg 51234 (a): The Exchange must redetermine eligibility of a QHP enrollee during the benefit year if the enrollee reports updated information and the Exchange verifies it and if the Exchange identifies updated information through the limited data matching to identify individuals who have died or gained eligibility to a public health insurance program. (b): The Exchange must require enrollee to report changes with respect to eligibility standards within 30 days of a change. Exchange must use verification procedures at the point of initial application for any	Reporting changes in income -- Exchanges should be able to propose in the exchange state plan what thresholds and time periods for reporting of changes in income would apply during the benefit year, in coordination with DHCS and MRMIB, to facilitate simplicity and consistency across programs. HHS should not as suggested develop percentage thresholds for income reporting since that may not be easily understood by enrollees. Data matching during the benefit year to identify changes which might affect eligibility should be consistent and coordinated across all health insurance affordability programs as outlined in the program state plans. Benefit Year Changes -- States should have the flexibility to propose in state exchange, Medicaid and CHIP plans consistent data matching time periods and processes across programs and the effective dates of coverage to be used following a redetermination of eligibility.

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	changes reported by an individual before using the self-reported data in an eligibility determination. (c)(2): The Exchange may make additional efforts to identify and act on changes that may affect an enrollee's eligibility for enrollment in a QHP if HHS approves the Exchange Plan or a significant change to the Exchange Plan. (d): To the extent the Exchange verifies updated information reported by an enrollee or identifies updated information through data matching, the Exchange must determine the enrollee's eligibility and provide an eligibility notice. Pg 51235 (e)(2): The Exchange may determine a reasonable point in a month after which a change captured through a redetermination will not be effective until the first day of the month after the month following the date of the notification to the enrollee and employer, as applicable, of the determination of eligibility. (e)(3): If a redetermination concludes that an enrollee is no longer eligible to enroll in a QHP through the Exchange, the Exchange must maintain eligibility for enrollment in a QHP without advance payments of the premium tax credit and cost-sharing reductions for a full month following the month in which the notice of determination is sent.	

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51221-51222	**Coordination With Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Condition Insurance Program (155.345)** Pg 51326 (a): The Exchange must enter into agreements with Medicaid and CHIP agencies as necessary to fulfill this subpart. Medicaid and CHIP eligibility determinations will be conducted with the other agencies. The Exchange may facilitate delivery system and health plan selection for individuals determined eligible for Medicaid or CHIP if the agencies administering those programs enter into an agreement authorizing the Exchange to perform this function. (b): The Exchange must perform a screen and refer function for applicants who may be eligible for Medicaid in a MAGI-exempt category or an applicant that is potentially eligible for Medicaid based on factors not otherwise considered. The Exchange must transmit eligibility information related to such applicants to the applicable state agencies promptly. (c): The Exchange must provide an applicant referred to the Medicaid agency for an eligibility determination to request a full screening of eligibility for Medicaid by that agency. To the extent an applicant requests this determination, the Exchange must transmit the applicant's information to the Medicaid agency promptly.	<u>Coordination across programs</u> -- California recommends that states be given maximum flexibility to align program processes, requirements and standards across all health insurance affordability programs to ensure effective coordination and simplicity at the state level. States should be able to propose in the exchange, Medicaid and CHIP state plans effective strategies to align program processes and standards.

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	(d): The Exchange shall work with Medicaid and CHIP agencies to establish procedures through which an application that is submitted directly to an agency administering Medicaid or CHIP initiates an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, or cost-sharing reductions. States are encouraged to develop integrated IT systems across the programs. (e): The Exchange must use a secure electronic interface for the exchange of data for the purpose of determining eligibility. The Exchange must use any model agreements established by HHS for the purpose of sharing data as described in the section. (f): CMS will develop procedures for the transition of PCIP enrollees to coverage in QHPs offered through the Exchanges to prevent a lapse in coverage.	PCIP -- California agrees that steps must be taken to ensure no gaps in coverage for PCIP enrollees. California recommends that any transition plan for PCIP enrollees inform them of all of the options they have to transition to coverage either through the exchange or to individual guaranteed issue coverage in the private individual market. California is concerned that emphasizing transition of all PCIP enrollees to the Exchange effective 1/1/14 could adversely affect the risk balance in the Exchange early in its implementation. California requests that states have the option to continue the PCIP with federal funding, for up to one year, and to, in addition, implement a transition plan to provide PCIP enrollees with information about available guaranteed issue coverage through the Exchange and the outside individual market.