STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

B U L L E T I N NO.: 14-04F

FROM: Sean Brown, Deputy Commissioner
Economic Services Division

DATE: July 28, 2014

SUBJECT: Health Benefits Eligibility and Enrollment

CHANGES ADOPTED EFFECTIVE: 7/30/14

INSTRUCTIONS

_X_ **Maintain Manual - See instructions below.**
___ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance ___**
___ **Information or Instructions - Retain until _____**

MANUAL REFERENCE(S):

4100	5300	5700
4200	5500	5900
4300	5600	HBEE
4400		

Attachments to DCF Bulletin 14-04F:

1. Attachment One - *List of Acronyms in Health Benefits Enrollment and Eligibility (HBEE)*
2. Attachment Two - Public Comments and Responses, *Description for Decisions on Public Comments and Explanation of Changes to Health Benefits Eligibility and Enrollment Final Proposed Rule Pursuant to 3 V.S.A. § 841*
3. Attachment Three - *Explanation of Changes Made to Final Proposed Rule and Approved by LCAR*

Health Benefits Eligibility and Enrollment (HBEE) final adopted rule (hereinafter referred to as "HBEE"), effective July 30, 2014, supersedes and replaces HBEE Amendment # 3 (B14-02E) in its entirety. HBEE can be viewed at http://dcf.vermont.gov/esd/rules, and will be posted at http://humanservices.vermont.gov/on-line-rules/esd.

HBEE implements the provisions of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001, and Vermont Act Nos. 48 of 2011, 171 of 2012 and 79 of 2013.

HBEE supersedes HBEE Amendment # 3 (B14-02E), an emergency rule that became effective March 31, 2014. HBEE Amendment # 3 superseded HBEE Amendment # 2 (B13-46E), an emergency rule that became effective January 1, 2014. HBEE Amendment # 2 superseded HBEE Amendment # 1 (B13-36E), an emergency rule that became effective October 1, 2013. HBEE Amendment # 1 modified the original HBEE (B13-12F) that was adopted on October 1, 2013.

HBEE makes changes to the proposed rule (B14-04P) based upon written public comments on the proposed rule. It also includes changes to align HBEE with recently issued federal regulations and guidance, to provide clarification, to add clarity and improve consistency, and to correct technical and typographical errors. Further, HBEE makes changes to the final proposed rule (B14-04FP) following Department discussions and agreements with stakeholders regarding certain provisions of the rule, and the Legislative Committee on Administrative Rule's (LCAR) approval of the final proposed rule with the amendments that were agreed upon by the Department and stakeholders.

Manual Maintenance

Health Care Rules

Remove	Insert
HBEE Amendment # 3 (B14-02E)	HBEE (B14-04F)

Rulemaking Process

1. The Department filed the proposed rule with the Interagency Committee on Administrative Rules (ICAR) on February 20, 2014 and presented the rule to ICAR on March 10, 2014.

2. The Department filed the proposed rule with the Secretary of State's Office and the Legislative Committee on Administrative Rules (LCAR) on March 21, 2014.

3. The Department posted the proposed rule on its website http://dcf.vermont.gov/esd/rules and notified advocates, subscribers, and members of the public of the proposed rule on March 24, 2014.

4. The Office of the Secretary of State published the notice of rulemaking on its website on March 26, 2014.

5. Notice of the proposed rule was published in newspapers of public record on April 3, 2014.

6. A public hearing was held on April 25, 2014 at 10:00 a.m., at the Agency of Human Service, Secretary's Conference Room, 208 Hurricane Lane, Williston, Vermont 05495. There were two public attendees, both attorneys with Vermont Legal Aid, but no comments were made at the hearing.

7. The comment period on the proposed rule closed on May 9, 2014. Vermont Legal Aid, Blue Cross Blue Shield of Vermont, Delta Dental, and Catholic Charities of Vermont submitted written comments on the proposed rule.

8. The Department filed the final proposed rule with the Office of the Secretary of State and the Legislative Committee on Administrative Rules (LCAR) on June 11, 2014.

9. The Department presented the rule to LCAR on June 26, 2014. LCAR postponed a decision on the rule in order to hear more testimony about the rule at its next scheduled meeting.

10. The Department resumed presentation of the rule to LCAR on July 10, 2014. LCAR approved HBEE at the hearing and by memorandum dated July 10, 2014.

11. The Department filed the final adopted rule with the Office of the Secretary of State and LCAR on July 14, 2014.

12. The rule is effective July 30, 2014.

Summary of Public Hearing and Written Comments

The Department held a public hearing on April 25, 2014, at the Secretary of the Agency of Human Service's office in Williston, Vermont. There were over 180 written public comments on the proposed rule that were submitted to the Department. Because the summary of the written public comments and the Department's responses is so lengthy, this summary, titled, *Description for Decisions on Public Comments and Explanation of Changes to Health Benefits Eligibility and Enrollment Final Proposed Rule Pursuant to 3 V.S.A. § 841*, is incorporated into this Bulletin as Attachment Two.

Attachments to Bulletin

The first attachment to this Bulletin is a list of the acronyms used in HBEE. This document, titled *List of Acronyms in Health Benefits Enrollment and Eligibility (HBEE)*, is incorporated into this Bulletin as Attachment One.

The second attachment to this Bulletin is a summary of the written public comments and a list of changes that the Department made to HBEE for reasons other than responding to public comments, including changes needed to align the rule with recently issued federal regulations and guidance, to clarify the rule, and to correct technical and typographical errors. This document, titled *Description for Decisions on Public Comments and Explanation of Changes to Health Benefits Eligibility and Enrollment Final Proposed Rule Pursuant to 3 V.S.A. § 841,* is incorporated into this Bulletin as Attachment Two**.**

The third attachment to this Bulletin is a summary of the changes that the Department made to HBEE and that were approved by LCAR. This document, titled *Explanation of Changes Made to Final Proposed Rule and Approved by LCAR*, is incorporated into this Bulletin as Attachment Three.

Viewing HBEE

HBEE, in its entirety, follows Attachment Three to this Bulletin. HBEE can be viewed electronically at http://dcf.vermont.gov/esd/rules and will be posted at http://humanservices.vermont.gov/on-line-rules/esd.

Information about the Rulemaking Process

To get more information about the Administrative Procedures Act and the rules applicable to state rulemaking, please see the website of the Office of the Secretary of State at: http://vermont-archives.org/aparules/ or call Louise Corliss at 802-828-2863. For information about Legislative Committee on Administrative Rules (LCAR), please see the website of the Vermont Legislature at: http://www.leg.state.vt.us/schedule/schedule2.cfm or call 802-828-5760.

List of Acronyms in Health Benefits Enrollment and Eligibility (HBEE)

Because of the many terms and organizations to which AHS refers by acronym in HBEE, we are listing these acronyms and their corresponding terms in alphabetical order below.

AABD	Aid to the Aged, Blind, and Disabled
ABP	Applicable Benchmark Plan
ACA	Affordable Care Act
ACCS	Assisted Community Care Services
ADA	Americans with Disabilities Act
AHS	Agency of Human Services
ANFC	Aid to Needy Families with Children
AOEP	Annual Open Enrollment Period
APTC	Advance Premium Tax Credits
BCCEDP	Breast and Cervical Cancer Early Detection Program
CDC	Centers for Disease Control and Prevention
CFC	Choices for Care
CHIP	Children's Health Insurance Program
CLA	Common Level of Appraisal
CMA	Community Maintenance Allowance
COBRA	Consolidated Omnibus Budget Reconciliation Act
CMS	Centers for Medicare and Medicaid Services
COLA	Cost of Living Adjustment
CRTS	Community Rehabilitation and Treatment Services
CS	Community Spouse
CSR	Cost-Sharing Reduction
CSRA	Community Spouse Resource Allocation
CSV	Cash Surrender Value
DAC	Disabled Adult Child
DAIL	Department of Disabilities, Aging, and Independent Living
DCF	Department for Children and Families
DCHC	Disabled Child in Home Care
DDS	Disability Determination Services
DED	Deferred Enforced Departure
DFR	Department of Financial Regulations
DHS	Department of Homeland Security
DVHA	Department of Vermont Health Access
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EIN	Employer Identification Number
ERC	Enhanced Residential Care
ERISA	Employee Retirement Income Security Act
ESD	Economic Services Division
FPL	Federal Poverty Level
HBEE	Health Benefits Eligibility and Enrollment
HDHP	High Deductible Health Plan
HHS	Health and Human Services (U.S. Department of)
HIPAA	Health Insurance Portability and Accountability Act

HIT	Health Information Technology
HMO	Health Maintenance Organization
HRA	Healthcare Reimbursement Arrangements
HAS	Health Savings Account
HVP	Healthy Vermonter Program
ICF-DD	Intermediate-Care Facilities for the Developmentally Disabled
IIRIRA	Illegal Immigration Reform and Immigrant Responsibility Act
HIS	Indian Health Service
IIS	Institutional Income Standard
INA	Immigration and Nationality Act
IOEP	Initial Open Enrollment Period
IRA	Individual Retirement Account
IRS	Internal Revenue Service
IS	Institutionalized Spouse
LPR	Lawful Permanent Resident
MABD	Medicaid for the Aged, Blind, and Disabled
MAGI	Modified Adjusted Gross Income
MCA	Medicaid for Children and Adults
MCO	Managed Care Organization
MCSR	Medicaid Covered Services Rule
MEC	Minimum Essential Coverage
MWPD	Medicaid for Working People with Disabilities
OASDI	Old Age, Survivors, and Disability Insurance
PASS	Plan for Achieving Self-Support
PHS Act	Public Health Service Act
PIL	Protected Income Level
PNA	Personal Needs Allowance
POA	Power of Attorney
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
QC	Quality Control
QDWI	Qualified Disabled and Working Individuals
QHP	Qualified Health Plan
QI	Qualified Individuals
QMB	Qualified Medicare Beneficiaries
RSDI	Retirement, Survivors and Disability Insurance
SAVE	Systematic Alien Verification for Entitlements
SEP	Special Enrollment Period
SGA	Substantial Gainful Activity
SHOP	Small Business Health Options Program
SLMB	Specified Low-Income Medicare Beneficiaries
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income Program
SWICA	State Wage Information Collection Agency
TBI	Traumatic Brain Injury

TMA	Transitional Medical Assistance
TPS	Temporary Protected Status
USCLS	United States Citizenship and Immigration Services
VA	Veteran's Administration
VAWA	Violence Against Women Act
VHC	Vermont Health Connect
VSH	Vermont State Hospital
WIA	Workforce Investment Act

Attachment Two to DCF Bulletin 14-04F

Description for Decisions on Public Comments and Explanation of Changes to Health Benefits Eligibility and Enrollment Final Proposed Rule Pursuant to 3 V.S.A. § 841

June 5, 2014

Pursuant to 3 V.S.A. § 841, the Department for Children and Families (DCF) is filing with the Office of the Secretary of State and the Legislative Committee on Administrative Rules final proposed Health Benefits Eligibility and Enrollment Rule (HBEE; Secretary of State Rule 14P014). HBEE implements the provisions of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001, and Vermont Act Nos. 48 of 2011, 171 of 2012 and 79 of 2013.

DCF filed proposed HBEE rule on March 21, 2014. HBEE, upon adoption, will supersede HBEE Amendment # 3 (Secretary of State Rule 14-E03), an emergency rule that became effective on March 31, 2014.

The first summary, below, is of DCF's responses to public comments made on the proposed rule. The deadline for public comments on the proposed rule was originally May 2, 2014, and was extended to May 9, 2014, to allow more time for comments. A public hearing was held on the proposed rule on April 25, 2014, though no oral comments were received at the hearing. Two interested parties attended the public hearing by telephone, and no one from the public attended the public hearing in person. DCF received 181 written comments from four commenters.

The second summary, below, is a list of changes made in HBEE for reasons other than responding to public comments. These additional changes were made in order to (1) bring the rule into alignment with recently issued federal regulations and guidance, (2) provide clarification, (3) add clarity and improve consistency, and (4) correct technical and typographical errors.

