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VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, MD 21244-8010

Attention: CMS-9989-F
Patient Protection and Affordable Care Act;
Establishment of Exchanges and Qualified Health Plans;
Exchange Standards for Employers
Final rule; Interim final rule

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. With the implementation of the Patient Protection and Affordable Care Act, it is critical to ensure that low-income and underserved individuals who are eligible for Advanced Premium Tax Credits, cost-sharing assistance, Medicaid and CHIP are found eligible for relevant subsidies and programs so they can fully benefit from the promises of health reform. We appreciate the ability to provide comments on the Interim final rule and offer some additional thoughts as well.

§ 155.220(a)(3)

This interim final provision permits agents and brokers to assist individuals in applying for advanced payments of premium tax credits and cost-sharing reductions. CMS would require agents and brokers to comply with the terms of an agreement with the exchange, including a requirement to register before assisting consumers, receiving training, and abiding by information privacy and security standards, and with state law.

NHeLP believes CMS should adopt stronger federal standards in this portion of the rule to appropriately define the “producer” role and to ensure that consumers receive adequate information about their options for obtaining coverage information and enrolling in the plan that is right for them. A key role of the exchanges is to connect people with insurance affordability programs for which they may be eligible, whether

federally financed premium tax credits and cost-sharing reductions in an exchange or programs such as Medicaid and CHIP. We note that applicants to the individual market exchange generally will be screened for eligibility for these affordability programs and many of them will have incomes low enough to qualify. This is, therefore, a new type of marketplace and a very different population than agents and brokers typically serve. Any agent or broker operating in this role must be held to a very high standard. They should be working in the best interests of consumers and the exchanges, not in the service of health insurance companies with which they may have financial arrangements or business relationships.

The exchanges are intended to be consumer-friendly marketplaces where families find important, unbiased information to help them make smart decisions about their health insurance. Producers can play a useful role in this system if they are similarly unbiased and if they provide useful assistance to customers. In the absence of explicit protections, the relationship agents and brokers have with health insurers raises the risk that some agents and brokers may not act in consumers' best interests or may engage in activities that undermine the stability of the exchanges. The federal standards should address this.

RECOMMENDATIONS for § 155.220(a)(3):

1. States that choose to allow agents and brokers to assist with applications for insurance affordability programs (i.e., advance payment of premium tax credits and cost-sharing subsidies as well as Medicaid and CHIP) should ensure that agents and brokers serve consumers in an optimal manner if they elect to use an agent or broker. CMS should require states that permit agents and brokers to provide assistance with applying for insurance affordability programs to:

    - Ensure that agents and brokers performing this function demonstrate to the exchange that they have adequate ability and knowledge to serve the needs of low-income, vulnerable, and underserved populations;

    - Require conflict-of-interest and code-of-conduct standards that, at a minimum, require agents and brokers to act in the best interest of consumers and that prohibit steering or other activities that could undermine the stability of the exchange. Without such standards, some agents and brokers may have incentives (arising from their arrangements with health insurance issuers inside or outside the exchange) to engage in activities that promote adverse selection against the exchange or to guide people to choose a plan within the exchange based on factors other than consumers' best interests. States should also require agents and brokers to disclose to the exchange and to consumers all payment arrangements with health insurance issuers (including QHP and non-QHP issuers) and ensure consumers have access

to legal and financial recourse if they are adversely affected by the actions of an agent or broker.

- Require that agents and brokers demonstrate they have expertise in the proper handling of tax information and can provide appropriate assistance and advice related to the premium tax credit reconciliation process at the end of the tax year. Eligibility rules and procedures governing advanced payment for premium tax credits require disclosure of the Social Security number of the taxpayer, regardless of whether the taxpayer is applying for coverage. CMS must require strong standards to ensure that agents and brokers will not use any information they may have access to while assisting with the application for other purposes, such as business an agent or broker may have with issuers outside the exchange.

2. CMS should require states that opt to permit agents and brokers to serve the "assistance" function at § 155.220(a)(3) to include in their exchange Blueprint (or other similar document if the state is performing selected functions in connection with a federally facilitated exchange or partnership model) details of any compensation arrangements the exchange has with agents and brokers. CMS should require states to describe any existing state laws that prohibit steering and how the state will monitor and minimize adverse selection and prohibit steering of enrollees for reasons unrelated to the consumers' best interests. This may include the collection of data by states, exchanges, and CMS to compare the enrollment trends of people enrolling on their own through the exchange to those enrolling through agents and brokers to uncover patterns or evidence of steering. It may also include a requirement that agents and brokers submit to exchanges or to states complete information about the compensation they receive from health insurance issuers.

3. CMS should require states that allow agents and brokers to perform the "assistance" function to develop rules specifying when, how, and what agents and brokers must disclose to consumers related to financial compensation from health insurers, other conflicts of interest the agent or broker may have, and the fact that consumers do not have to use an agent or broker to enroll in a QHP, apply for insurance affordability programs, compare plans and coverage options, or receive other benefits of the exchange.

4. The final exchange rules include a number of requirements for Web sites used by agents and brokers (other than the exchange Web site), but these standards apply specifically to agents and brokers that assist with enrollment in QHPs in a manner that constitutes enrollment through an exchange, not to agents or brokers assisting individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. In addition, the Web site standards apply only to plan selection information that an agent or broker

provides on a Web site, not to information about QHPs that agents and brokers may provide in other forms.

CMS should modify the final regulation to ensure that agents and brokers (whether they are permitted by a state to assist people with applying for insurance affordability programs or enroll people in QHPs through the exchange) provide information about plan options that is complete, unbiased, and understandable to consumers. These standards should apply whether the information is provided on a Web site, in person, over the phone, or using printed materials other than what is available from the exchange. CMS should also require states to ensure that agents and brokers provide information about the full range of coverage options available to a consumer through the exchange in an unbiased manner, avoid rebates or giveaways that incentivize the choice of one plan over another, and present the information in plain language and in a form that is accessible to people with disabilities, low literacy or limited proficiency in English. (CMS should strengthen the requirements for Web sites used by agents and brokers in future guidance as described further below.)

In addition, CMS should require agents and brokers assisting people with applying for insurance affordability programs to inform consumers that the exchange has its own Web site, through which consumers may apply for premium credits and other programs and enroll in QHPs, with or without the assistance of an agent or broker.

ADDITIONAL RECOMMENDATIONS: While we recognize some regulatory provisions are final, a number of issues arise that are related to those discussed above. Thus, we urge CMS to address these issues through adding a new subsection (f) and in subregulatory guidance.

1. CMS should ensure appropriate standards apply when states opt to permit agents and brokers to operate in the SHOP. The final rule includes standards outlined in § 155.220(d) and (e) to agents and brokers serving individuals, but not those serving employers. SHOP agents and brokers should have to abide by requirements similar to those that apply to agents and brokers operating in the marketplace serving individuals, including:

    - having an agreement with the SHOP;
    - registering with the SHOP;
    - displaying to qualified employees the full range of plans available to them in connection with their employer's offer of coverage; and
    - receiving training in SHOP eligibility requirements, the federal small business health insurance tax credit, the ability of employees to obtain federal subsidies in connection with an individual exchange QHP if the

employer coverage does not meet affordability and minimum value standards, and the availability of other insurance affordability programs.

