APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

May 11, 2012

VIA ELECTRONIC SUBMISSION

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National Advocates for Asian American, Native Hawaiian & Pacific Islander Health

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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

To Whom It May Concern:

The Asian & Pacific Islander American Health Forum ("APIAHF") thanks you for the opportunity to submit comments on the Establishment of Exchanges and Qualified Health Plans. We are dedicated to improving the health and well-being of Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPIs) living in the United States and its jurisdictions. Many in our communities stand to benefit from the ability to purchase health insurance through the Exchanges and we are pleased to comment on the development of these Exchanges so that individuals and families receive the most comprehensive and affordable health insurance coverage available to them.

Comments on specific sections

§155.20 Definitions

Lawfully present

We understand that HHS will develop future rulemaking on the definition of "lawfully present" in Medicaid, CHIP and the Exchange. While this section is not currently open to comment, we strongly believe that the current definition of "lawfully present" used in the Pre-Existing Condition Insurance Plan (PCIP), at 45 CFR §152.2, is not consistent with the definition used in Section 214 of the Children's Health Insurance Program Reauthorization Act (CHIPRA).

The PCIP definition should include categories eight and nine that are currently listed in the CHIPRA definition: individuals who are lawfully present in the Commonwealth of the Mariana Islanders and individuals who are lawfully present

in American Samoa. These categories were omitted from the PCIP definition because residents of the U.S. territories are not eligible to participate in the PCIP program. By contrast, territorial residents are eligible to participate in the Exchanges, if the territories elect to create one. As such, HHS should fully adopt the CHIPRA definition, which more accurately encapsulates the existing categories of lawfully present individuals.

§ 155.220(a)(3)—Related to the ability of a State to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

Section155.220(a)(3) permits states the option to allow agents and brokers to assist those who are applying for advance payment of premium tax credits and cost-sharing reductions. These affordability elements of the law are essential to making health insurance coverage within reach for AA and NHPI families who will be newly able to purchase coverage through the Exchanges. Therefore, APIAHF continues to support a "no wrong door" approach that would allow agents and brokers to assist individuals and families in applying for any and all coverage and affordability options for which they may be eligible.

We recommend that the rule clarify that states have the option to permit agents and brokers to have a role in providing assistance to applicants of all insurance affordability programs (including Medicaid and CHIP) covered by the single streamlined application for the new affordable insurance exchanges as described in section 155.405.

RECOMMENDATION: Revise as follows:

> 155.220(a)(3) —Subject to paragraphs (d) and (e) of this section, assist applicants with completion of an eligibility verification and enrollment application through the Exchange Web site as described in §155.405 ~~individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.~~

Additionally, we continue to oppose with concern any pressure to impose a requirement for licensing or certification of Navigators. Many health workers with considerable community knowledge will be eligible to work as Navigators and assist consumers in selecting coverage in the Exchanges. Since Navigators will not be selling insurance, they should not be subject to licensure requirements as brokers or agents. Completion of a required training course should be sufficient to ensure Navigators are capable of fulfilling the duties of the position without imposing a barrier on the ability of trusted health workers to provide consumer assistance to

their communities.

§ 155.302—Related to options for conducting eligibility determinations;

Section 155.302 proposes a bifurcated eligibility determination process that would permit an Exchange to conduct an "assessment" of Medicaid eligibility rather than a determination. The Exchange could then forward the applicant's file to the state agency for a final eligibility determination. If determined to be ineligible by the state agency, the file would then be returned for further processing. APIAHF raises concerns that this process will frustrate the ACA's goal of a single, streamlined process for consumers.

APIAHF believes that this new option does not meet the requirements of Section 1413 of the Affordable Care Act, which requires an eligibility and enrollment process that is simple, streamlined, and seamless for consumers.

Generally, APIAHF joins the comments of the National Health Law Program (NHeLP) in opposing the sections of §155.302(a), which, as written, could be read as allowing non-public agencies to conduct eligibility determinations for Medicaid. We urge CMS to explicitly prohibit, as required by both Medicaid law and the ACA, Exchanges from delegating the function of making Medicaid determinations to a non-public Exchange agency.

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***;

§ 155.302(b)

APIAHF shares the concern of NHeLP that Exchanges could fail to identify individuals who are eligible for Medicaid and will instead enroll those individuals in QHPs under the Exchange.