All changes being made in the final proposed HBEE rule are identified in gray highlight in the annotated version of the final proposed rule being filed contemporaneously herewith.

Description for Decisions on Public Comments and Explanation of Changes in Response to Public Comments

DCF thanks all of the commenters for their constructive suggestions on the proposed rule. Reading and analyzing a rule of this size and complexity is a significant undertaking, and the final proposed rule is a better product as a result of the efforts of the commenters.

DCF received several comments on the general structure of the rule and on the confusion some readers experienced in attempting to determine to which program or programs a specific section applied. Whereas DCF recognizes that combining rules for Medicaid with rules for Qualified Health Plan (QHP) enrollment and Advance Payment of the Premium Tax Credit (APTC) and Cost-Sharing Reduction (CSR) has some disadvantages, a consolidated set of rules for health benefits avoids duplication and better serves the reader, in that the reader is not required to

shuttle between two documents. For most applicants, a determination of their eligibility for Medicaid will be made first, which could lead directly to a determination of their eligibility for enrollment in a QHP with or without APTC. Since all of the health benefits are closely integrated, all aspects of eligibility administration, including rules, IT, call center functions, and staff should be integrated as well. In the final proposed rule DCF has attempted to label sections and subsections to clarify to which program or programs they are relevant. If a section or subsection is not specific to a program, it is intended to cover all health benefits.

Notwithstanding the comments above on the advantages of a consolidated rule, DCF recognizes that the rule as it is currently written could be improved. Unfortunately, there was not time to incorporate some of the suggestions for improvement, particularly those related to restructuring of the rule, but those suggestions will be considered in future rulemaking.

In the responses below, the explanations often use the first person "we" in referencing DCF.

General Comments

Comment: The rules confuse Choices for Care (Vermont's Long-Term Care Medicaid Program) and Medicaid for the Aged Blind and Disabled (MABD). They are distinct Medicaid coverage categories with their own financial and clinical eligibility criteria. Although, in general, the same financial criteria apply to both programs, the clinical criteria are different and responsibility for making clinical or disability determinations rests with different departments within the Vermont Agency of Human Services (AHS). Eligibility for Choices for Care (CFC) is based on the need for institutional level of care under Medicaid. It is implemented in Vermont through the CFC regulations (the high and highest need criteria) and is an eligibility determination made by the Department of Disabilities, Aging and Independent Living (DAIL).

By equating CFC with MABD, this rule makes a significant policy change that is not related to the implementation of the exchange. We are concerned that this new policy will delay access to long term care by forcing some individuals to go through what is often a lengthy Disability Determination Services (DDS) evaluation.

Furthermore, this change will deny CFC services to individuals who need institutional level of care for less than a year.

We have raised these issues since August 2013, and met with AHS about it. AHS has still not offered any explanation why Vermont made major policy changes to long term care by burying them in these rules related to implementing the exchange.

Response: There has been no policy change. Both prior to the Affordable Care Act (ACA) and since its implementation, a disability determination is not a prerequisite to eligibility for Choices for Care (CFC) although in certain cases, a person may have to have a disability determination in order to have categorical eligibility. The institutional "level of care" clinical determination made by Department of Disabilities, Aging and Independent Living (DAIL) for purposes of CFC

eligibility (highest and high need criteria) has never been, and is not now, a substitute for that disability determination.

It has always been true, and continues to be true, that in order for a person to be eligible for CFC they must be categorically eligible for Medicaid. Before the ACA this meant Medicaid eligibility under one of the Supplemental Security Income (SSI) - related or Aid to Needy Families with Children (ANFC) - related categories. Since the implementation of the ACA, SSI-related Medicaid (now referred to in the HBEE rule as Medicaid for the Aged, Blind and Disabled (MABD)) has remained unchanged. Under MABD, there is categorical eligibility based upon age, disability, or blindness.

The ACA has changed the Medicaid eligibility that was under the former ANFC-related categories. ANFC-related Medicaid is now referred to in the HBEE rule as Medicaid for Children and Adults (MCA) and includes a new adult category. Accordingly, persons who are eligible for Medicaid under an MCA category of pregnant, parent/caretaker relative or the new adult group may be eligible for CFC if all other eligibility requirements are met, including an institutional "level of care" determination by DAIL.

Comment: AHS needs to create a system whereby it can quickly implement changes in federal law. Of particular importance are changes that ameliorate unfairness and hardship caused by prior federal rules or guidance. AHS needs a way to immediately help people when federal agencies relax or change the rules.

The system could be akin to the former AHS system of "PP&D" interpretive memoranda, or the bulletins that the Department of Vermont Health Access and the Department of Financial Regulation issue periodically. We suggest AHS issue numbered Guidance Bulletins. These bulletins could be issued for changes that are either temporary allowances from federal agencies to relax certain rules, or important changes that should become effective immediately. For the latter changes, AHS could simultaneously pursue rulemaking.

A formal, public system of guidance bulletins would be more transparent, reliable and readily available to applicants, advocates, navigators, and other assistors than the current somewhat confused method of communicating changes. Navigators and other interested parties could better keep track of changes if there were a series of numbered, published guidance bulletins initially sent out by email and then posted online.

Response: We agree that we need a system outside of the formal rulemaking process to implement quickly federal guidance and regulations and issue other guidance. Such a process is now under development.

Comment: AHS should pursue two options provided by HHS in May 2013 guidance: Strategy 3, enrolling individuals into Medicaid based on Supplemental Nutrition Assistance Program (SNAP) eligibility; and Strategy 5, adopting 12 months of continuous eligibility (without regard to changes in circumstances) for adults through the Medicaid section 1115 waiver authority. Facilitating Medicaid and CHIP Enrollment and Renewal in 2014, Center for Medicaid & CHIP

Services, SHO #13-003, ACA #26, May 17, 2013, available at ttp://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf.

In particular, continuous 12 month eligibility for adult Medicaid beneficiaries would significantly address the problem of income fluctuation and resulting "churn". We have not seen this problem yet in Vermont Health Connect (VHC), as the focus has been on initial enrollment, but we expect to see these cases shortly. In our experience, low income workers frequently have changes in their income. Under the current eligibility rules, a family could potentially transition between Medicaid for Children and Adults (MCA) and a QHP with subsidies multiple times per year.

These transitions will disrupt access to health care and gaps in coverage may occur. The provider network may change each time a family transitions between programs. Churning will be financially difficult as well, since the family will have to meet a new deductible each time they enroll in a new QHP.

Response: The Agency of Human Services (AHS) is currently considering the 12-month continuous eligibility option but has as yet made no decision. An analysis of the fiscal impact will need to be completed before a decision can be made. Although AHS has not adopted Option 3 from the Centers for Medicare and Medicaid Services (CMS) guidance the commenter mentions (automatic enrollment in Medicaid based on Supplemental Nutrition Assistance Program (SNAP) eligibility), our integrated eligibility system does evaluate Medicaid eligibility when an applicant or beneficiary is determined eligible for SNAP. An integrated eligibility system, which many states do not have, helps ensure that applicants for one program are also screened for other programs they might be eligible for.

Comment: Throughout this rule it is not always clear to what extent certain provisions apply to all Qualified Health Plans or to only those that are medical plans, as opposed to stand alone dental plans. Greater clarification could be offered to identify which sections and related definitions apply only to Medicaid or other governmental programs and which apply to the private insurance offered on Vermont Health Connect.

Response: Requirements for certification of stand-alone dental benefits are addressed through the form and rate review process through the Department of Financial Regulation. The federal government has released extensive regulations and guidance regarding which regulations apply to stand-alone dental benefits. Our state rule, where drawn from federal regulations, contains citations to the federal rule to clarify the applicability of the provision.

Comments by section

Part One: General Provisions and Definitions

Section 2.02(b): Medicaid eligibility

Comment: This section requires additional clarification. Is the §1115 waiver referenced in this section the Global Commitment waiver, the Choices for Care waiver or both? This provision implies that the 1115 waiver is a separate eligibility category. Is that the case? If not, how do the §1115 waivers interface with the three eligibility groups listed in this section?

Response: Vermont is in the process of negotiating with CMS to combine the Global Commitment waiver and the CFC waiver into on § 1115 waiver. The § 1115 waiver is not a separate eligibility category, although it does include "expansion groups" whose members would not be eligible under the Medicaid state plan, as well as modifications to eligibility criteria or benefits available to existing state plan groups. CFC is not an eligibility category; rather, it is a service, or group of services, available to certain individuals who are eligible for Medicaid under federally defined categories.

Section 2.04(a) and (b): The Health Benefits Exchange

Comment: This section of the rule provides an overview of the health benefits exchange as envisioned by federal law. As we have previously noted, we believe this type of overview is not necessary to include in a legally binding rule, but we understand there may be some historical precedence for this approach within the Agency of Human Services. However, we recommend removing much of the detail provided in this section, both because the rules referenced may change and also because some of the concepts are more complex than can be explained in a short overview. Specifically we would recommend removing specific references to various rules applicable to qualified health plans (QHPs). For example, the rule states that QHPs must limit annual cost sharing to the current Health Savings Account limits; this is no longer an accurate statement as such limits are indexed after the implementing year. The reference to HSAs as related to catastrophic plans in the same section is also no longer accurate. We would recommend redrafting this section to refer to such things as standardized plan designs and DFR certification.

Likewise, we recommend modifying the language in 2.04(b) to be more general in nature. Although the use of the term "refundable" as it relates to the federal tax credit may be legally accurate, it is not explained in this section and would seem to be a technical detail that is not necessary for a broad overview. Likewise, the reference in 2.04(b), fourth paragraph, to the "basic" benefit plan may be somewhat confusing.

Response: We have modified § 2.04(b) by removing "refundable and advanceable" as modifiers for "federal premium tax credits," and have added a reference to silver plans in the context of CSR. We have simplified the general description of the Health Benefits Exchange given that coverage standards and other details are addressed elsewhere in the rule.

Section 3.00: Definitions

Section 3.00 General

Comment: There are several definitions sections throughout this rule. We strongly encourage a review of these definition sections to ensure that general definitions included in this Section 3.00 apply to all sections of the rule. We would also encourage you to ensure that these definitions are necessary for implementation of the rule. In some instances, it appeared that the term being defined was not used in the rule or was used in the rule in a very narrow context that may not warrant a stand-alone general definition.

Response: We agree that a thorough review of the definitions section would be beneficial and will consider such a review prior to the next rulemaking process.

Applicant

Comment: The federal rules have different definitions for "applicant" as applied to individual QHPs and group QHPs. Because the application process is expected to be different in the individual and group market, this might be an appropriate approach for the state rule.

Response: We agree that the federal definition provides clarity. We will use a definition similar to the federal definition.

Application

Comment: The last phrase should be deleted. AHS should not use an entirely separate application form for non-MAGI-based Medicaid, even though it may be permitted under federal regulations. AHS should commit to maximum implementation of the "single streamlined application" and "no wrong door" ideals of health care reform.

Response: The single, streamlined application does not collect some information necessary to make an eligibility determination for Medicaid that is not based upon Modified Adjusted Gross Income (MAGI); it does not collect information on resources. In order to keep the single, streamlined application "streamlined" for use by individuals applying for MAGI-based Medicaid, we believe that using a separate application for non-MAGI-based Medicaid is an appropriate solution at this time. We may consider other solutions in the future.

Comment: As there are several different applications for different programs, we suggest broadening this definition to capture the concept embodied in all of the various applications. Additionally, we wonder if a definition of application is necessary for the implementation of this rule.

Response: We would prefer to retain this definition in § 3.00. Although application filing is covered in § 52.02, that section does not cover applications by employees. We believe that the

definition in § 3.00 is broad enough to cover employees, since the definition of "applicant" includes a "qualified employee."

Application date

Comment: Revise definition to clarify the application date of an applicant who is ultimately found eligible for non-MAGI-based Medicaid, who initially applied for Medicaid using the single streamlined application. We believe the application date should be the date the individual submitted the streamlined application, even if other forms were subsequently required.

Response: We agree and have made this change.

Comment: This does not seem to capture the "post mark date" rule which is being utilized currently. Although we believe the post mark date rule may pose operational challenges, if that rule is going to continue, we suggest referencing that rule here.