2. If an agent or broker assisting with enrollment in a QHP is using a Web site other than the exchange's Web site to assist a consumer, CMS should require states to put additional protections in place. While § 155.220(c)(3) establishes requirements for the ***information*** certain agent or broker Web sites must display, CMS provides few specifications regarding ***how*** the Web site must display that information. The rule or future guidance should clarify that agent and broker Web sites must display the information in a manner that maximizes the ability of consumers to find the plan that best meets their needs and avoids elements or displays that inappropriately advantage certain plans (such as those paying a higher commission) over others. For example, agent and broker Web sites should ensure prominent display of any consumer tools the exchange Web site makes available (such as the required premium calculator or the ability to filter by whether a particular physician is in a plan's network). In addition, alternative agent and broker Web sites should ensure that consumers are aware of the default sort order of plans, that consumers can easily alter the sort order or reduce the number of plans displayed based on factors important to them, and that the Web sites make clear when some plans are hidden from the display. In addition, the agent and broker Web sites should be prohibited from displaying sponsored links to health plans, particularly in a manner that makes such links appear to be part of the plan selection display, and should not be permitted to utilize confusing, look-alike data elements such as "customer reviews" or "best seller" designations that are likely to be much less robust than the results from customer satisfaction surveys and other data that exchanges are required by statute to provide. In addition, the agent and broker Web sites should ensure that individuals with low-literacy, limited English proficiency, and disabilities can read and understand the information and can compare plan features by using plain writing that is clear, concise, and well-organized and presented in an understandable structure and layout.

3. It is critical that consumers are aware that the exchange in their state has its own Web site, through which they may enroll in QHPs and receive premium assistance with or without the assistance of an agent or broker and at no additional cost. States that allow agents or brokers that assist consumers with enrollment in QHPs using Web sites other than the exchange's site should develop rules that require such agents and brokers to make clear to consumers which site they are on. Agents and brokers' alternative Web sites should prominently display some distinguishable feature that clearly indicates to consumers that they are no longer on the exchange's Web site, but that they may return to the exchange's Web site at any time to complete enrollment without losing any of the information they have entered. As an example, the following

might be displayed in a contrasting boldfaced color at the top of each Web page that is not on the exchange's site:

> "This is **not** the public exchange's Web site. This is the Web site of a private insurance [agent or broker]. You may discontinue enrollment here at any time and complete enrollment on the exchange's Web site without losing any of the information you have entered by clicking here."

4. CMS should add a requirement to ensure that exchanges, agents and brokers provide transparent information about the financial compensation and issuer affiliations of agents or brokers assisting exchange consumers with enrollment in QHPs.

   NHeLP recommends adding a new §155.220(f) to read as follows:

   (f) Transparency: An agent or broker that enrolls qualified individuals or qualified employers in an QHP in a manner that constitutes enrollment through the exchange must disclose all fees and payment arrangements from QHP issuers, non-QHP issuers and the exchange, which the exchange must display in a manner that is readily available to consumers, including, at a minimum, on the exchange website.

5. Under the final rules, if a state permits a Web-based agent or broker to enroll people in QHPs through the exchange, the exchange nevertheless remains at the center of the eligibility determination and enrollment process in accordance with the statute. The agent or broker enrolling people in QHPs would have to ensure the consumer completes the eligibility verification and enrollment application through the exchange Web site, and the exchange would transmit the enrollment information to the QHP issuer (not to the agent or broker) to allow the issuer to effectuate enrollment. It is crucial to ensure that this process, if a state opts to use it, is as seamless as possible for consumers, that consumers are appropriately connected to the eligibility determination process, and that the Web-based agent or broker does not request consumers' personal information unnecessarily or use any personal information that is provided for unrelated purposes.

   Through future guidance or rulemaking, CMS should clarify that Web-based agents and brokers that enroll people in QHPs through the exchange must send all applicants to the exchange for an eligibility determination. Web-based agents and brokers should not be able to selectively send people for this determination based on income or other information that the broker might request from the consumer. In addition, Web-based agents and brokers serving in this capacity should not ask for such information themselves; consumers should only have to provide it directly to the exchange as part of the eligibility determination and

enrollment process. CMS should also ensure that, in states where Web-based agents and brokers are permitted to enroll people in QHPs, consumers are linked seamlessly to the exchange for eligibility determinations and enrollment and are given prominent notification (consistent with 155.220(c)(3)(vi)) that they may withdraw from the Web-based agent or broker process and utilize the exchange Web site at any time.

§ 155.302

While NHeLP recognizes CMS' interest in allowing flexibility for states in the implementation of the ACA, we have significant concerns about CMS' proposed "bifurcated" eligibility process, by which an exchange has the option of doing an "assessment" only, rather than a "determination," of Medicaid eligibility. We agree that, considering law and policy, a bifurcated process is necessary, but we think CMS's proposed process is problematic. The most important basis for our conclusion is the simple fact that both Medicaid law and the ACA require that only public agencies can make Medicaid eligibility determinations:

- CMS' bifurcation is too broad where it allows private exchanges or private contractors with public exchanges to make any final Medicaid eligibility determinations (whether or not based on MAGI). In these cases, the process must be bifurcated as the ACA requires non-public exchanges and contractors to pass Medicaid eligibility decisions to a public agency.

- CMS' bifurcation is also too broad where it allows a state-run exchange, with a public agency or contractor, to pass MAGI Medicaid eligibility determinations to the Medicaid agency. As a matter of policy the state should require such public agencies to conduct MAGI determinations using standards, procedures, and implementation methods identical to those employed by the state's Medicaid agency.

In all cases, we believe it is a much better policy for CMS to develop higher up-front requirements for uniformity in Medicaid eligibility standards, procedures, and their implementation than it is to have back-end repetition of standards. Most notably, any state-run exchange should use Medicaid verification processes identical to the state Medicaid agency, and state agreements with federal exchanges should set higher standards for maximizing uniformity. In recognition of the fact that there may not be capacity for perfect uniformity with *federally-facilitated* exchanges (or partnership exchanges where eligibility is federally determined) in 2014, NHeLP recommends that CMS place the burden on states to explain any divergences in the standards, procedures, and implementation, and develop a plan and timeline for the adoption a uniform process (whether by modifications to state processes, federal processes, or both). CMS should work with states to ensure that federal exchanges collaborate with

states to work towards uniformity. Ultimately, CMS should require this information as part of the agreement between a state and CMS for a federally-facilitated exchange.

Additionally, states should be required to conduct quality assurance surveying (e.g., based on sample batch reviews) to evaluate accuracy where exchanges are making Medicaid MAGI and/or non-MAGI determinations. This is critical to ensure accurate results for the complex non-MAGI eligibility processes in general. It is also especially necessary if CMS does not accept our suggestion and allows exchanges to make Medicaid eligibility determinations by non-public employees. States should report results of this surveying publicly. CMS should require a corrective action plan when the exchange accuracy rate falls more than a set amount (e.g., two percentage points) below the state Medicaid agency's accuracy rate.