§ 155.302(b)(1)

Under § 155.302(b)(1), the Exchange can base an eligibility assessment on "the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with 42 CFR

parts 435 and 457, *without regard to how such standards are implemented by the State Medicaid and CHIP agencies*." (Emphasis added.)

This provision allows an Exchange to use income verification rules and procedures that are **not** consistent with those implemented by the state Medicaid and CHIP agencies. This may result in applicants being referred back and forth between the state Medicaid agency and the Exchange 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. This could result in coverage gaps or in eligible individuals failing to receive cost reduction benefits. We recommend that Exchanges and Medicaid/CHIP agencies be required to employ the same policies and procedures when assessing eligibility. The interim final rule should be amended to eliminate or strictly limit differences between the procedures used by Exchanges in assessing eligibility and those used by state Medicaid and CHIP agencies.

- For state-run Exchanges, the Exchange should be required to use income verification rules and procedures that are identical to those used by the Medicaid agency, including with regard to how the rules and procedures are implemented by the agency. Again, states should be required to ensure that *their own* agencies implement *their own* Medicaid standards.
- APIAHF understands that federally-facilitated Exchanges may not be able to meet the above standard in 2014. We support NHeLP's recommendation that CMS place the burden on states to explain any divergences in the rules, procedures, and implementation, and develop a plan and timeline for the adoption a uniform standard (whether by modifications to state processes, federal processes, or both). CMS should work with states to ensure that federal Exchanges entities collaborate with states to work towards uniformity. Ultimately, this information should be a required part of the agreement between a state and CMS for a federally-facilitated Exchange.
- For partnership models, states should be required to run the verification function, and the state-run Exchange rules should apply

§ 155.302(b)(3)

APIAHF 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. We join the concerns of NHeLP in recommending a specific timeliness standard. We do not believe that the timeliness standard of "promptly and without undue delay" is sufficient to ensure that significant delays in application processing do not result from the proposed

bifurcated process. Accordingly, we suggest that CMS set a specific timeliness standard, requiring that the electronic transmission of the application, along with all information collected either from the applicant or available electronic resources, be transmitted 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.

§ 155.302(b)(4)

As a matter of consumer protection, APIAHF strongly opposes permitting an Exchange to allow a consumer to withdraw a Medicaid or CHIP application as allowed by § 155.302(b)(4)(A). We urge CMS to eliminate this provision because it implicates rights that are too essential for individuals to forfeit. Although § 155.302(b)(4)(B) states that the applicant must be provided with the opportunity to request a full determination of eligibility, we do not believe that this protection is adequate. We are concerned that the choice to withdraw will and the consequences of that decision will not be fully explained to the consumer. 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.

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

To further mitigate the harm that will result from suggesting that applicants withdraw their Medicaid or CHIP applications, we also support NHeLP's recommendation that the regulations 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 as applicants with incomes above that level would not likely have Medicaid or CHIP eligibility. This threshold should be even higher than 250% if a state has a higher FPL limit for Medicaid or CHIP eligibility. We also recognize that families with individuals eligible for multiple programs are likely to be confused by a withdrawal policy; therefore, families where any individual may be eligible for Medicaid should never be asked to withdraw the applications of other family members.

§ 155.305(g)—Related to eligibility standards for cost-sharing reductions

Cost sharing reductions are an essential element of the ACA and make insurance affordable to many lower income members of the AA and NHPI community. APIAHF particularly applauds CMS for adding clarification about the eligibility for cost-sharing of non-citizens who are lawfully present 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.

We disagree with the new provision in § 155.305(g)(3) that applies the lowest level of cost-sharing reductions when multiple tax households are covered by a single insurance policy. Under this section, members of some households may not receive the maximum cost sharing benefit for which they are eligible. We recommend that the section be amended 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.

Additionally, APIAHF agrees with and joins the analysis of the National Immigration Law Center with regard to the application of the rule to lawfully present immigrants. The current rule provides that lawfully present immigrants who are eligible for premium tax credits and whose household income is less than 100% of the Federal Poverty Level (FPL) will be found eligible for the same cost-sharing reductions provided to individuals with household incomes between 100% to 150% FPL. See Section 155.305(g)(2)(i). As such, individuals whose household income is below 100% FPL will be assumed to have household incomes above 100% FPL and will be provided cost-sharing reductions that are based on an artificial income level of 100% FPL and above, rather than based on their actual income.