Response: Currently AHS uses the date the application is received as the application date, not the post mark date.

Benefit year (or taxable year)

Comment: We recommend changing this to the definition of "benefit year," removing "(or taxable year)" and keeping the footnote. Although we appreciate the idea that in Vermont, with all plans being calendar year plans, all benefit years on the Exchange will mirror the typical taxable year, we believe that the concepts are so legally distinct as to create some confusion in some contexts.

Response: Since CMS regulations use the term "benefit year," and IRS regulations use the term "tax year" or "taxable year," we would prefer to keep both terms in the definition. Both terms are used multiple times in the rule. At some point it may make sense to use one of the terms consistently throughout the rule, but we will not be able to make that change at this time.

Cancel

Comment: The federal government has proposed new definitions for the terms "termination," "cancellation," and "reinstatement." See 79 Fed. Reg. 15808 (March 21, 2014) (proposed 45 C.F.R. § 155.430). We recommend incorporating these concepts into this rule and ensuring that they are used consistently throughout the rule. Please note the defined terms "close" "reenroll" "disenroll" and "reinstate" may merit further review.

Response: Since the federal regulation containing these definitions has now been finalized, we have added the definitions to § 76.00.

Catastrophic plan

Comment: We suggest referring to the federal requirements to define a catastrophic plan, specifically noting that such plans shall be compliant with federal law. We also note the term "prevention benefits" might need to be changed to "preventive benefits as defined by federal law." Note that as related to QHP benefits, "preventive benefits" are a very specifically defined set of benefits dictated by the United States Preventive Services Task Force; some explicit reference to this in the rule could help clarify that the term, as used in this context.

Response: We believe the reference to 45 C.F.R. § 156.155 makes clear that this definition is based on federal standards. However, we are revising subsection (c) of the definition to align it with the language in the federal rule.

Community spouse

Comment: Does this definition need to be limited to a specific program? It would not appear to be relevant for QHP purposes.

Response: We have clarified that the term is specific to Medicaid.

Cost of a QHP

Comment: This definition cross references Section 60.02(a) which defines it as "The premium a plan charges." It might make sense to simply include that definition either in this section or just include the definition itself in Section 60.00 where it is relevant. We also note that the use of "plan" in this context, while consistent with commonly understood terms, is not consistent with other terms used in the rule. Would a more appropriate term be "QHP issuer"? However, we would also encourage an analysis of what purpose this definition is intended to serve and either the deletion of this term or more specifics. For example, does the "cost of a QHP" include all premium regardless of subsidy? If so, it may be beneficial to explicitly include this in the definition.

Response: We do not think this definition is necessary here and have removed it.

Eligible employer sponsored plan

Comment: This definition is included in the IRS definition of "minimum essential coverage." 26 U.S.C. § 5000A(f). The concept of "minimum essential coverage" is relevant to Vermont Health Connect because individuals who have minimum essential coverage outside of individual coverage are not eligible for a tax credit. We do not believe including this definition in the general definitions section is necessary, as the term as defined here is really only applicable in a narrow scenario within this rule. We recommend moving this definition out of the general definitions section and including it in the section of the rule (if it is not already included) which addresses when someone is not eligible for a government subsidy due to the opportunity to enroll in an eligible employer sponsored plan.

Response: Although it is not always clear whether a definition should go into the general definitions section, the section or sections to which it applies, or both places, we are leaving this definition in the general section at this time.

Grace period

Comment: We don't believe this definition is accurate. The definition attempts to capture some of the concepts related to APTC by referring to enrollment, but more broadly the grace period is really the period of time a person has to pay their premium without having their coverage terminated. Since the specifics of the APTC grace period are addressed in more detail elsewhere in the rule, we recommend redrafting the definition of grace period to refer to the concept of payment and termination and make it applicable to all programs.

Response: For purposes of this rule, the "grace period" refers to the period of time between the date the premium was due and the date of termination. We believe the definition is accurate within this context.

Grandfathered health plan

Comment: We believe this concept is only relevant in this rule as it applies to what constituted "minimum essential coverage" such that an individual is not eligible for a subsidy. We would remove this definition from the general definitions section and include it in the minimum essential coverage section, if necessary.

Response: See answer above on "eligible employer-sponsored plan." We are leaving this definition here for now, although we may consider moving it in future rulemaking.

Health insurance issuer or issuer

Comment: Technically Blue Cross and Blue Shield of Vermont is a nonprofit hospital and medical service corporation under Vermont law. We would recommend aligning this definition (which came from federal law) with Vermont law.

Response: We have added to the definition the phrase "nonprofit hospital and medical service corporation," from 18 V.S.A. § 9402, to comply with Vermont law.

Hospice Services

Comment: This section defines hospice services as a long term care service. This is a change from the existing rules which list Hospice and Long Term Care as distinct Medicaid services. See sections 7402 and 7601. Defining hospice as a long term care service is inconsistent with existing rules. Also, we ask that you clarify the legal basis for sections (b) and (c).

Response: The definition of "hospice services" is not a change from the prior rule (see Medicaid Rule 4412, last paragraph). We have added "Medicaid for" to the beginning of the definition to clarify that the definition applies to Medicaid.

Level of coverage

Comment: It is not clear that this definition is necessary for the successful implementation of this rule. However, if it is, we would recommend simply referring to the metal levels and removing the more technical references to actuarial value and de minimis variations – federal rules in this area are prone to change.

Response: We have removed actuarial value and de minimis variation language from the definition for purposes of simplification.

Long-term care and long-term care services

Comment: The definitions of long-term care and long-term care services are confusing as drafted and inconsistent with one another and with other applicable regulations and policies. The previous definitions under rule 4201 did not have a separate definition for "long term care services" so adding that additional definition creates confusion. What is the purpose of adding an additional definition for "long term care services" in these rules? The proposed federal rule cited in support of this section has not been finalized. 78 Fed. Reg. 4593, 4692 (proposing an amendment to 42 C.F.R. § 435.603(j)(4)) (Jan. 22, 2013).

The definition of long term care services here conflicts with the existing DVHA rule for coverage of Long-Term Care Services, 7601. We request that the additional definition for long term care services be deleted.

Response: We have included definitions of both "long-term care" and "long-term care services" to differentiate the level-of-care determination ("long-term care" taken from prior Medicaid Rule 4201-G and the services provided to someone needing that level of care ("long-term care services"). We will add a cross reference to the definition of "waiver services" so that the reader will be able to find more detailed information on the various programs available under a waiver.

We do not believe that the definition of "long term care services" conflicts with Department of Vermont Health Access (DVHA) Rule 7601. The definition is a summary of the content of 7601. We will add a cross reference to 7601.

Minimum essential coverage

Comment: As noted above, we question whether the definitions specific to minimum essential coverage need to be included in the general definitions section as the concept has narrow application. In the event it is determined to be necessary in the general definitions, we recommend a more generic definition such as: "As defined by federal law, health coverage,

other than that offered in the individual market by VHC, that disqualifies an individual from being eligible for state or federal subsidies."

Response: We would prefer to leave the definition in the general definitions section. The concept of "minimum essential coverage" (MEC) is also relevant to avoidance of the shared responsibility payment (tax penalty). The significance of MEC is also explained in § 23.01(a).

Minimum value

Comment: Similarly to minimum essential coverage, the concept of minimum value has a specific and technical relevance as it applies to Vermont Health Connect. Specifically, if a plan offered to an employee fails to offer minimum value, the employee may be eligible for a subsidy, despite the offer of employer coverage. We recommend removing this definition from the general definitions section and capturing the definition of minimum value in the section of the rule which addresses how an individual obtains a subsidy despite an offer of employer sponsored coverage. We would also explicitly reference federal law in the definition as federal law will dictate whether coverage is minimum value and such law has been relatively fluid. Note also that the footnote should refer to 45 C.F.R. § 156.145.

Response: We would prefer to leave this definition in the general definitions section. We will add the reference to 45 C.F.R. § 156.145, since § 155.300 refers to that section.

Plan year

Comment: This definition could be amended to reflect that all plan years on Vermont Health Connect are calendar year plans.

Response: Since the current definition already applies to all plans, we have not amended it.

Qualified Health Plan

Comment: In order to stay ahead of changing federal rules, we would amend this definition to: "A health plan certified by the Vermont Department of Financial Regulation as a qualified health plan." Note that a plan could be a QHP, although it may not be the current year QHP (hence the certification is not technically in effect because the plan has changed).

Response: We agree that this change would simplify the language while simultaneously ensuring federal and Vermont-specific requirements for a QHP are met. The requirement of the plan being offered through Vermont Health Connect (VHC) further complies with the definition of a qualified health plan under 45 C.F.R. § 155.20.

Renew

Comment: This definition seems to be focused on renewal of eligibility, which is distinct from renewal of coverage. We recommend analyzing whether extending the definition to include both

renewal of eligibility and renewal of coverage is supportable as the term "renew" as it relates to QHPs is typically used to describe the actual renewal of coverage itself – not necessarily relating to eligibility.

Response: For purposes of this rule, "renewal" refers to the annual renewal of eligibility for Medicaid or APTC and CSR, as well as qualification to enroll in a QHP. Since the definition in the rule is clear that it refers to eligibility, we do not wish to expand it to include coverage in a QHP.

Section 4.04: Case records

Comment: Case records must include all information relevant to the individual's case. The proposed definition is too narrow. For example, phone logs and notes regarding voicemail messages or phone calls are often important for determining whether an individual attempted to notify AHS of a change in circumstance.

Response: Section 4.04 is not intended to be a definition of "case record," nor is it intended to be an exhaustive list of every possible document that a case record might contain, as is indicated by the phrase "but not limited to" in § 4.04(a)(2). We have not modified this section in the final proposed rule.

Section 4.06: Fraud

Comment: This section addresses fraud. We recommend adding a provision to this section that states how individual should report suspected fraud to AHS or at least indicating that individuals have the ability to report suspected fraud to AHS.

Response: We have added a general statement to the rule that individuals may report suspected fraud to AHS. We do not want to include references to specific units within AHS in the rule; however, individuals may report suspected fraud to the managers in the Health Access Eligibility Unit or by calling the toll-free hotline. Reports of provider issues, excess use of medical products or services, and other related issues may be reported to the DVHA's program integrity unit. The Office of Attorney General's Medicaid Fraud and Residential Abuse Unit investigates Medicaid fraud.

Section 5.00: Eligibility and enrollment assistance

Comment: During open enrollment in 2014, BCBSVT front line staff expressed some frustration in their ability to help people who were struggling to enroll in VHC. Although we understand that 2015 open enrollment will be smoother, we would like to explore with the State whether there are areas where BCBSVT could provide assistance to individuals in the application process such that the overall enrollment process is more satisfying. We understand that specific consumer protections would be required, but we would be interested in having conversations with the State about how BCBSVT employees could more robustly support individuals as they seek to enroll in Vermont Health Connect.

Response: We would be glad to work with you on improving the application and enrollment process and appreciate your desire to assist.

Section 5.01: Assistance offered through AHS

Comment: Stronger language is needed regarding AHS's affirmative obligation to assist people in applying for benefits. Eligibility and enrollment assistance should be provided to all applicants and recipients who need it, and not just individuals with disabilities or limited English proficiency. Many English-speaking Vermonters without disabilities will need in-person and on-call assistance to enroll and maintain eligibility.

This assistance may be required for AHS to gather and collect the necessary information to perform the proper application screening as specified in section 58.01(a). This section should also cross reference section 52.02 on application filing, to make it clear that AHS will accept applications from someone acting on behalf of an incapacitated individual, and that AHS has an affirmative duty to assist that person in the application, under the duties to the applicant as set out here. AHS's obligation to advise applicants about their options is well established in Vermont.

Response: We agree that all applicants and beneficiaries should be able to access help if needed. We believe that the availability of a network of application counselors and navigators, as described later in this section, makes it clear that adequate eligibility and enrollment assistance is available.

We believe that § 5.02 is sufficient in describing that authorized representatives may act on behalf of applicants and beneficiaries in the application and renewal processes, as well as with all communications with AHS regarding eligibility.