§ 155.302(a)

As written, § 155.302(a) would allow non-public exchange agencies, or non-public exchange contractors, to conduct Medicaid eligibility determinations. Such a policy is contrary to long-standing Medicaid law and the ACA and NHeLP strongly opposes this provision. Section 1413(d)(2)(B) of the ACA explicitly affirms that Medicaid eligibility "must be determined by a public agency." Given the checkered history of private contractors determining Medicaid and CHIP eligibility in some states (e.g., Texas), we have serious concerns about the lack of transparency, privacy, cost-efficiency, accountability and accessibility, whether contracted by the Medicaid agency or an exchange. *See, e.g.,* Kulkarni, M., Fendell, S., & Berry, E., *Public Health and Private Profit: A Witch's Brew*, Clearinghouse Review (Jan.-Feb. 2002). The ACA allows for a state to use a private exchange, and ACA § 1311(f) allows exchanges, whether public or private, to contract out one or more of their functions. However, it should be clear that use of a private exchange cannot interfere with or contradict the Medicaid single state agency requirement or the requirement that any streamlining of enrollment through an exchange must use a "public agency" to make the final eligibility determination for Medicaid. CMS should include an exception in § 155.302(a) to prohibit exchanges from contracting out the function of making a final determination of Medicaid eligibility. Non-public exchanges, or those with non-public contractors, must handle all Medicaid determinations on a "screen and pass" system; the exchange may do a preliminary screening, but the file must ultimately be passed to a public agency for the determination.[1]

[1] A determination of Medicaid MAGI eligibility by the Exchange is required by § 155.305(c), without regard to whether public employees make the determination. While our suggested language for § 155.305(a) would apply to the entire subpart, including § 305(c), we believe CMS should specifically amend § 305(c) to cross-reference § 302(a) or to explicitly require that only public employees may make a determination of Medicaid MAGI eligibility.

Based on past experiences, we also have concerns about how effectively private entities will operate in determining eligibility for advance premium tax credits and for the CHIP program.

RECOMMENDATION: Amend § 155.302(a)(1) as follows:

> (a) *Options for conducting eligibility determinations.* The Exchange may satisfy the requirements of this subpart—
> (1) Directly or through contracting arrangements in accordance with § 155.110(a), ***except that a non-public Exchange or a non-public Exchange contractor shall not make the final determination of an applicant's eligibility for Medicaid***; or

§ 155.302(b)

For states and exchanges conducting Medicaid screenings (i.e., "assessments" or any other review less than a full determination), CMS should require some minimum screening standards that will lead to a more efficient system. NHeLP is particularly concerned that exchanges will fail to identify large numbers of non-MAGI eligible individuals and enroll them in QHPs under the exchange, instead of the Medicaid program, when enrollment in Medicaid might be in their best interest. For example, if CMS includes only a few basic questions as part of a non-MAGI screen on the streamlined application, exchanges might fail to identify certain individuals with complex needs who are eligible for a Medicaid program based on their need for HCBS services. As another example, exchanges might fail to identify elderly individuals who qualify for Medicare Savings Programs (MSP) programs which are historically under-enrolled due to poor eligibility screening systems and poor data transfers between states and the federal government. CMS must require exchanges to develop screening standards that will identify vulnerable non-MAGI populations, such as the older adults and persons with disabilities in the above examples, and ensure they are enrolled in the programs which will best serve their health needs. It is not sufficient for the state to ask only "a single triggering question." See 77 Fed. Reg. 18352.

NHeLP recommends that CMS develop a performance standard to measure successful identification of potential non-MAGI eligibility by exchange screenings. Quality assurance monitoring should be used to periodically determine each exchange's non-MAGI identification success rate. Exchanges failing to meet a specified threshold (for example, correctly identifying 90% of non-MAGI eligibles) should then be required to review and improve their screening process. The success rates would also serve as an important state learning tool, allowing for national identification of screening questions and practices leading to an optimal balance of simplicity and accuracy. While we appreciate that exchanges cannot be expected to identify non-MAGI eligibility perfectly, we believe that failure to create any standard around non-MAGI screening would be very harmful to vulnerable individuals and we urge CMS to address this.

We also strongly recommend that CMS clearly distinguish between exchanges doing non-MAGI determinations and those doing only screenings. As we stated above, we appreciate that exchanges cannot be expected to identify non-MAGI eligibility perfectly, and this shortcoming is acceptable for *screening* in the context of a "screen and refer" system. However, exchanges which have taken on the role of doing non-MAGI *determinations* must be required to fully evaluate Medicaid eligibility. As discussed in § 155.302 above, exchanges making Medicaid determinations should use standards, procedures and implementation methods that are identical to those used by the Medicaid agency, and CMS should requires states to survey and maintain the accuracy of exchange Medicaid determinations.

Finally, we believe that there is a potential gap in coverage for a small population of individuals who are over the age of 64, not Medicare eligible, and with income above the applicable state SSI level but below 100% FPL. In a state not extending optional eligibility above the SSI level, such an individual would not qualify for Medicaid based on SSI or the adult expansion group, and would not qualify for APTCs because her income falls below the federal APTC minimum. CMS should clarify that in these instances older adults, like some legal immigrants, should be eligible for APTCs even if their income is below 100% FPL.

§ 155.302(b)(1)

NHeLP opposes the provision that would allow all *state-operated* exchanges (using a public agency (or a public contractor for eligibility) to perform only an "assessment" of MAGI-based Medicaid eligibility and then refer the application to the state Medicaid agency for the final determination of eligibility. We believe that it is better policy to require state-operated exchanges using a public agency (or a public contractor for eligibility) to make determinations, rather than just assessments, of Medicaid eligibility based on MAGI criteria for those applications that enter through the exchange portal, as originally anticipated and assuming, as discussed above, that these determinations are made by public employees. (As discussed below, exchanges should use identical standards, procedures and implementation for these determinations, such as for verifications, as the state Medicaid agency process.) This would be more consistent with the goal of having a streamlined eligibility process that, whenever possible, results in real time determinations.

We understand the apparent reluctance of some states to allow federal exchanges to make final determinations of eligibility for Medicaid, and we understand that CMS has some concerns about establishing two different possible processes for states that have their own exchanges and states that have federal exchanges. However, we believe that the best solution for this issue is to, in fact, have separate rules. For states with federally-facilitated exchanges or a partnership model where the federally-facilitated exchange is making eligibility determinations, CMS could allow the exchange to make

an assessment only and then refer the application to the state Medicaid agency for final determination. While this will inevitably delay Medicaid determinations, it will accommodate the states' interest in having some control over who is determined eligible for Medicaid. For states with state-operated exchanges, however, there is no definitive reason why CMS should not require such exchanges (assuming public employees are involved) to make the determination of eligibility for MAGI-based Medicaid. CMS should require states to ensure that *their own* agencies implement *their own* Medicaid standards. The minimal burden of CMS developing two separate regulatory standards – only one of which will operate in an individual state – is not a sufficient rationale to force all potentially eligible Medicaid applicants to suffer through likely delays, confusion and duplication of effort.