In order to ensure coverage is truly affordable to all eligible individuals, we strongly recommend lawfully present non-citizens with household incomes of less than 100% of the FPL who would be eligible for Medicaid but for immigration status, should be determined eligible for affordability programs based on their actual household income, similar to all other eligible individuals. As currently drafted, this provision places an unfair burden on the lowest income individuals who will be seeking coverage because the rule wrongly assumes this population has incomes between 100% and 150% of the FPL, when they in fact have incomes below 100% FPL. The cost-sharing reductions for individuals with incomes below 100% FPL should be based on their actual income and a separate eligibility category for cost-sharing reductions should be added for this population to ensure affordability. We therefore recommend the following change:

RECOMMENDATION: Amend §155.305(g)(2) by adding a separate eligibility category for individuals with household incomes below 100% FPL as follows:

(2) Eligibility categories. The Exchange must use the following eligibility categories for cost-sharing reductions when making eligibility determinations under this section –

(i) An individual who is eligible for advance payments of the premium tax credit under paragraph (f)(2) of this section, a household income less than 100 percent of the FPL for the benefit year for which coverage is requested;

~~(i)~~ *(ii)* An individual who is expected to have a household income greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested~~, or for an individual who is eligible for advance payments of the premium tax credit under part agraph (f)(2) of this section, a household income less than 100 percent of the FPL for the benefit year for which coverage is requested~~;

§ 155.310(e)—Related to timeliness standards for Exchange eligibility determinations

APIAHF supports the goal of attaining eligibility determinations "promptly and without undue delay." However, we believe that this phrase alone will be inadequate for achieving near real-time determinations as envisioned in the preamble, and we therefore suggest that the regulation stipulate specific timeliness standards. We recommend that these standards be clarified to ensure that they apply from the time that an individual seeks coverage, through the application period, and until an eligibility determination is received. Along with the National Health Law Program, we suggest the following improvements to this provision:

- 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;
- Add a requirement in Exchange agreements with other insurance affordability programs 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 are explicitly subject to Medicaid and CHIP timeliness and performance standards established in 42 C.F.R. § 435.912.

§ 155.315(g)—Related to verification for applicants with special circumstances;
We strongly support the inclusion of § 155.315(g), which requires Exchanges to accept attestations of eligibility information (other than citizenship and immigration status) in the event that an inconsistency occurs along with an explanation of why documentation is not available. This provision is essential to the ability of extremely vulnerable AA and NHPI individuals—including victims of domestic violence, transient workers, homeless individuals, or those who earn income seasonally or sporadically— who have no way of providing documentation of required eligibility information such as their residency or employment to be enrolled in coverage.

While we have commended 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 adds no value. Furthermore, a possible implication of including "case-by-case" could be that it allows 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 the "case-by-case" language.

§ 155.340(d)—Related to timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-

sharing reductions

We recommend that this section also develop specific timeliness standards consistent with the standards we suggest in § 155.310(e), above.

§ 155.345(a) and § 155.345(g)— Related to agreements between agencies administering insurance affordability programs.

APIAHF commends the effort by CMS to ensure a streamlined and coordinated eligibility determination process for all insurance affordability programs, as well as 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 Basic Health Program (BHP). Given the significant likelihood that lower income 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.

§ 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) to be ***consistent with the standards in § 155.310(e) and 42 C.F.R § 435.912.***

In regards to subsection (e), we commend CMS for including a requirement that the Exchange continue processing applications for advance premium tax credits (APTCs) and cost-sharing reductions for applicants who have been determined potentially eligible for Medicaid and had their files transmitted 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 do, however, note that in the preamble 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. We commend CMS for making this clarification which should be made very clear to states and Exchanges to avoid unnecessary and inappropriate requests for repayment of these premium tax credits.

Language clarifying that 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, should be included in the regulation text of subsection (e).

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 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 to be no pathway for such individuals to be eligible for APTCs, and this does not appear to be solved by § 155.345(f), which merely requires 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) has been added to this subpart to maintain 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 there be a single timeframe during which eligibility determinations must be made, and 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. It is therefore consistent and reasonable to require that the Exchanges complete the process identified in subsection (g) within a single specified time period. Including such a 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.

Conclusion

In conclusion, we thank you for this opportunity to offer comments on these interim final rules, and we look forward to working with you as the Exchanges are established. Please direct any questions to Priscilla Huang, Policy Director, at phuang@apiahf.org.

Respectfully,

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