DCF's Economic Services Division (ESD) will provide the following assistance to applicants who come to a district office seeking assistance with completing an application:

If an applicant for MABD is seeking assistance, ESD staff will help the person complete the application form, but will refer the person to the toll-free hotline for answers to questions about MABD.

Applicants for MCA seeking assistance will have the opportunity to use a district office work station to apply online with VHC, or they will be able to call the toll-free hotline to complete an application over the phone. In addition, applicants for MCA can be referred to local application assistors and navigators for additional assistance if needed.

Section 5.02: Authorized representatives

Comment: This section addresses the processes and rights of an authorized representative. This section should be clarified to indicate that such authorizations do not extend to the issuer of a QHP. For example, we would suggest adding "from AHS" to the end of the first sentence in

Section 5.02(b)(1)(iii) and to the end of 5.02(b)(1)(iv). Additionally, adding "with AHS" after "valid" in the first line of Section 5.02(c)(1). We would also recommend adding "AHS" in front of the term "call center representative" in Section 2.06(g) (first line).

Response: We have adopted a modified version of your suggestions that we believe addresses your concerns. We believe that § 5.02(a)(1) is clear that authorized representatives are for purposes of communicating with AHS; such authorizations do not extend to communications with carriers.

Part Two: Eligibility Standards

Section 7.03(a)(6) and (7): Transitional Medicaid

Comment: These sections refer to what is currently called Transitional Medicaid in Vermont. Recent federal legislation extended Transitional Medicaid through March 31, 2015. Just prior to filing these comments we learned that AHS plans to change these sections because of the TMA program's recent one year extension. We have not yet seen the proposed language. We expect to continue to talk to AHS in order to clarify how the program will work.

Here are the comments we had written prior to the news that the sections are going to be rewritten:

We had hoped that Vermont would continue Transitional Medicaid as it now operates. The program allows a parent or caretaker relative who has been on Reach Up, but has new or increased earnings, to continue on Medicaid for up to an additional 36 months if the household income is below 185% FPL and certain other requirements are met.

Response: The final proposed rule adds Transitional Medical Assistance (TMA) as set forth in § 1925 of the Social Security Act. As you stated above, Congress has extended TMA under this section through March 31, 2015. However, § 1925 allows for an extension up to a maximum of 12 months. Vermont was able to achieve a 36-month TMA period through the use of income disregards that are no longer allowed for the determination of income based on Modified Adjusted Gross Income (MAGI) methodologies. We must therefore adhere to the 12-month limit going forward.

Comment: Sections 7.03(a)(6) and (7) of the HBEE rule are taken directly from federal proposed rules that do not make sense, and they bear no relation to Vermont's Transitional Medicaid program. The income limits in sections 7.03(a)(6)(iii) and 7.03(a)(7)(iii) appear to fully nullify the provisions, because the income limits are not higher than the regular MCA eligibility level for the applicable individuals. This is baffling. We do not see how anyone could be eligible under these sections.

The relevant proposed federal rules have not been finalized. (42 C.F.R. §§ 435.112, 435.115, NPRM, 78 FR 4593, Jan 22, 2013.) These sections should either be deleted from the Vermont

rules, or they should be changed to accurately reflect the current Transitional Medicaid program. If these rules are retained unchanged, please explain to whom they might apply.

Response: The TMA described in § 7.03(a)(6) and (7) was added to the HBEE rule to ensure that, in the event that Congress does not extend TMA under § 1925 of the Act beyond March 31, 2015, TMA under § 1902(e)(1)(A) of the Act would remain available to parents, caretaker relatives, and some pregnant women (§ 1931 of the Act) who lose coverage due to new or increased earnings.

The income limits in §§ 7.03(a)(6)(iii) and 7.03(a)(7)(iii) refer to the income a parent, caretaker relative, or pregnant woman was receiving in at least 3 of the 6 months preceding the month in which ineligibility occurs. We agree that this is confusing as written and have clarified this in the final proposed rule.

Comment: Tracking the proposed federal regulation word for word (42 C.F.R. §435.112, NPRM, 78 FR 4593), §7.03(a)(6)(i)(B) states that "If Transitional Medical Assistance under §1925 of the Act is not available or applicable, extended eligibility must be provided in accordance with this subclause, if applicable." Vermont currently offers Transitional Medicaid, so we are assuming that it is available.

Response: TMA under § 1925 is available through March 31, 2015. The 4-month TMA described in the sections referenced would apply if Congress does not extend § 1925 TMA beyond March 31, 2015.

Comment: Section 7.03(a)(6)(ii)(B)(II)(ii) discusses when eligibility for a parent or other caretaker relative is lost due to "increased hours from a parent's employment resulting in the parent no longer having a 'dependent child,' as defined at §3.00 living in his or her home." It is not clear how this would occur. We realize this is word for word from the proposed federal regulation, but it doesn't really make sense. Under the definition of 'dependent child' in §3.00, increased earnings would have no effect on whether a child continues to be dependent. AHS may be intending a different definition of "dependent child" than that stated in §3.00, in which case that needs to be explained and a reference cited.

Response: We believe you may be looking at an earlier version of the rule. Section 7.03(a)(6)(ii)(B)(II)(ii) was removed in response to an earlier comment from Vermont Legal Aid (VLA), since it was no longer relevant in Vermont. The language is retained in federal regulations since many states still require a "deprivation factor" for families to be eligible for Medicaid. The deprivation factor could be the absence of a parent from the child's home, the incapacity of a parent, or the unemployment of a parent. A parent was considered unemployed if working fewer than 100 hours per month; therefore, if the unemployed parent began working 100 or more hours per month, the child would no longer meet the definition of "dependent child." Vermont dropped the "deprivation factor" many years ago.

Section 8.05(k): MABD for long-term care services

Comment: These revised rules have deleted two important rules from the 4200s that governed long term care eligibility under CFC: 4201(k), the definition for waiver services, which specified that CFC applicants were not subject to a disability determination, and 4202.3 Long-Term Care Coverage Groups, which specified that CFC was a form of categorical eligibility under SSI-related Medicaid. This proposed rule is also inconsistent with current rule 7605 which states clearly that DAIL alone is responsible for establishing and determining clinical eligibility for individuals needing nursing home level of care. We strongly object to these changes, and request again that the clear provisions from the old rules that have been inexplicably dropped from these rules be restored.

If the prior language is not restored, please clarify when, under the proposed rule, someone applying for CFC must be evaluated by DDS. Also, please explain AHS's rationale for deleting former rule 4201(k).

Response: The former Medicaid rules cited by the commenter have not been deleted.

Former Medicaid Rule 4201(k), which defined "waiver services," can now be found in the definitions section of the HBEE rule (§ 3.00) under "waiver services." The HBEE rule did abbreviate the definition of "waiver services" from its prior version, but not to change substance. A decision was made by the agency that the HBEE rule should not contain any references to departments within the agency or to specific responsibilities of those departments. In our effort to accomplish that objective, we can see that too much of the definition of "waiver services" was removed and, accordingly, we have restored a portion of it in this proposed rule. It does not, though, include any statement that CFC applicants are not subject to a disability determination because that is not our understanding, nor is it our reading of the definition of "waiver services" in former Medicaid Rule 4201(k). Former Medicaid Rule 4201(k) stated that when DAIL administers the waiver services, it determines whether applicants meet the level of care for the program. That "level of care" determination made by DAIL for purposes of CFC eligibility (highest and high need criteria) has never been, and is not now, a substitute for a disability determination.

Former Medicaid Rule 4202.3, which described long-term care coverage groups, can now be found in § 8.05(k) of the HBEE rule. Former Medicaid Rule 4202.3 was a subsection under Medicaid Rule 4202. The purpose of Medicaid Rule 4202 was to identify the "categorically needy coverage groups" for SSI-related Medicaid. Meeting the criteria of one of the coverage groups under 4202 was not, in and of itself, a determination of eligibility for SSI-related Medicaid. The introductory paragraph to 4202 stated the following (emphasis added): "To be eligible for SSI-related Medicaid as categorically needy, individuals must meet the criteria in one or more of the following coverage groups, **in addition to other nonfinancial and financial requirements**." The nonfinancial eligibility requirements for SSI-related Medicaid, including for individuals that met the criteria under one or more of the Long-Term Care Medicaid cover groups in 4202.3, were stated in Medicaid Rules 4210 through 4218.3. Those requirements are now stated in § 8.01 through § 8.04 of the HBEE rule.

In response to the commenter's request that we provide clarification as to when someone applying for CFC must be evaluated by Disability Determination Services (DDS), we refer the commenter to our response to their earlier comment on this topic at the beginning of this summary.

Comment: We object to these substantial revisions of the former rule, 4202.3 Long-Term Care Coverage Groups. There is no justification for making changes to long term care eligibility as part of these rules. Specifically, the additional resource test at section 8.05(k)(3)(iii) is confusing and ambiguous and should be deleted. There should be no change to the general principle governing resource eligibility for long term care. Further, the added language "Meets the MABD non-financial criteria" at section 8.05(k)(3)(iv) is misleading because it suggests that long term care requires a disability determination, and should also be deleted.

Response: There has been no change to the general principle governing eligibility for long-term care, and § 8.05(k)(3)(iii) does not state an additional resource test. The information contained in § 8.05(k)(3)(iii) was derived from former Medicaid Rule 4264 and cross references to § 29.10(e), which contains the details of that former rule.

We acknowledge that the content of § 8.05(k) differs from that of former Medicaid Rule 4202.3. As stated in response to the comment immediately preceding this one, former Medicaid Rule 4202, of which 4202.3 was a subsection, only identified the categorically needy coverage groups for SSI-related Medicaid (now MABD). In order to review the other nonfinancial and financial requirements for Medicaid eligibility, it was necessary to refer to other rule sections. One of the goals of Part Two of the HBEE rule is to state, in one location, the eligibility "standards" of all of the health-benefits programs.

Section 11.02: Non-financial Criteria for Enrollment in a QHP

Comment: This section provides the non-financial enrollment criteria for enrollment in a QHP. We continue to struggle to understand how something ends up in Part 2 of the rule or in Parts 3 or 7 of the rule. We request that this be more explicitly described in the rule. Also, note that the non-financial criteria do not include any information about Medicare eligibility. Once the Medicare/QHP eligibility rules are fully defined, we recommend including them in this section (wherever it might end up in the final rule) because it would appear to be non-financial criteria.

Response: We agree that clarification on how Medicare eligibility status affects eligibility should be added to this section; however, CMS is still in the process of issuing guidance on this point. We would prefer to wait until guidance is finalized. We have added an explanatory sentence to the beginning of Part Two, as well as to the beginnings of Parts Five and Seven, to clarify the content of the part.

Section 12.00: APTC

Comment: This section addresses advance payment of the premium tax credit eligibility. Unlike some of the other sections in Part 2, this section is detailed and appears to be the primary

section in the rule addressing eligibility and enrollment. It is unclear why this would not be in Part 7. When trying to find quick answers in the rule, it is difficult to navigate when the relevant parts of the rule are in two potentially different places. We recommend re-examining this structure and determining whether some structural modifications to the rule would provide a more consistent approach to eligibility criteria across the entire rule? We also wonder if there are opportunities to bring the minimum essential coverage/minimum value/affordability part of the eligibility rules closer to this APTC section. We also recommend renaming the subsections of this Section so that they more logically relate to one another.

Response: We appreciate your suggestion on restructuring the rule and will take it into consideration for a future revision.

Section 12.01: APTC general

Comment: We recommend adding the following sentence to the end of this section: "APTC is paid directly to the QHP issuer on behalf of the applicable tax filer." We also recommend a reference in this section acknowledging that federal law dictates the eligibility for ATPC and CSR.

Response: We have added the sentence you suggested. We have not added a reference to federal law, as you recommended. Since federal law takes precedence over most of the provisions in this rule, we do not feel we could add a reference to this section without adding it to all sections. We are in the process of developing a method to issue timely updates to this rule, outside of the normal rulemaking process, as future federal guidance and regulations are issued.