We are also concerned about the provision in § 155.302(b)(1) that allows an exchange conducting an assessment to use verification rules and procedures that are **not** consistent with those implemented by the state Medicaid and CHIP agencies. We are very concerned that this may result in applicants being "ping-ponged" back and forth between the exchange and the state Medicaid or CHIP agency if the exchange determines that the applicant is potentially eligible for Medicaid or CHIP, and then the state agency, using different criteria, finds that the applicant is **not** eligible for Medicaid or CHIP and sends the applicant **back** to the exchange for determination of eligibility for APTCs. This could leave the applicant without any health care coverage for an extended period of time, since he or she would not be eligible for APTCs or cost-sharing reductions if the exchange finds him or her potentially eligible for Medicaid or CHIP. Even if individuals are not ping-ponged, they might be subject to a whole new round of verifications after their file is transferred. NHeLP believes CMS' policy should be as follows:

- For state-run exchanges, CMS should require the exchange to use verification standards and procedures that are identical to those used by the Medicaid agency, including with regard to how the standards and procedures are implemented by the agency.
- NHeLP understands that federally-facilitated exchanges may not be able to meet the above standard in 2014. As mentioned above in our comments to § 155.302, we recommend that CMS require states to explain any divergences in the Medicaid eligibility rules, procedures, and implementation conducted by the federal exchange, develop a plan and timeline for adopting a uniform standard, and include this information as part of state exchange agreements.
- For partnership models, CMS should require states to run the verification function, and the state-run exchange rules should apply.

§ 155.302(b)(2)

We appreciate CMS' intention to promote coordinated interaction between exchanges and state Medicaid and CHIP agencies. It is critical that the responsibilities of each

agency are clearly delineated to ensure a smooth and efficient eligibility determination. However, we have concerns that the language in § 155.302(b)(2) generates ambiguities that may lead to beneficiaries receiving less than the full notice and due process rights accorded by Medicaid law. The preamble discussion of this paragraph, however, has clearer language:

> We provide that notices and other activities that must be conducted in connection with an eligibility determination for Medicaid or CHIP are conducted by the exchange consistent with the standards identified in this subpart or **by** the State Medicaid or State CHIP agency consistent with applicable law. (77 C.F.R. 18347, emphasis added)

We believe that it was a simple drafting error to not carry the "by" through to the regulation itself. Unfortunately, the omission allows for a different interpretation of the regulatory paragraph. Furthermore, notice and other eligibility-related activities should be governed by the respective standards and procedures of Medicaid ***and*** the exchanges. We recommend that CMS change the "or" to "and" to ensure that the respective rules and procedures of *both* agencies are applied appropriately to notice and other eligibility related activities.

We also suggest adding a clause to clarify the regulatory language because the grammatical construction seemed incorrect. That is, the reference to notices, when you take out the other activities language, would read "notices. . .are performed by the Exchange." Since an exchange does not "perform" notices, we suggest adding language to clarify that an exchange ***issues*** notices and ***performs*** other activities.

RECOMMENDATION: Amend § 155.302(b)(2) as follows:

(b)(2) Notices ***issued by an Exchange*** and other activities required in connection with an eligibility determination for Medicaid or CHIP are performed by the Exchange consistent with the standards identified in this subpart ~~or~~ ***and by*** the State Medicaid or CHIP agency consistent with applicable law.

§ 155.302(b)(3)

In the event that an exchange performs only an assessment, rather than a determination, of Medicaid or CHIP eligibility, NHeLP supports the provision that the exchange transmit all information obtained or verified by it to the state Medicaid or CHIP agency so that there is no duplicative collection of information from the applicant. However, we do not believe that the timeliness standard of "promptly and without undue delay" is sufficient to prevent significant delays in application processing from the bifurcated process. Accordingly, we suggest that CMS set a specific timeliness standard and require that the exchange transmit electronic transmission of the application, along with all information collected either from the applicant or available electronic resources,

to the state Medicaid or CHIP agency within one business day of the completion of the assessment determining an applicant is potentially eligible for Medicaid or CHIP. (See our comments below on § 155.310(e) for further discussion of timeliness standards.)

RECOMMENDATION: Amend § 155.302(b)(3) as follows:

> *(2) Applicants found potentially eligible for Medicaid or CHIP.* When the Exchange assesses an applicant as potentially eligible for Medicaid or CHIP….the Exchange transmits all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency or CHIP agency via secure electronic interface ***within one business day of the completion of the assessment, as required in § 155.310(e)(2)(iv).***

§ 155.302(b)(4)

NHeLP is strongly opposed to the authorization for an exchange to provide the applicant the opportunity to withdraw his or her application for Medicaid or CHIP when an assessment results in a finding that the applicant is not potentially eligible for Medicaid. CMS should eliminate this provision because it implicates rights that are too essential for individuals to forfeit by a process that is subject to manipulation. Even without such a provision, individuals who are wrongly denied potentially life-saving Medicaid coverage often abandon applications and appeals based on misinformed or biased agency personnel. Individuals would not benefit by withdrawing their Medicaid applications and foregoing due process rights and the potential of more comprehensive coverage at a lower cost. NHeLP has serious concerns that if exchanges notify applicants that they can withdraw their Medicaid applications, many applicants will unnecessarily forgo a complete eligibility screening and receive exchange coverage although actually qualified for Medicaid or CHIP. Further, the level of education that exchanges would have to undertake to ensure an applicant is truly informed about his or her options and affirmatively chooses to withdraw, understanding all the potential legal and financial repercussions, would be significant. We are concerned that the choice to withdraw will often be ill advised and undertaken without understanding the consequences. To codify such a policy, particularly where states may have a financial interest in minimizing Medicaid enrollment, would be a significant set-back to due process in the Medicaid program.

This is of particular importance if the exchange is permitted, as presently proposed, to (1) use different verification rules and procedures than the Medicaid or CHIP agency would be using to determine eligibility and (2) to delegate the Medicaid eligibility assessment process to a non-public entity. (As discussed above, NHeLP opposes both of these proposals.) If exchanges are using different rules and procedures to assess

eligibility than are being used by the state Medicaid or CHIP agencies, or implementing them differently, it is virtually certain that an exchange may assess some persons as not eligible for Medicaid or CHIP who are actually eligible. Without state agency oversight, we are further concerned about the potential inaccuracy of assessments made by private contractors. .

If, contrary to our recommendation, CMS allows this withdrawal policy, it is important that states must design this "opportunity for withdrawal" in a manner that is carefully controlled and monitored to ensure only fully-informed applicants withdraw their applications.

We recommend that CMS provide states with model language they can use in presenting the option to withdraw an application. CMS should work with beneficiary advocates to develop the language for this notice, and test it with low-income consumers before states begin using it.

The regulation should also clarify that if an individual does not affirmatively choose to withdraw the application, it will proceed without delay, and that the failure of the individual to respond to an opportunity to withdraw should not delay the application process. CMS should ensure that the opportunity to withdraw cannot effectively create an additional application step which materially slows the application process.

To further mitigate the harm that will result from suggesting that applicants withdraw their Medicaid or CHIP applications, NHeLP recommends that if CMS allows withdrawals that it only permit exchanges to suggest withdrawals to those applicants whose income is above a threshold that makes it highly unlikely that they are eligible for these other programs. A reasonable threshold would be 250% FPL (or higher if a state has higher Medicaid and CHIP eligibility) as applicants with incomes above that level would not likely have Medicaid or CHIP eligibility. Since families with individuals eligible for multiple programs are likely to be confused by a withdrawal policy we recommend CMS prohibit withdrawals where any individual may be eligible for Medicaid regarding that individual as well as other family members' applications.

We are also concerned because this subsection does not seem to clearly address situations where applicants may be eligible for non-MAGI based Medicaid. The assessment that an applicant is not potentially eligible for Medicaid cannot be made on the basis of MAGI rules alone. CMS must gear the single streamlined application and the assessment standards to be used by the exchange toward determining whether the applicant is potentially eligible for non-MAGI based Medicaid. Exchanges should not ask applicants who meet those screens to withdraw their applications. When an applicant is determined to be potentially eligible for non-MAGI based Medicaid, CMS should require the exchange to promptly (within one business day) transmit all information obtained and verified by the exchange concerning this individual to the Medicaid agency.

Further, for the assessments to be as accurate as possible and for there to be as few instances as possible where exchanges assess potentially eligible applicants as ineligible for Medicaid or CHIP, the exchange and state Medicaid and CHIP agencies should have access to all the information available to the other entity or agency, such as information used to determine eligibility for SNAP.

RECOMMENDATION: Amend § 155.302(b)(4) as follows:

(4) *Applicants not found potentially eligible for Medicaid and CHIP.* (i) If the Exchange conducts an assessment in accordance with paragraph (b) of this section and finds that an applicant is not potentially eligible for Medicaid or CHIP based on the applicable Medicaid and CHIP MAGI-based income standards ***and the verification rules and procedures used by the Medicaid and CHIP agencies in the state where the Exchange is located,*** the Exchange may provide the applicant with the opportunity to withdraw his or her application for Medicaid and CHIP ***if his or her income is above 250% of the FPL (or higher in a state that has higher income thresholds for Medicaid or CHIP).***

(ii) To the extent that an applicant not found potentially eligible for MAGI Medicaid or CHIP requests a full determination of eligibility for Medicaid and CHIP, ***has income at or below 250% of the FPL (or higher in a state that has higher income thresholds for Medicaid or CHIP) or is assessed through screening to be potentially eligible for Medicaid based on a non-MAGI basis,*** the Exchange must-

(A) Transmit all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency and CHIP agency via secure electronic interface, ~~promptly and without undue delay~~ ***within one business day of the completion of the assessment***; ~~and~~

(B) Consider such an applicant**, *along with an applicant who chooses to withdraw an application for Medicaid and CHIP in accordance with (4)(i)(A) above*,** as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notifies the Exchange that the applicant is eligible for Medicaid or CHIP; and

(C) Process an application for the premium tax credit and cost-sharing reductions within the timeliness standards set forth in § 155.310 (e).

§ 155.302(b)(6)

We believe that the agreements made between exchanges and state Medicaid and CHIP agencies are key to meeting the goal of a seamless and coordinated eligibility system. Therefore, we suggest that CMS amend this provision to require the Medicaid agency to obtain Secretary approval of agreements before finalizing them. By requiring Secretary-level oversight, CMS can ensure that all agreements truly meet the goal of providing consumers with seamless access to coverage. We recommend CMS require stakeholder involvement in the development of these agreements. We also suggest that CMS amend this provision to require the Medicaid agency to publicly post copies of the agreements so that members of the public will have access to them. Making the agreements between the Medicaid agency and other insurance affordability programs accessible and transparent will foster public confidence in these programs.

RECOMMENDATION: Amend § 155.302(b)(6) as follows:

> (6) The Exchange and the State Medicaid and CHIP agencies ***shall*** enter into an agreement, which must be subject to Secretarial approval, specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP. ***When approved, Exchanges must post all agreements on the Exchange website electronically for public access.***

§ 155.302(c)

According to the preamble, § 155.302(c) addresses the exchanges' *option* to have CMS determine individuals' eligibility for APTCs and cost-sharing. We believe that the language in the regulation does not clearly reflect CMS' intentions and introduces potential contradictions. First, we recommend that CMS amend the title of this section to clearly indicate that it describes a particular option available to states, not APTC determinations in general. Second, there appears to be a contradiction between the language in the preamble and the regulation itself. § 155.302(c) states that: "the Exchange **may** implement a determination…made by HHS" (emphasis added). This language can be interpreted to allow exchanges to selectively implement APTC and cost-sharing determinations made by CMS, which seems to directly contradict the preamble: "In §155.302(c) of the final rule, we describe that the exchange **must** implement a determination of eligibility for advance payments of the premium tax credit and cost sharing reductions" (77 C.F.R. 18348, emphasis added). We suggest that CMS rename and amend the subsection so it clearly gives the exchanges the option to work with CMS on determinations, not the option to selectively implement CMS determinations.

RECOMMENDATION: Amend §155.302(c) as follows:

(c) "~~*Advance payments of the premium tax credit and cost-sharing reductions.* Notwithstanding the requirements of this subpart, the Exchange may implement a determination of eligibility for advance payments of the premium tax credits and cost-sharing reductions made by HHS, provided that--~~ ***Option for the Exchange to use HHS to make eligibility determinations for advance payments of the premium tax credit and cost sharing reductions. Notwithstanding the requirements of this subpart, the Exchange may enter into agreements to allow HHS to make eligibility determinations for advance payments of the premium tax credit and cost sharing reductions for the Exchange, provided that--***"

…

(5) The Exchange must implement a determination for advance payments of the premium tax credit and cost sharing reductions made by HHS."

§155.305(g)

NHeLP supports CMS's decision to reorganize § 155.305(g) and (h) into a revised § 155.305(g) and to add clarification about the eligibility for cost-sharing reductions for lawfully present non-citizens with income below 100% FPL but ineligible for Medicaid due to immigration status. We also support CMS's clarification that cost sharing reductions are available based on "expected" rather than actual income, since eligibility for this assistance will be determined in advance.

NHeLP does not agree, however, with the addition of the provision in § 155.305(g)(3) that would restrict multiple tax households who are under one insurance policy to the lowest level of cost-sharing reduction that would otherwise be available to one of the applicants. While we commend CMS for recognizing the potential situation where the appropriate level of cost-sharing reduction would otherwise be unclear without guidance, CMS's explanation in the Preamble provides no justification for choosing the least favorable alternative in this situation. We note that Section 1402 of the ACA, which this provision purports to implement, does not include such a restriction. We thus strongly recommend CMS selects a more favorable alternative. We see no reason why CMS should not reverse this provision and allow the entire family to benefit from the level of cost-sharing reduction that would be available to the least financially secure tax household member. We note that it is inconsistent with language in § 1402(e)(3), which provides that "rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an exchange and taxpayers eligible for the credit allowable under this section." While we realize that CMS may have intended this language only to apply to the situation within subparagraph (e), pertaining to households that include an individual who is not lawfully present, we nonetheless

believe that this reflects the overall intent of Congress to construe the cost-sharing provisions in a manner to most successfully enable individuals to afford health insurance.

We do not believe it is sufficient to rectify the inequity of this proposal that, as CMS suggests, individuals in this situation could possibly apply for recognition under separate policies. This would add complications to the family's situation and might be disadvantageous in terms of total cost to the family. We suggest amending § 155.305(g)(3) to allow a family on one policy, but composed of multiple tax households, to receive the most generous cost-sharing reductions available to any of the individuals if they were enrolled in a separate Qualified Health Plan.

RECOMMENDATION: Amend § 155.305(g)(3) as follows:

> (3) *Special rule for multiple tax households.* To the extent that an enrollment in a QHP under a single policy covers individuals who are expected to be in different tax households for the benefit year for which coverage is requested, the Exchange must apply ~~only the first category of~~ ***the most generous level of*** cost-sharing reductions ~~listed below~~ for which the Exchange has determined that one of the applicants in the tax household is eligible.