Section 12.02: APTC nonfinancial criteria

Comment: We recommend adding "as defined in Section 11.02" before the semi-colon in Section 12.02(a). Again, we note that Medicare eligibility should be addressed in Section 11.02.

Response: We have added a cross-reference to § 11.00.

Section 12.03: Applicable tax filer

Comment: This section is entitled "Applicable tax filer" but contains financial criteria for APTC eligibility as well as some additional requirements applicable to someone beyond meeting the income thresholds for eligibility. However, the structure of each requirement is not consistently tied to eligibility, making it difficult to understand the relevance, as it relates to the other provisions, of each subsection. This section might be easier to follow if the initial section included a general rule (such as "Except as otherwise provided in this subsection, an applicable tax filer meeting the income thresholds identified in subsection [x] shall be eligible for advance payments of the federal premium tax credit.") We also recommend stating each specific limitation on eligibility in a parallel manner so that it is easier to understand the criteria. (For example, each subsection could begin "An individual shall be eligible for APTC if:")

Response: We are reluctant to make extensive changes to § 12.03, since the language in that section closely follows the language in federal tax regulations at 26 C.F.R. § 1.36B-2(b). We believe that the key provision in §§ 12.00-12.05 is in § 12.02. Section 12.03 sets forth various criteria that allow an individual to be designated as an "applicable tax filer."

Section 12.03(b): Married tax filers must file joint return

Comment: The cross reference to the 26 C.F.R. 1.7703-1 relating to marriage can be removed.

Response: We disagree that the cross-reference should be removed, since the IRS does not recognize parties to a civil union as being married. The requirement that married couples file joint returns applies only to couples who are married as defined in the IRS regulations.

Section 13.02: CSR eligibility categories

Comment: We recommend removing the AV value chart from the rule and noting that VHC will publish such information on its website or provide it by mail upon request. The AV values, particularly as they relate to the state subsidy amounts, are likely to change. It's also unclear that the information is of use to the general public, and it lacks the detail necessary to make it legally relevant.

Response: The chart is helpful for individuals who believe they are in the wrong plan. Vermont Health Connect refers to these plans by actuarial value and by tier. We have deleted the federal CSR column and added the tier column for further clarity. If the actuarial value changes, the chart will be updated. Language was also added to clarify that the actual actuarial plan value may vary by one percentage point.

Section 14.00: Eligibility for enrollment in a catastrophic plan

Comment: It appears that this section lays out some of the eligibility criteria for enrollment in a catastrophic plan. We believe the "unaffordablity" criteria are not as clearly described as they could be. The current rule simply cross references the hardship exemption section. We would recommend laying out how the unaffordability criteria and the hardship exemption criteria apply specifically to the catastrophic coverage to make the eligibility criteria easier to understand. Again, we feel that Section 14 illustrates some of the difficulties associated with the current structure in that the eligibility criteria are in several places. We recommend a cross reference to Section 11.02 in the line that references QHP eligibility.

Response: We have added a cross-reference to § 11.00.

Part Three: Nonfinancial Eligibility Requirements

Part Three Generally

Comment: As we understand it, Part Three provides the non-financial eligibility criteria for the different programs. However, as noted above, it is not entirely clear that this is consistently applied. Additionally, the fact that Part Two is called generically "Eligibility Standards" makes it unclear which Part is intended to address which type of eligibility standards.

This section is difficult to navigate. One way to make it easier to navigate might be to have each financial criteria section have a stand-alone lead in section which says "This subsection applies to the following health benefits programs only:" and then list the programs.

Response: Although we have not changed the title of Part Two, we have added a statement to more clearly explain what it contains. We have also added clarifications to sections that apply to only one health benefits category; sections that are not clearly limited to one category are intended to apply to all categories.

Section 17.02(b): Enrollment in a QHP

Comment: This subsection might be easier to understand if the last part of the sentence was changed to read: "if the individual otherwise satisfies the eligibility criteria for a QHP."

Response: We agree and have made your suggested change, as well as others that we think improve the clarity of this section.

Section 21.00: Residency

Comment: This section outlines Vermont residency rules as applied to various programs. We suggest making these rules as specific as possible. Vermont provides additional subsidies above those provided by the federal government, potentially making our QHPs more attractive than other states. Clearly articulated residency requirements will facilitate the State's ability to prevent abuse. Furthermore, clearly articulated residency requirements will ensure that such standards are applied consistently to everyone. We also recommend that the first sentence in Section 21.01 be amended to state the eligibility rule more proactively. Perhaps: "As outlined in this section, an individual must be a resident of the State of Vermont to be eligible for health benefits."

Response: We will consider your suggestion for future rulemaking; however, our review leads us to conclude that all subsections to this section apply to all health benefits unless otherwise stated.

Section 21.02: Incapability of indicating intent

Comment: This section outlines the rules applicable to indicating "intent" as it applies to residency requirements. Since this is a clarification to the general rule, it may be more appropriate to move it so that it follows the provision referencing intent.

Response: We agree that the layout of this section could be improved and will consider your suggestions in future rulemaking.

Section 21.06: An individual age 21 and over

Comment: This rule lays out the general rule applicable to residency requirements for adults. We suggest this be moved to the beginning of Section 21 since it appears more general in nature.

Response: See our response above. We will consider your suggestion in future rulemaking.

Section 23.00: Minimum essential coverage

Comment: Section 23.00 details various rules related to "minimum essential coverage." An individual must have "minimum essential coverage" or be subject to a tax penalty. However, the IRS is the regulatory entity that will enforce whether an individual has a tax penalty. VHC, on the other hand, must determine whether an individual has "minimum essential coverage" because if an individual has minimum essential coverage other than individual market coverage offered on the Exchange, the individual is not eligible for subsidies. We understand that VHC may eventually also provide certificates of exemption to the tax penalty, which sometimes will implicate an analysis of a person's access to certain types of minimum essential coverage. Section 23.00 could be redrafted to tighten the focus of the concept of minimum essential coverage to those elements that relate specifically to VHC. We also note that it appears federal law has changed somewhat since this section of the rule was drafted. Finally, we would recommend clearly noting that minimum essential coverage is defined by federal law and that to the extent the state rule conflicts, federal law will control.

Response: We have made modifications to this section to clarify that subsections (b) through (e) describe the circumstances in which MEC is considered to be available to an individual, who would therefore not qualify for APTC.

Section 23.01(c): Employer-sponsored MEC

Comment: We recommend switching sections (c)(1) and (c)(2) so that the general rule is provided before the details.

Response: We would prefer not moving sections at this time, since doing so would change the numbering and could create cross-referencing errors.

Section 23.02: Affordable coverage for employer-sponsored MEC

Comment: This section pertains to when, despite an offer of employer sponsored insurance, such insurance is "unaffordable" for the employee and, as such, the employee is eligible for subsidies. We believe this section would be easier to follow if the general rule were stated first, followed by the details and exceptions. So for example, maybe 23.02 could start with language such as "An individual will not be eligible for federal and state subsidies if the individual has an offer of employer sponsored coverage." The rule could then provide the two exceptions to this rule (the coverage does not provide minimum value or the coverage is not affordable) and then provide the details of these provisions?

Response: We have added a statement under § 23.02(a) that we believe incorporates the intent of your suggestion.

Section 23.02(a)(3): Employee safe harbor

Comment: We suggest providing some context about how the concept of a "safe harbor" relates to these options.

Response: We have added a statement that will provide the context for the safe harbor provision.

Section 23.03: Minimum value for employer-sponsored MEC

Comment: This section outlines to the requirements relating to minimum value as they pertain to an exception to the rule that an employee must have an offer of employer sponsored coverage that provides minimum value in order to be ineligible for subsidies. We believe there are applicable federal regulations pertaining to these requirements and referencing those might be appropriate. Additionally, including language that federal law defines "minimum value" might help ensure that it is clear if the state rule and the federal law are not aligned, the federal law applies.

Response: We have added a statement to this section to clarify its purpose, and we have added a reference to 45 C.F.R. § 156.145, which defines how minimum value is calculated.

Section 23.06: Eligibility determinations for MEC exemptions

Comment: This subsection describes various scenarios where an individual can seek an exemption to the tax penalty. The structure of this provision makes it difficult to follow. For example, 23.06(b) is called "Eligibility standards for exemption" but the first few sections aren't exemption categories, but specific rules pertaining to exemption. Restructuring the concepts in this subsection could make this easier to understand. We also note that to the extent that this is being administered by the federal government for now, that could be referenced in the rule.

Response: The rule at § 23.06(a) does state that the U.S. Department of Health and Human Services (HHS) will make the exemption determination prior to October 15, 2014. We will not

restructure this section at this time but will consider your suggestions for future rulemaking; however, the rule as it is currently structured aligns with the structure in the federal regulation.

Section 23.06(a)(1): Eligibility determinations for MEC exemptions, definitions

Comment: Could you please clarify what section or sections of the rule to which these definitions apply? We are also curious about the definition of "shared responsibility payment" – it would appear that something more specific could be helpful (for example, tying it directly to taxes).

Response: We have added a statement to clarify that the definitions contained in § 23.06 pertain to § 23.06. The definition of "shared responsibility payment" is verbatim from the federal regulation at 45 C.F.R. § 155.600; however, we have modified the definition to clarify that the shared responsibility payment is the penalty imposed by the IRS for failing to maintain MEC.

Section 23.06(b)(7)(i)(C): Enumeration of possible hardship circumstances

Comment: AHS should add "but not limited to" after the word "including" at the end of this phrase. This will ensure that navigators, beneficiaries, and others know that the list is non-exclusive. In addition to the general non-exclusive nature of the list, HHS has continued to announce additional hardship exemptions in guidance.

Response: We are not modifying this section at this time since HHS is making the hardship determinations until October 15, 2014, and CMS is still issuing guidance on this issue. We will consider modifications to this section at a later date.

In addition, under Vermont statute at 1 VSA § 145, the term "including" means that the language following the term is illustrative and not exhaustive, and has the same meaning as though the term were followed by the words "but not limited to." Accordingly, we will not revise the rule to include the phrase requested. We will, however, do our best to outreach to navigators, beneficiaries, and others on this issue.

Part Four: Special Rules for Medicaid for Long-Term Care Services - Eligibility and Post-Eligibility

Section 24.00: Patient share

Comment: 24.04(a): Allowable deductions from patient-share; Income deductions. The allowable deductions should include reasonable expenses related to the receipt of unearned income, withheld income that is not actually available to the individual, and court-ordered obligations. It is contrary to public policy to deny an individual the income to support an ex-spouse as ordered by a court. This further impoverishes the ex-spouse by denying them essential support. This provision should be expanded to include the following:
(9) Ordinary and necessary expenses of managing, maintaining or receiving the unearned income. For example, court costs, fees of an attorney, guardian, fiduciary, or other authorized representative;

(10) Federal and State offset of benefits for the recovery of an overpayment, support or other debt;
(11) Alimony, support, maintenance or other court-ordered payments.

Response: We will not be adding to the list of allowable deductions from patient share as requested by the commenter. Sections 24.04(a) and (b) list all required and optional deductions against patient share that are available under federal regulations (42 C.F.R. §§ 435.725 and 435.726).

Section 25.03: Transfer penalty

Comment: 25.03(c) on transfers for less than fair market value should state the statutory presumption and cite the federal law. The following initial sentence should be added to this section: "There is a rebuttable presumption of ineligibility for transfers for less than fair-market value. 42 U.S.C. § 1396p(c)(1)(A) & (B)."

Response: We will not be adding the language requested by the commenter. This section is not a substantive change from prior policy (see Medicaid Rule 4473). It was not intended in prior policy, and is not intended now, to be a general statement on transfers for less than fair market value. Rather, it is only intended to identify transfers for less than fair market value that are not subject to the imposition of a penalty period.

Comment: To be consistent with federal law and Human Services Board precedent, the transfer penalty exemption at 25.03(c)(4) should be reworded. It should say:

"The transferor <u>has made a satisfactory showing</u> that the resources were transferred exclusively for a purpose other than for the individual to become or remain eligible for MABD for long-term care. 42 U.S.C. § 1396p(c)(2)(C)(ii). A signed statement by the transferor is not, by itself, a satisfactory showing. Examples of <u>satisfactory</u> evidence are documents showing that:...."