§ 155.310(e)

NHeLP commends CMS for its stated goal to attain near real-time eligibility determinations for insurance affordability programs through the single, streamlined application process. These regulations take important steps towards realizing CMS' goal, including establishing a federal data hub, increasing coordination between different programs, and providing matching funds for states to upgrade their IT and application systems. The interim final regulations for exchanges should do more, however, to create specific standards for timeliness and performance to align the single streamlined process across all insurance eligibility programs. To this end, NHeLP recommends four important changes – also recommended for Medicaid and CHIP in prior comments – to the interim final exchange regulation:

- Establish specific timeliness standards in exchanges for:
  - processing assessments of eligibility for other insurance affordability programs – 5 calendar days;
  - requesting additional information necessary for an eligibility determination from an applicant – 3 business days;
  - transferring electronic accounts – 1 business day; and
  - for making eligibility determinations for qualified health plans (QHP), advance payments of premium tax credits (APTC) and cost-sharing benefits – 30 calendar days;

- Require that exchanges' agreements with other insurance affordability programs ensure that each applicant receives a final determination within 30 calendar days of the date of application (60 days for individuals applying to Medicaid based on disability) regardless of which program they apply to or which program they end up in;
- Establish and track performance standards for: eligibility determinations within exchanges, processing and transferring applications and renewals to other insurance affordability programs, and processing applications and renewals received from other insurance programs; and
- Clarify that Medicaid eligibility determinations and assessments conducted by exchanges (which should only be conducted by public employees) are explicitly subject to Medicaid and CHIP timeliness and performance standards established in 42 C.F.R. § 435.912.

First, NHeLP urges CMS to issue explicit timeliness and performance standards for exchanges to determine eligibility for Qualified Health Plans, Advanced Premium Tax Credits (APTCs) and cost-sharing. To fulfill the goals of an increasingly efficient, single-streamlined process, these standards should align with the standards for state Medicaid agencies' determination of MAGI-based Medicaid, which, in our comments on the Medicaid eligibility interim final regulation, we have recommended setting at 30 days (and 60 days for Medicaid disability-based applications). Given the development of a streamlined eligibility system, setting the outer limits for eligibility, cost-sharing and tax credits determinations at 30 days should not be burdensome.[2] While the use of performance standards to encourage states to streamline the overall eligibility process will be important, explicit timeliness standards represent a more concrete consumer protection that should not interfere with CMS' stated goal of real-time determinations for the vast majority of cases.

We also have concerns that the exchange regulations do not establish adequate protections to ensure efficient processing and transferring of individuals' account information to other insurance affordability programs. NHeLP recommends that CMS establish a timeliness standard of no more than five days for evaluating and processing a Medicaid assessment. In addition, CMS should also include a rule that appropriate

[2] The current 45-day Medicaid limit would interact poorly with the structure of the Qualified Health Plan enrollment process. Following § 155.410(c)(1), if an individual not subject to exceptions applied to an exchange in the first half of April, then waited 45 days for a determination, she would be eligible to enroll in a QHP in the second half of May and would not begin receiving APTCs and cost-sharing benefits until the first of July, nearly three months after she applied. Because many individuals lose or change coverage at the beginning of the month, a disproportionate number of individuals could be adversely impacted by this extra delay. For these reasons, NHeLP recommends 30 days as a reasonable outer time limit for exceptionally complicated individual eligibility determinations for Qualified Health Plans, Advanced Payment Tax Credits, and cost-sharing.

electronic account transfers to state Medicaid and CHIP agencies, Basic Health Plans, Qualified Health Plans, or CMS must occur within one business day of completing any assessment or determination. In rare cases where the exchange receives a transferred account from another insurance affordability programs and needs further information from an applicant, CMS should require a timeliness standard of three business days after the exchange receives the transfer to contact an applicant and request the needed information. These timeliness standards should provide a federal floor for interagency agreements per § 155.345(a) to ensure coordination so that no individual's initial or renewal determination exceeds 30 calendar days from the initial date of application to ***any*** insurance affordability program to the date an exchange determines final eligibility for APTCs and cost-sharing reductions.

Furthermore, NHeLP recommends that exchanges, in the agreements developed with other insurance affordability programs per § 155.345(a), must establish performance standards coordinated with other insurance affordability programs. As in the Medicaid regulation at 42 C.F.R. § 435.912, CMS should require exchanges to establish performance standards for:

- determining eligibility for QHPs, APTCs and cost-sharing in the exchange;
- processing and appropriately transferring information for applicants potentially eligible for other insurance affordability programs; and
- processing applications received from other insurance affordability programs.

In cases where the exchange receives the application from another insurance affordability program, performance standards should be measured from the date the exchange receives the transferred application, while all other timeliness standards should be measured from the date of application submission to the original transferring program. The standards could tighten each year as the exchange becomes more experienced in its operations.

We do not think that CMS should allow exchanges to set their own performance standards independently. Having over fifty different sets of standards will preclude state-to-state comparison and also eliminate any ability to motivate non-performing exchanges into compliance by contrasting them against other exchanges that do meet the standards. CMS should also tighten the performance standards year-to-year to encourage states to move towards the goal of real-time eligibility processing for the vast majority of MAGI-based applications.

To the extent CMS does choose to allow exchanges to set their own standards, we believe that CMS should review and approve proposed standards so that there is some consistency across states to allow comparison. We recommend CMS require that each exchange involve interested stakeholders in the development of its performance standards. Final performance standards must also be publicly available and easily

accessible to stakeholders so they can work with exchanges and CMS to improve performance.

Exchanges should report performance standard data monthly to allow prompt and efficient evaluation of their performance on application processing, and, as necessary, make improvements. If an exchange has not met its performance standards, CMS should require the exchange to develop and implement a corrective action plan with clear goals for improving performance. CMS should require submission of a corrective action plan within 60 days of the reporting of data showing that performance standards have not been met. It should set forth specific steps and timelines to address the issue.

Further, CMS should require exchanges to report, in some detail, on the timeliness of processing applications for different populations. Further, exchanges should collect data on the processing of applications submitted via different portals and for paper vs. electronic applications. Performance standard reporting should also break down eligibility processing data based on race/ethnicity and people who require language services. This will help identify any disparate impacts in the eligibility process that may violate § 1557of the ACA and could exacerbate health disparities.

Finally, while NHeLP understands that Medicaid state agencies are ultimately responsible for ensuring that all Medicaid applications get processed according to applicable Medicaid rules, the exchange regulations never explicitly refer to § 435.912, and in other places seem to indicate that exchanges might be permitted to develop alternative standards for Medicaid and CHIP determinations and assessments made by exchanges. The interim final regulation at § 155.300(b) requires that exchanges follow Medicaid and CHIP rules and procedures ***or*** the terms of an agreement established according to § 155.345. Section 155.345(a), however, does not refer to § 435.912 and instead requires only "prompt determinations of eligibility and enrollment in the appropriate program without undue delay." Furthermore, § 155.310(e)(1) seems to establish an explicit standard for exchanges making Medicaid determinations, but again uses the vague standard "promptly and without undue delay" without reference to § 435.912. We believe that CMS intended to ensure that exchanges make Medicaid eligibility determinations according to the same standards regardless of where the application or renewal originates, and so recommend that the final exchange regulations clarify this ambiguity by including explicit references to § 435.912 with regards to Medicaid and CHIP eligibility determinations made by exchanges.

RECOMMENDATION: Amend § 155.310(e) as follows:

*(e) Timeliness **and performance** standards.*

~~(1) The exchange must determine eligibility promptly and without undue delay.~~

(1) For the purposes of this part,

(i) "Timeliness standards" refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, subject to the exceptions in paragraph (e)(5) of this section;

(ii) "Performance standards" are overall standards for determining eligibility in an efficient and timely manner across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standard for an individual applicant's determination of eligibility;

(iii) "Date of application" refers to the calendar date that an individual submits an application to one of the insurance affordability programs including at least their name, address, and signature. An exception to the address requirement must be made for any individual who lacks an address. If an insurance affordability program requires additional information from the applicant to finalize an eligibility determination, the program may request that information, but this shall not be considered a new application, the date of application does not change, and the timeliness standards apply based on the date of application.

(2) At a minimum, the Exchange must comply with timeliness and performance standards established by CMS for, promptly and without undue delay--

(i) determining eligibility for Qualified Health Plans, Advance Payment of Premium Tax Credits, and cost-sharing for an individual who submits an application to the Exchange consistent with paragraph (e)(4) of this section;

(ii) assessing potential Medicaid or CHIP eligibility for an individual who submits an application to the Exchange, such that no individual assessment exceeds 5 days from the date the application is submitted to the date the assessment is completed;

(iii) determining eligibility for Qualified Health Plans, Advance Payment of Premium Tax Credits and cost-sharing for individuals whose accounts are transferred from other insurance affordability programs to the Exchange, consistent with paragraph (e)(4) of this section; and

(iv) transferring electronic accounts, such that no transfer exceeds one business day from the time the Exchange completes an eligibility assessment or determination to the time the Exchange transfers the account to the State Medicaid or CHIP agency, the Basic Health Plan, a Qualified Health Plan, or HHS, as appropriate.

(v) requesting additional information, only as required to make an eligibility determination, from an applicant after receiving an account from another agency, such that within three business days of receiving the transfer, the Exchange

(A) contacts the applicant by telephone, e-mail or written correspondence;
(B) requests any additional information necessary for a determination of eligibility; and
(C) informs the applicant of the next steps that will be taken regarding his or her application.

(vi) determining eligibility for Medicaid and CHIP for an individual who submits an application to the Exchange for whom the Exchange is authorized to make a final determination such that the Exchange makes a final determination consistent with 42 C.F.R. § 435.912(c)(3).

(3) Exchanges must develop performance standards through an open process that involves interested stakeholders including consumers and their advocates. When adopted and approved by CMS, Exchanges must post electronically for public access both performance standards and the data collected to demonstrate how such standards are being met. Exchanges shall report and publicly post performance data monthly. Within 60 days of the reporting of data showing that performance standards have not been met, the Exchange must submit to CMS a corrective action plan, with specific steps and timelines for achieving compliance with the governing performance standards.

(4) The final determination of eligibility for Qualified Health Plans, Advance Payment Tax Credits, and cost-sharing may not exceed 30 days from the date of application to any insurance affordability program.

(5) The Exchange must not use the timeliness standards—
(i) As a waiting period before determining eligibility; or
(ii) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

While § 155.310(d)(3) is not open for comment, we believe that CMS must clarify the language so that the timeliness standards from Medicaid and CHIP apply when an exchange makes an eligibility determination and needs to transfer information to the Medicaid or CHIP agency. In these situations, CMS should refer to the timeliness standards in 42 C.F.R. § 435.912 rather than the broad language "promptly and without undue delay." If CMS does not amend § 155.310(d)(3), we suggest adding language into § 155.310(e) to specify this and clarify in subregulatory guidance that § 155.310(d)(3)'s language regarding "promptly and without undue delay" is defined in (e).

RECOMMENDATION: Amend § 155.310(d)(3) to delete "promptly and without undue delay" and substitute "in compliance with 42 C.F.R. § 435.912."

§ 155.315(g)

NHeLP commends the inclusion of a verifications exception process in § 155.315(g) to enable enrollment of individuals who do not have certain documentation but will attest to the veracity of the information provided. NHeLP strongly recommends CMS retain this provision in its final regulation (including the use of the term "must"), as this provision is essential to enrolling numerous vulnerable populations who have no reasonable way to document information. In particular, this policy will help exchanges process applications for many lower income individuals who have informal employment and residential relationships which are inherently undocumentable. We agree that this policy is well within the Secretary's authority under the ACA and that it will, in many instances, help states simplify and coordinate eligibility between Medicaid and exchange systems.

While we commend the purpose and inclusion of this provision, we believe the inclusion of language providing the exception on a "case-by-case basis" serves no purpose and confuses the provision's requirement. The provision's applicability is strictly limited to "an applicant who does not have documentation with which to resolve the inconsistency." And the standard of "reasonable availability" used by the provision *already* allows an exchange to deny the exception in unreasonable cases, so the "case-by-case" language seemingly adds no value. Furthermore, a possible implication of including "case-by-case" could allow an exchange to deny use of the exception in a case where verification documentation indisputably "does not exist." We see no reason why "does not exist" situations should be subject to case-by-case discretion. We therefore believe "case-by-case" is unnecessary, leaves open the door to misinterpretation and possibly subverts the entire exception requirement. Since there is no adjudicatory standard for the "case-by-case" decisions, the language essentially eliminates the requirement and instead turns it into an arbitrary discretionary power for the exchange. We suggest CMS delete "case-by-case."

Further, we believe there is an error in a cross-reference in § 155.315(f)(5)(i). The first cross-reference in (f)(5)(i) is made to § 155.315(i), but we believe it was CMS' intent to cross-reference to § 155.315(g). This intent is supported by CMS' explanation in the preamble at page 18362, citing section (g), and not section (i), as the exception to section (f)(5)(i).

RECOMMENDATIONS:

Amend § 155.315(f)(5)(i) as follows:

(i) Determine the applicant's eligibility based on the information available from the data sources specified in this subpart, unless such applicant qualifies for the exception provided under paragraph ***(g)*** ~~(i)~~ of this section, and notify the applicant of such determination in accordance with the notice requirements

specified in § 155.310(g), including notice that the Exchange is unable to verify the attestation; and

Amend § 155.315(g) to delete ", on a case-by-case basis," as follows:

(g) *Exception for special circumstances.* For an applicant who does not have documentation with which to resolve the inconsistency through the process described in paragraph (f)(2) of this section because such documentation does not exist or is not reasonably available and for whom the Exchange is unable to otherwise resolve the inconsistency, with the exception of an inconsistency related to citizenship or immigration status, the Exchange must provide an exception~~, on a case-by-case basis,~~ to accept an applicant's attestation as to the information which cannot otherwise be verified along with an explanation of circumstances as to why the applicant does not have documentation.

§ 155.340(d)

RECOMMENDATION: To be consistent with our suggestions regarding the development of specific timeliness standards, amend § 155.340(d) as follows.