The underlying federal statute asks for a "satisfactory showing" that the transfer was made for a purpose other than qualifying for benefits. 42 U.S.C.A. § 1396p(c)(2)(C). To the extent that "convincing evidence" is different from a "satisfactory showing," the requirement of "convincing evidence" is inconsistent with the governing statute.

Moreover, a transferor need only make a "satisfactory showing" of the reason for the transfer, even if that showing does not convince AHS. If AHS is unconvinced, the evidentiary burden shifts to AHS to produce evidence contradicting the transferor's stated reason for the transfer. In F.H. 20,388, AHS was not satisfied by evidence that resources were transferred exclusively for a purpose other than becoming eligible for MASD. The applicant had presented undisputed evidence that he transferred assets purely for reasons other than qualifying for MABD for long-term care. He also presented documentary evidence that after making the transfer, he experienced a wholly unexpected and tragic accident when he fell down a cellarway onto a concrete floor. The fall created an unexpected need for long-term care.

Although this evidence did not document the purpose of the transfer "to AHS's satisfaction," the Human Services Board found that state and federal law required the denial of long-term care Medicaid to be reversed.

Response: Except for the references to "transferor" and "AHS," this rule remains the same as its predecessor, Medicaid Rule 4473(D). The long-standing requirement that there be convincing evidence that assets were transferred exclusively for a purpose other than to qualify or remain eligible for Medicaid is consistent with the federal statutory requirement that the transferor make a satisfactory showing to the State as to the exclusive purpose for which the asset was transferred.

Comment: The rule at 25.03(c)(7), transfer of excluded income or resources, should remove the inconsistency that suggests that the transfer of an excluded resource other than the home could result in a penalty. There is no basis for such a rule, and the transfer of an excluded resource cannot be "for the purpose of qualifying for Medicaid" since the resource is already excluded. Therefore, revise to:

"The transferor transferred excluded income or resources. Penalties are imposed for the transfer for less than fair market value of any asset considered by the SSA's SSI program to be countable ~~or excluded~~ or that result in the imposition of a penalty period under SSI. ~~For example, transfer of a home or of the proceeds of a loan are both subject to penalty.~~"

Response: If we understand the commenter correctly, we do not agree with their position that transfers of excluded resources can never result in a transfer penalty. It is our understanding from CMS guidance that some excluded resources, if transferred, are subject to transfer penalties. CMS states the following in its State Medicaid Manual at § 3259.6(F):

> Section 1917(e) of the Act provides that, for trust and transfer purposes, assets include both income and resources. Section 1917(e) of the Act further provides that income has the meaning given the term in §1612 of the Act and resources has the meaning given that term in §1613 of the Act. The only exception is that for institutionalized individuals, the home is not an excluded resource. Thus, transferring an excluded asset (either income or a resource, with the exception of the home of an institutionalized individual) for less than fair market value does not result in a penalty under the transfer provisions because the excluded asset is not an asset for transfer purposes.

We will not be making any changes to this section at this time, but we would be glad to discuss with the commenter possible revisions to it to improve its clarity provided that those revisions take into consideration CMS's guidance on this topic and are in compliance with that guidance.

Comment: Nominal gifts should be included in transfer penalty exemptions, as 25.03(c)(8):

"A penalty period is not imposed for transfers totaling a nominal amount in any month. The average daily cost to a private patient of nursing facility services is considered nominal. See P-2420(D)(13)."

Response: Efforts are made to make the verification process less onerous for applicants, and a "nominal" gift exception is an example of those efforts. It is not intended as an "allowed" transfer penalty exemption and will not be codified as such. The procedure cited by the commenter is for purposes of calculating the amount of a transfer penalty; it does not state a nominal gift exemption.

Comment: The last sentence in 25.03(j)(1), jointly owned income or resources, concerning transfers involving jointly owned income or resources established on or after January 1, 1994, should be reworded as:

"The individual may rebut the presumption of ownership upon a satisfactory showing ~~by establishing to AHS's satisfaction~~ that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other joint owner (or owners), and thus did not belong to the individual."

Response: This rule remains the same as its predecessor, Medicaid Rule 4473.5(A), and is consistent with federal law.

Section 25.05: Undue hardship

Comment: Under 25.05(c)(4), abuse or exploitation as undue hardship, reported abuse or exploitation should constitute undue hardship. This rule currently sets unreasonably stringent standards that will be nearly impossible for abused or exploited applicants to meet. This provision should be changed to read:

"Whether the individual was deprived of an asset by exploitation, fraud or misrepresentation. Such claims must be documented by police reports or civil or criminal action against the alleged perpetrator or substantiated by AHS or by a report to AHS for investigating abuse, neglect or exploitation."

Response: The commenter previously commented on this section during the rulemaking process for HBEE Rule 13-12. At that time, the commenter stated the following:

> 25.05(c)(4): Reported abuse or exploitation should constitute undue hardship. This provision should be changed to read: Whether the individual was deprived of an asset by exploitation, fraud or misrepresentation. Such claims must be documented by official police reports or civil or criminal action against the alleged perpetrator or substantiated by AHS or by a sworn statement to AHS attesting to the fact that the claim was reported to the police or to the AHS department responsible for substantiating such claims report to AHS for investigating abuse, neglect or exploitation.

In response to that comment, we revised this section to reflect most of the changes requested by the commenter. No further revisions will be made at this time.

Part Five: Financial Methodologies

Section 28.03(e): Household composition

Comment: The new method of household composition requires a major conceptual shift for those familiar with current Medicaid rules. AHS should include some introductory language about how the new system works. We suggest something along the lines of this addition:

28.03(e)(1)(iv) "Household composition is determined separately for each individual seeking coverage. Individuals residing together may have different MCA household compositions."

Examples would be enormously helpful, including a mixed MABD/MCA household, and a child with a caretaker relative on Medicare. We propose adding a section 28.03(k) for examples.

Response: We agree that the new method of determining household composition is a conceptual shift. We have added a statement to § 28.03(b) to the effect that household composition is determined separately for each individual. Although the rule does contain examples in other sections, we are not comfortable adding examples to this section due to the large number of possible permutations. We have developed training materials that do contain numerous examples, and we are happy to make those materials available to anyone who wants them.

Section 28.05: APTC and CSR

Comment: This subsection has some information about the applicable financial eligibility criteria for CSR and APTC eligibility. We recommend consolidating this with other provisions in the rule relating to APTC/CSR eligibility. As noted above, eligibility criteria can be difficult to understand because different pieces of the eligibility criteria are in different parts of the rule and it's not always apparent where information can be found within the rule.

Response: Section 28.00 describes how household composition and income are determined for the various health benefits programs. We believe it is to the reader's advantage to have these rules in one section. We have added a cross reference in § 12.03(a) to § 28.05 to link the two APTC sections.

Section 29.00: Financial eligibility standards – Medicaid for the aged, blind, and disabled (MABD)

Comment: We continue to be confused by the change from "MABD for long term care" to "Medicaid for long term care" in these rules, and whether that change is intended to have any substantive meaning. If the change in terminology does change any aspect of eligibility for long term care, we request that be explained by the Department and justified. It is also confusing that the change was not made in Rule 29, which continues to refer to MABD for long term care. However, as long as our other comments are adopted, including restoring the critical provisions related to eligibility for CFC (4201(k) and 4202.3) and deleting the confusing addition of a

separate definition for "Long Term Care Services", we don't oppose referring to long term care in these rules as generally "Medicaid for long term care services."

Response: Medicaid coverage of long-term care services is not just available to someone who becomes eligible for Medicaid by being aged, blind, or disabled (MABD) and meeting all related non-financial and financial criteria. In Vermont, Medicaid coverage of long-term care services is also available to individuals eligible for Medicaid under the new MAGI methodology required by the ACA – what we refer to in the rule as MCA (parents/caretaker relatives, children, pregnant women and the new adult group). By having the rule worded in such a way as to link Medicaid covered long-term care services only to MABD, we did not have the necessary rule provisions for individuals who would be entitled to Medicaid covered long-term care services under MCA. Accordingly, where appropriate, we changed the rule reference from "MABD" for long-term care services to "Medicaid" for long-term care services so that the rule could apply to individuals receiving Medicaid under MABD and those receiving Medicaid under MCA. We did not make that change in § 29.00 of the rule because § 29.00 is specific to financial eligibility for individuals seeking Medicaid as aged, blind, or disabled (MABD), including MABD for long-term care services. Financial eligibility for MCA using the ACA's MAGI methodology is covered in § 28.03.

Section 29.02: MABD definitions

Comment: This section contains definitions. It would be helpful for this rule to specifically note that these definitions apply to all Sections and Subsections of Section 29.00.

Response: The language in § 29.02 has been clarified as suggested.

Section 29.09: Value of resources

Comment: The phrase "in the discretion of AHS" should be deleted from sections 29.09(d)(5)(ii), 29.09(d)(1), and 29.08(d)(2)(iii). These rules should specify AHS's financial methodology for eligibility. That methodology must be clear and cannot be at the whim or discretion of AHS on a case by case basis.

Response: The language in the sections cited is not a substantive change from prior rule at Medicaid Rule 4252.5. We believe that it remains appropriate.

Section 29.13(b)(1): Income exclusions

Comment: Reasonable costs associated with accessing income should be excluded. The proposed language is too narrow. This provision should be changed to,

"Reasonable and necessary expenses of acquiring, managing, maintaining or receiving the unearned income. For example, fees of a guardian, fiduciary, authorized representative or attorney and court costs may be deducted."

Response: Section 29.13(b)(1) is not a substantive change from the prior rule at Medicaid Rule 4280.2(A). We do not believe that the suggested language is broader than the language in the rule: "Expenses incurred as a condition of receiving the unearned income."

Part Six: Small Employer Health-Benefits Program Rules

Introduction Section

Comment: We note language clarifying that issuers are not responsible for implementing the VHC rules for direct enrollment into qualified health plans (QHPs) has been removed. We understand that this removal reflects the on-going uncertainty about what CMS will require of Vermont health plans directly enrolling employer groups into QHPs. However, we want to again reiterate that many of the requirements for an enrollment through VHC cannot and are not being imposed by BCBSVT.

We are also renewing our request to begin discussions with the state, including the Department of Financial Regulation and other interested stakeholders, about what 2015 small group enrollment can and should look like. Although we understand there are many legal and technical questions outstanding, we believe that we can begin productive work on this process now and that doing so will alleviate some of the potential challenges in the 2015 enrollment processes for small groups. This meeting would be useful even if VHC cannot support direct enrollment in the fall of 2015.

Response: We agree that more collaboration with stakeholders will ensure a smoother transition into 2015 plans. We plan to continue engaging the stakeholders throughout the summer.

Section 31.00: Definitions

Comment: Definition of Annual employee open enrollment period: We recommend adding the word "current" in front of "plan year" in the last sentence in this section. We might also recommend changing the tenses in this sentence so that it reads: "The annual employee open enrollment period shall precede the end of the employer's current plan year and shall follow the annual employer election period."

Response: We agree with this comment and have incorporated the change.

Comment: Definition of Annual employer election period: It might be simpler to track this provision and its adherence to the federal requirements if it follows 45 C.F.R. § 155.725. So for example, starting with employer choice model as provided for in 45 C.F.R. § 155.725(c)(2)(i).

It is also not entirely clear what the current (i) in the state rule means because it refers to the employer choosing a month for which it is seeking coverage. Is this intended to mean the effective plan start date? As it reads now, it could be read to mean that this needs to be done on a monthly basis.

Response: The federal definition of "annual employer election period" does not necessarily allow for federal guidance that may be specific to Vermont. We would like to maintain this flexibility. As a result, we will track to our own rule and will not incorporate the suggested change.

We agree that "the month for which it is seeking coverage" is confusing. We have removed this provision.

Comment: Definition of "Dependent": Removal of "or may become eligible" from "Any individual who is or may become eligible…" will rule out any unintended consequences of this expanded definition that does not include people currently fitting the description of dependent.

Response: The definition of "dependent" comes from Health Insurance Portability and Accountability Act (HIPAA) regulations at 45 C.F.R. § 144.103. The use of "or may become eligible" reflects that the group health plans determine which individuals are eligible for coverage as a dependent under the plan.[1] Since this definition has been in effect for a number of years, we do not view it as an expansion and it will not change.

Comment: Definition of Full Time Employee: The definition of full time employee now tracks the federal rules. Will VT be transitioning to the federal definition of full time employee in 2015? Otherwise, I think we need to defer to the VT definition of full time employee here and provide the 2016 definition here effective for plan years beginning on or after January 1, 2016?

Regarding the "with respect to any month" language, we continue to believe this should be stricken. The phrase, as used in IRS Code 4980H, is appropriate in that context because it is specific to the application of the employee counting rules for the purposes of pay or play. With regards to determining which "full time employees" must receive an offer of coverage, however, IRS regulations provide various methodologies that make it clear that a person can work an average of 30 hours per month and still not be considered a "full time employee" that requires an offer of coverage (although they would still be considered a full time employee for that respective month when the employer is counting employees to determine employer size). Because this rule is primarily focused on the "full time employee" who must be offered coverage, the term creates some confusion by implying that each month an employee works 30 hours on average, they would be required to receive an offer of coverage. That said, it may be easier to actively separate these concepts within the rule and define "full time employee" for the purpose of establishing employer size and define "full time employee" for purposes of assessing the requirement that all full time employees must be offered coverage to be a qualified employer.

Response: We agree that the term "with respect to any month" is confusing. We are deleting the term. We have clarified that the definition of full-time employee will exclude seasonal workers when counting the number of employees for the purpose of determining if the employer is a

[1] Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV, 69 Fed. Reg. 78720, 78720 (Dec. 30, 2004) (amending 45 C.F.R. § 144.103), http://www.gpo.gov/fdsys/pkg/FR-2004-12-30/pdf/04-28112.pdf#page=62 .

small employer, and the definition of full-time employee will exclude seasonal employees for the purpose of determining if an employer is a qualified employer who has offered coverage to all full-time employees. This rule will be revisited prior to 2016 to ensure compliance with federal law.

Comment: Definition of "Initial employer election period": This section no longer seems relevant with any such period now past and, in fact, could add confusion.

Response: We agree. We will make the requested change and delete the definition of "Initial employer election period."

Comment: Definition of Seasonal Employee and Seasonal Worker: We agree that making the distinction between seasonal employee and seasonal worker is a good idea. Within the definitions itself, it may be a good idea to specifically point out the context in which the different definitions apply. We would also recommend an explicit reference to federal law such that federal law would control in a dispute.

Response: We have added the context for seasonal employees and seasonal workers in the definition of full-time employee. We have also cited the federal law in a footnote to indicate the basis of the definition.

Comment: Definition of Small Employer: Again, we suggest adding an explicit reference to federal law that would allow federal law to control after January 1, 2016 in case the Vermont rules and the federal rules are in conflict.

Response: We have updated the rule to better align with federal law. We also reference the applicable federal rule and state law for this provision. The federal law provision will pre-empt state law if necessary.

Section 32.00: Employer Eligibility

Comment: It seems like this section might read more clearly if (1) and (2) were switched?

Response: We agree. We have incorporated this change.

Comment: We also wonder about the section (1)(ii): Does this mean employers may purchase insurance on the SHOP prior to an eligibility decision? Or that employees may purchase on the individual exchange? Also, is this supported by the VHC technology?

Response: We agree that this is confusing. We have added language to clarify direct enrollment for VHC coverage.

Section 33.00: Employee Eligibility

Comment: Definition of "Employee eligibility," paragraph (2) of subsection (b) "Enrollment in employer's plan not required. To avoid confusion, this paragraph should either refer specifically to the Affordable Care Act's individual responsibility payment with the related federal citation, or be removed as it is reciting what is exclusively a federal requirement.

Response: We agree that deletion of this provision will provide greater clarity and have made the requested change.

Comment: Definition of Qualified Employee: The example might be more useful if it is simplified to eliminate the discussion of part time employees. Assuming the Vermont definition applies in 2015, but not in 2016, the counting of part time employees will be changing.

We also note that many of the more complicated facts in this scenario are never used in the example, so may not be helpful.

Furthermore, we are not sure this statement is accurate: "Under (a)(1), the New Hampshire employer is a qualified employer if it offers all of its employees coverage through VHC." It is not clear that a NH based employer, with some employees in VT, could legally obtain insurance for all of its employees through VHC, nor is it clear that the health plans selling insurance on VHC would be licensed to sell VT insurance to NH employees of a NH based employer. Note that (a)(1) by its terms requires that the employer be based in Vermont. We do not believe (a)(1) applies to the example.

Finally, we believe that whether an employer is a small employer or a large employer is determined based on the rules that apply in the state where the employer is principally based (i.e. New Hampshire in the example). In 2016, the rules will be uniformly applied across all states.

Response: We agree that this example could be made more accurate. As a result, we are deleting this example. We will likely put a more helpful example into the rule at a later date.

Section 36.00: Employee enrollment waiting periods

Comment: Although outside the scope of this rule at this time, it will be helpful for the state to have a clear understanding of which state entity will be responsible for enforcing this provision. Also, BCBSVT would like to understand how this will be administered at VHC once group enrollment is supported by VHC.

Response: We agree, and will work with stakeholders accordingly.

Section 38.00: Employer election period

Comment: Section 38.00(b): We support simplifying this section. However, it might be easier to track if the employer annual election period is still included and it is noted that the completion of the tasks identified in the definition will end the employer annual election period. It might also be helpful to note that the employee annual election period cannot begin until the employer period ends.

Response: We will consider adding this comment to future rules after we further clarify the employer and employee enrollment process.

Comment: 38.00(f) Rolling enrollment for new qualified employers: We support this change. One open question is whether a large group that becomes a small group during the plan year can choose to purchase coverage on VHC. We do not believe that should be permitted – if the group size changes, the employer should have to wait until the end of the plan year. Otherwise, employers will select the rating pool that favors their specific risk, thus degrading the rating pool overall.

Response: We will take this into consideration for our next set of rules.

Section 40.00: Employee enrollment periods

Comment: "Employee enrollment periods", subsection (a) "Employee enrollment periods, generally", paragraph (1). For clarity, add the words "stand alone" prior to the word "dental" ("Employees will have the opportunity to select qualified health plans, and a ***standalone*** *dental plan if the employer offers* ***stand alone*** *dental coverage,…"*

Response: We agree and have incorporated your comment.

Section 41.00: Special employee enrollment periods

Comment: We have the same comment here as below in 71.03. The existing rule is extremely harsh. Also, please clarify how it relates to the SEP provided in 40.00(g). As currently written, it appears that an individual who had previously elected COBRA could not enroll in SHOP insurance offered by his employer, if he became eligible for the new plan outside of open enrollment. Individuals should be permitted to drop COBRA coverage when in favor of a SHOP plan.

Response: We believe federal rules are clear that loss of MEC does not include voluntary termination of coverage. See 45 C.F.R. § 155.420(e). However, we have revised § 71.03 to clarify that eligibility for COBRA does not preclude the availability of a special enrollment period upon loss of MEC.

Comment: We agree that special enrollment period language should be aligned with the special enrollment periods language in the other parts of the rule. However, it seems possible that there

are some special enrollment periods that are either different for individuals seeking coverage through an employer or that how the rule describes the scenario would be different. We suggest a thorough review of these rules and how they work in both the individual and the small group market. Allowing access to a small employer plan mid-year in scenarios where it is not mandated by law could potentially place a burden on an employer that may be inconsistent with health policy goals.

Response: The rule has been aligned to refer to the relevant Vermont rule provisions as required by federal rule, 45 C.F.R. § 155.725(i)(2)(i).

Section 42.00: Enrollment

Comment: We support simplifying this section. However, we note that to the extent logistically possible, we would recommend incorporating payment deadlines into the rule. Failure to do so could create challenges for VHC to enforce such rules on a go forward basis and are likely to be the basis of litigation in certain circumstances.

Response: We agree with this comment and will incorporate more details in future rulemaking.

Comment: It is our current understanding that the business rules, once VHC SHOP is operational, provide that a group enrollment would not be transmitted via 834 to the health plans until the group has paid the initial premium in full. If this intended to continue, it should be clearly stated in these rules. If there is some interest in changing this rule, BCBSVT would be willing to have that conversation, but there are logistical details that would need to be addressed.

Response: We will work with stakeholders on this issue and address it in future rulemaking.

Comment: BCBSVT would like to discuss the possibility of having more flexible enrollment timelines for group coverage. Imposing a one month waiting period seems unreasonable. Also, it's not clear that this aligns with Section 41.00.

Response: We will work with stakeholders on timelines and provide flexibility to the extent allowed under federal law.

Comment: In Section 40.00(a)(1)(ii), should the word "full" be included? It seems awkward with the lead in language from (1). In Section 40.00(a)(3), the reference to "carrier" should be changed to issuer for consistency.

Response: We agree. We have changed the language for clarity.

Section 43.00: Coverage effective dates

Comment: "Coverage effective dates", subsection (b) "Coverage effective April 1, 2014". While most or possibly all operational issues with this subsection are past, the reference to full

payment needing to be received by March 21, 2014 reflects a larger issue, that being the due date for monthly payments and the related section covering terminations for non-payment, Section 45.00.

Response: We agree. We have deleted this provision and we are revisiting our payment and termination policy. We will engage the stakeholders during this process and put the process into rule once it is complete.

Comment: "Coverage effective dates", subsection (c) "Coverage effective dates generally, for plan years beginning on or after January 1, 2015". To address the non-payment possibility and to add clarity, the following substituted language (as indicated in ***bold****) is suggested: "VHC shall ensure that for a QHP selection received by VHC from a qualified employee on or before November 30 of the year before a plan year beginning January 1, 2015 and subsequent years, QHP issuers* ***will*** *adhere to a January 1 coverage effective date.* ***This shall not supersede the requirements of Section 45.00 regarding terminations for non-payment or cancellations****." Further, as the federal government has defined and now utilizes the term "cancellation" to describe enrollments that did not complete the process with full payment effectuated enrollments, the State of Vermont needs to add this defined term and related language to this rule.*

Response: Because we are revisiting our payment and termination policy, we referred to non-payment directly instead of referring to a specific rule.

Comment: This provision requires for January 1, 2015 coverage, plan selections must be made by November 30th. BCBSVT would like to discuss supporting more generous timelines than this. Please note that for direct enrollments in 2015, we are currently planning to honor plan selections by employees well past this date and, if we stick with current practice, we will probably honor some plan selections into January on a retroactive basis.

Response: We will work with stakeholders on timelines and provide flexibility to the extent allowed under federal law.

Comment: Special enrollment coverage dates: It is unclear how this is intended to align with Section 39.00? We would recommend putting them together (if anything ultimately remains in 39.00). Also, if these are the same as in the individual market, should this cross reference these rules?

Response: We will consider combining sections in future rulemaking. We agree that a cross-reference would provide clarity and consistency and have incorporated this suggestion.

Section 46.00: Termination of coverage by an employee

Comment: "Termination of coverage by employee". A subsection (d) is needed to codify VHC's duty to notify issuers of an employee's termination. Suggested language for subsection (d):"VHC must notify the issuer of the coverage being terminated within [X] days of receipt of employee's notice of termination to VHC."

Response: We agree that the rules require more details around VHC's termination and cancellation policies. We note that relevant federal provisions apply to coverage on or after January 1, 2015.[2] As a result, we are deleting the current provisions around terminations and cancellations. We will revisit our current termination, cancellation, and payment policies over the summer and engage stakeholders for feedback. Once we have determined the details for our termination, cancellation, and payment policies, we will include them in the rule.

Section 47.00: Employer withdrawal from VHC

Comment: "Employer withdrawal from VHC", subsections (a) and (b). As currently written, the requirement of issuers to provide prior to termination certain notifications to employees of a terminating employer will not be possible in all cases. Issuers will not necessarily have prior notice of an employer's termination of coverage and, thus, cannot be required to provide notice to employees prior to the termination. The requirement to notify employees and provide them with "information about other potential sources of coverage, including access to individual market coverage through VHC" is more appropriately placed with and better handled systemically by VHC.