(d) *Timeliness standard*. The Exchange must transmit all information required in accordance with paragraphs (a) and (b) of this section promptly and without undue delay***, consistent with the standards established in § 155.310(e)(2)(iv).***

§ 155.345(a)

NHeLP commends the effort by CMS to ensure a streamlined and coordinated eligibility determination process and a close alignment of policies between the exchange and all other insurance affordability programs. We support the addition of subsection (a) to require agreements between the exchange and other agencies administering Medicaid, CHIP, and if applicable, the BHP. Given the significant likelihood that individuals will encounter both the exchange and one or more of these other agencies, an agreement describing the delineation of responsibilities is extremely important to avoid duplication of efforts that ultimately result in delayed eligibility determinations and disruptions in coverage. As CMS noted in this new provision, the agreements must specify how the agencies will minimize the burden on individuals seeking coverage, and we applaud CMS for recognizing and prioritizing this concern.

The proposed rule requires that the exchange provide copies of an agreement made pursuant to subsection (a) to CMS ***upon request***. We do not believe that this is sufficient. Since the agreements will have a significant impact on the roles that the various agencies play in the eligibility and enrollment process, we believe that such

agreements should be subject to CMS approval. Further, such agreements should be made publicly available, by posting on the exchange website for easy accessibility by interested stakeholders. We do not believe that individuals or advocates should have to submit FOIA requests to obtain this information. Due to past attempts to obtain arguably public documents that have resulted in denials of requests and lengthy delays, we believe similar results may occur if CMS does not explicitly require that the documents not only be "available" but actually posted on public websites.

RECOMMENDATION: We recommend amending § 155.345(a) as follows:

> (a) *Agreements.* The Exchange must enter into agreements, ***which shall be subject to Secretarial approval*****,** with agencies administering Medicaid, CHIP, and the BHP as are necessary to fulfill the requirements of this subpart and provide copies of any such agreement. ***When approved, Exchanges must post all agreements on the Exchange website electronically for public access.***

§ 155.345(a)(2)

To be consistent with our earlier suggestions regarding the development of specific timeliness standards, and to ensure that interagency agreements align with the timeliness and performance standards in Medicaid, CHIP and the exchanges, respectively, we also recommend changes to § 155.345(a)(2).

RECOMMENDATION: Amend 155.345(a)(2) as follows:

> (a)(2) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, ***consistent with the standards in § 155.310(e) and 42 C.F.R § 435.912*** ~~based on the date the application is submitted to or redetermination is initiated by the agency administering Medicaid, CHIP, or the BHP, or to the Exchange~~;

To the extent that the agreements described in subsection (a) require compliance with other provisions in this subpart, we believe it is important to note some concerns that we have identified with some of these other provisions even if not currently open for comment.

CMS clarified in the preamble that the use of the term "screening" in the proposed rule may have been misleading to the extent that it could mean an application could collect additional questions or information to determine eligibility for Medicaid based on factors not otherwise considered in this subpart. As a result, CMS states in subsection (b) that the exchange must "assess" (described in the preamble as a "simple check") the information provided on the application to determine potential eligibility for Medicaid based on other factors, for example disability or age. We recognize CMS' concern to not

overburden applicants with additional questions. However, we believe that depending on the content of the single streamlined application, and the ability to create a "dynamic" on-line application that only asks each applicant relevant questions, this type of assessment may be significantly less likely to identify individuals who may be eligible for Medicaid or CHIP based on other factors, particularly if the application simply asks for identifying information such as name, date of birth, and Social Security Number. A simple check over the application may identify potential non-MAGI eligibility for Medicaid based on age, but it is less likely to identify those who may be eligible for non-MAGI Medicaid for various other categorical reasons (such as needing HCBS, being an older adult with Medicare cost-sharing, or having a disability). It is therefore important to clarify that if CMS determines that an application can consist of limited identifying information only, an assessment must involve more than checking back over this limited information, but instead will require an applicant to complete, at a minimum, a carefully developed set of additional questions to have sufficient information to make the appropriate assessment or determination.

In regards to subsection (e), we commend CMS for including a requirement that the exchange continue processing applications for APTCs and cost-sharing reductions for applicants who the exchange determines as potentially eligible for Medicaid and transfers their files to Medicaid. We agree with CMS and other commenters who have stated that this standard will ensure that consumers have access to continuous health coverage as they navigate the eligibility and enrollment process. We support the language in the preamble where CMS clarifies that for individuals who enroll in a QHP and receive advance payments of the premium tax credit but are later found eligible for Medicaid, these individuals are not liable to repay advance payments received, including for any period of retroactive eligibility. This is an important clarification which CMS should make very clear to states and exchanges to avoid unnecessary and inappropriate requests for repayment of these premium tax credits.

RECOMMENDATION: Add the following new language at the end of subsection (e):

> ***Individuals enrolled in a QHP and receiving advance payments of the premium tax credits who are later determined eligible for Medicaid must not be held liable for repayment of those credits, including for any period of retroactive eligibility.***

While the inclusion of new subsection (a) will promote simplified and streamlined eligibility processes, we note that CMS has also added subsection (f) in an attempt to coordinate policies across insurance affordability programs and avoid negative outcomes for consumers. While this subsection is not up for comment, we do recommend that CMS clarify this provision. The special rule described in (f) requires the exchange to provide information and an explanation to an applicant who is below 100 percent of the FPL for the period in which coverage is requested, but for whom the exchange has determined is ineligible for advance payments of the premium tax credit

and one or more applicants in the household are determined ineligible for Medicaid and CHIP based on income. CMS notes in the preamble that this provision is meant to close a gap in coverage, acknowledging that most individuals in this position will ultimately be eligible for Medicaid under the Medicaid final rule at 42 C.F.R. § 435.603(i). It is unclear, however, how subsection (f) will close the gap for the individuals who do *not* become eligible for Medicaid under § 435.603(i). There still appears no pathway for such individuals to be eligible for APTCs, and this does not appear to be solved by § 155.345(f) by merely requiring the exchange to verify the applicant's application information and provide information and an explanation to the applicant. CMS should provide further clarification on this issue.

§ 155.345(g)

Subsection (g) maintains streamlined eligibility determination processes for consumers, namely by bringing this subpart in line with the Medicaid final rule. We commend CMS for this alignment, particularly in terms of the requirement that the exchange must not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent that such findings are done in accordance with this subpart, as well as the specification in (g)(6) that there be a streamlined process for eligibility determinations regardless of the agency that initially received an application. Related to subsection (g)(6), we urge CMS to promote such a streamlined process by requiring that a single timeframe during which eligibility determinations must be made. This timeframe must include all inter-agency transfers of applicant information. Subsection (g) contemplates that the process should happen securely and via secure electronic interface, and that duplication of information and additional requests for information already provided by the applicant must not be made. Including a specific requirement will ensure that all determinations made in accordance with this subsection are processed in timely and efficient manner, offering a more concrete standard than the "promptly and without undue delay" language.

RECOMMENDATION: Amend § 155.310(e) as provided above and amend § 155.345(g)(4) as follows:

> (4) Determine the individual's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, ~~promptly and without undue~~ ***~~delay~~ in accordance with the timeliness standards in § 155.310(e) (considering the date when the application was submitted to the agency administering Medicaid, CHIP or the BHP as the date of application)*** and in accordance with this subpart.

Conclusion

In sum, while we are encouraged that elements of the Final and Interim Final Rule will enhance and streamline eligibility determinations for all insurance affordability programs, we believe that CMS should implement a number of improvements. If you have questions about these comments, please contact Leonardo Cuello at (202) 289-7661 or cuello@healthlaw.org. Thank you for consideration of our comments.

Sincerely,

Emily Spitzer
Executive Director