An additional subsection needs to be added: "(c) VHC provides notice to the issuer providing the coverage being terminated within [one business day] of receipt of employer's termination notice to VHC."

This section prompts the operational question of when the employers' coverage is to be terminated – upon notice to the issuer from the employer or upon official notice to the issuer from VHC. The rule must address this.

Response: We agree that the rules require more details around VHC's termination and cancellation policies. We note that relevant federal provisions apply to coverage on or after January 1, 2015.[3] As a result, we are deleting the current provisions around terminations and cancellations. We will revisit our current termination, cancellation, and payment policies over the summer and engage stakeholders for feedback. Once we have determined the details for our termination, cancellation, and payment policies, we will include them in the rule.

Section 48.00: Terminations

Comment: "Terminations", subsection (a) "Conditions under which QHP issuer may terminate coverage", paragraph (3). The reference to Section 40.00(e) needs to be updated as there is no such section in the current proposed rule.

Response: We agree. This provision was deleted because the rule referred to was deleted.

[2] 45 C.F.R. § 155.735(f)
[3] 45 C.F.R. § 155.735(f)

Comment: "Terminations". This section currently addresses "Terminations of coverage by issuer" (section 45.01) and "Termination of participation by VHC" (section 45.02). Provisions related to terminations or withdrawals by employers currently contained in section 45.01 should be moved to a new section 45.03 and titled "Terminations by employers". A redrafting of the circumstances under which notices of intent to terminate must be sent to employers and/or employees needs to be clarified, as well as the circumstances under which an issuer must provide 30 days advance notice of a termination. The subsections of 45.00 muddle these requirements.

Response: We agree that the rules require more details around VHC's termination and cancellation policies. We note that relevant federal provisions apply to coverage on or after January 1, 2015.[4] As a result, we are deleting the current provisions around terminations and cancellations. We will revisit our current termination, cancellation, and payment policies over the summer and engage stakeholders for feedback. Once we have determined the details for our termination, cancellation, and payment policies, we will include them in the rule.

Comment: "Terminations", subsection (b) "Termination of coverage to primary enrollees and qualified employers", paragraph (2) "A non-payment occurs when full payment has not been received by the last day of the month". There are several issues with this language. Necessary distinctions between employer and employee payment due dates and subsequent notice requirements are missing or are not clearly stated. Second, DVHA published a document titled, "Individual and Small Business Enrollment and Billing Timelines, 'Final' Version 2.0, June 2013" that provides for a different termination date than the one currently proposed in this subsection, depending on whether the last day of the month deadline relates to employers or employees. Consistency between the rule and that operational document is needed.

Response: We agree that the rules require more details around VHC's termination and cancellation policies. We note that relevant federal provisions apply to coverage on or after January 1, 2015.[5] As a result, we are deleting the current provisions around terminations and cancellations. We will revisit our current termination, cancellation, and payment policies over the summer and engage stakeholders for feedback. Once we have determined the details for our termination, cancellation, and payment policies, we will include them in the rule.

Section 48.00(c): Notice of termination of coverage

Comment: "Notice of termination of coverage to primary enrollees and qualified employers". This section requires an issuer to provide termination of coverage notices to primary enrollees and qualified employers at least 30 days prior to the last day of coverage when the enrollee's coverage is terminated "by the issuer for any reason". Enrollee coverage may be terminated for many reasons, several of which occur without advance notice to the issuer making it impossible for an issuer to comply a requirement to give advance notice to the enrollee.

[4] 45 C.F.R. § 155.735(f)
[5] 45 C.F.R. § 155.735(f)

This is an example of the need for further collaborative efforts between stakeholders and VHC before an effective rule can be promulgated to ensure the rule is workable and relates directly to the as yet undetermined operational systems for the SHOP enrollment and payment procedures.

Response: We agree on the need for a more collaborative process around VHC's termination and cancellation policies. We note that relevant federal provisions apply to coverage on or after January 1, 2015.[6] As a result, we are deleting the current provisions around terminations and cancellations. We will revisit our current termination, cancellation, and payment policies over the summer and engage stakeholders for feedback. Once we have determined the details for our termination, cancellation, and payment policies, we will include them in the rule.

Section 48.00(d): Termination of coverage effective dates

Comment: "Termination of coverage effective dates". "In the case of a termination where the enrollee is no longer eligible, the last day of coverage is the last day of the month in which notice of termination is sent". The result of this regulation in tandem with the others requiring 30 days advance notice of termination <u>even in cases of knowing nonpayment</u> is the following: An invoice is sent timely for June 1 coverage and no payment is received from the employee by June 1. A termination letter is sent to the employee on June 2. The issuer must cover the employee until June 30 with no premium received. This is problematic for issuers.

Another example: An employer goes out of business in May and the QHP learns that has happened only after not receiving payment for June's coverage. Under the proposed rule in this scenario, it is impossible for the issuer to provide 30 day advance notice to employees, and it is unclear what the employees' termination of coverage date is, particularly if the employee made any payment towards the June premium.

This is an example of the need for further collaborative efforts between stakeholders and VHC before an effective rule can be promulgated to ensure the rule is workable and relates directly to the as yet undetermined operational systems for the SHOP enrollment and payment procedures.

Response: We agree on the need for a more collaborative process around VHC's termination and cancellation policies. We note that relevant federal provisions apply to coverage on or after January 1, 2015.[7] As a result, we are deleting the current provisions around terminations and cancellations. We will revisit our current termination, cancellation, and payment policies over the summer and engage stakeholders for feedback. Once we have determined the details for our termination, cancellation, and payment policies, we will include them in the rule.

[6] 45 C.F.R. § 155.735(f)
[7] 45 C.F.R. § 155.735(f)

Section 50.00: Premium Processing

Comment: "Premium processing", subsection (c) "Invoice", paragraph (2) "Premiums will be due on a consistent date determined by VHC". This date must coincide with the date in Section 45.00(b)(2), which Northeast Delta Dental suggests be the 21st of the month.

Response: We agree that this rule requires a payment date that works for stakeholders. We will revisit our current payment policy over the summer and engage stakeholders for feedback. Once we have determined the details for our payment policy, we will include them in the rule. For now, we have deleted the provision.

Comment: "Premium processing", subsection (d) "Receipt of late payment". This section provides for a "notice of intent to terminate coverage to the employer" to be issued the day after the due date for a premium payment that was not made. The late payment notice is to state that "the full premium payment must be received for the month already billed and additionally the following month, by the 21st of the next month to avoid termination". Without additional language indicating at what point the issuer may place a hold on claims filed during the month for which payment has not been received, this proposed rule would require an issuer to continue group coverage for up to 51 days for an employer that has not made payment. This proposed rule potentially provides employers with a benefit for which they have not paid to the detriment of the issuer.

This is another example of the need for further collaborative efforts between stakeholders and VHC before an effective rule can be promulgated to ensure the rule is workable and relates directly to the as yet undetermined operational systems for the SHOP enrollment and payment procedures.

Response: We agree on the need for a more collaborative process around VHC's payment policies. As a result, we are deleting all of the detailed provisions around premium processing. We will revisit our current payment policy over the summer and engage stakeholders for feedback. Once we have determined the details for our payment policy, we will include them in the rule.

Part Seven: Eligibility and Enrollment Procedures

Part Seven Generally

Comment: As noted in several sections above, the distinctions between what should be included in certain parts of the rule is not always clear. Various Parts of the rule, including Part Seven, appear to have overlapping subject matter content. It may be possible to correct most of this issue be renaming the various parts of the rule to more specifically describe the intended content. Additionally, an introductory provision to start Part Seven and define the scope of the Part could facilitate navigation.

Response: As stated in the beginning of our responses to comments, we believe that the advantages of combining the rules for Medicaid, QHPs, APTC, and CSR outweigh the disadvantages due to the integrated nature of health-benefits programs. We have added a statement to the beginning of Part Seven to better explain what it is intended to cover, and we have also labeled some of the sections to clarify to which programs they are relevant.

Section 51.00: Automatic entitlement to Medicaid following a determination of eligibility under other programs

Comment: This is the first section in Part Seven, titled "Automatic entitlement to Medicaid following a determination of eligibility under other programs." It seems that starting Part Seven with provisions that have more general application to the subject matter of the Part may make it easier to navigate the rule.

Response: We do not disagree with your point and will consider incorporating your suggestion in future rulemaking.

Section 52.02(a)(6): Application filing; MAGI-based Medicaid.

Comment: We would delete the last phrase beginning with "or an appropriate." As we explain above under section 3.00, we believe it is important that AHS not use an entirely separate application form for non-MAGI-based Medicaid. AHS should commit to maximum implementation of the "single streamlined application" and "no wrong door" ideals of health care reform.

Response: Please see our earlier response on the comment for § 3.00. We believe it is appropriate at this time to use a separate application for MABD but will consider making a change in the future.

Section 52.02(d): Application filers

Comment: This section is called "Application filers" as if the section will define "application filer" (which is defined in Section 3.00), but actually describes who is authorized to file an application. We suggest assessing whether both Section 3.00 and Section 52.00(d) are necessary and if so, clearly delineating the respective purpose of each provision as it relates to the rule.

Response: Section 3.00 defines who may file an application; this same language is contained in § 52.02(d). Although § 52.02(d) could merely contain a cross reference to the definition in § 3.00, we believe that, since the definition is short, it makes sense to retain the language in both sections.

Section 53.00: Attestation and verification – in general

Comment: This section and the several sections following this section outline various verification processes related to eligibility for certain programs. We recommend ensuring that each of these

verification provision sections is clear in scope as to which program and which criteria each verification process applies.

Response: We have added clarification where needed.

Section 54.07(f): Assistance

Comment: Section 54.07(f) provides, "AHS will assist individuals who need assistance to secure satisfactory documentary evidence of citizenship in a timely manner." We would like to see that same language applied to all documentation and verification requests. Also, AHS has an affirmative duty to assist people with disabilities, including but not limited to documentation and verification requests.

Response: We believe that assistance to people, either with or without disabilities, in all aspects of the application, enrollment, and review processes, as well as with all communications with AHS regarding these processes is adequately covered in § 5.00. We do not feel it is necessary to repeat this assurance throughout the rule.

Section 56.03: Verification process for APTC and CSR – general procedures

Comment: The lead in section to this provision (which relates to APTC and CSR generally) provides that: "To receive the Vermont CSR, the individual must also be enrolled in a silver plan." This is also true of federal CSR. It might be clearer to reference both programs in this sentence.

Response: We have added this clarification.

Section 56.04: Eligibility for alternate APTC and CSR verification procedures

Comment: Similar to our comments above related to Section 53.00 and verification process provisions, these provisions related to "alternate" verification processes for APTC and CSR seem to potentially overlap other provisions? It would be helpful to understand how this relates to the other verification processes. Also, the following provisions dealing with alternate verification processes seem to overlap with each other somewhat. We suggest restructuring of these provisions.

Response: Although we agree that the verification processes are complex, we believe they correctly follow the federal regulations for both Medicaid and QHP/APTC. There are similarities (overlaps) and differences between the regulations for both programs. We have labeled the subsections to clarify to which program the subsections apply. Section 56.04 is specific to APTC, since there is no "alternate" verification process for Medicaid.

Section 56.10: Education and assistance

Comment: This subsection states that AHS will provide education and support for the "process specified in this section." It is not clear that Section 56.00 contains one "process" so it may be more appropriate to refer to "processes." We also suggest that this provision might be better to be included in the beginning, as opposed to in the middle of the section.

Response: We have changed "process" to "processes." We have not, however, moved the section to the beginning, as suggested.

Section 57.00: Inconsistency procedures

Section 57.00 general

Comment: This section is titled "inconsistencies" and details various scenarios where information appears to conflict and how those conflicts will be resolved. It may be easier to navigate this section if the section started with a general overview of how these provisions apply, i.e. "In the event AHS determines that information provided by the applicant conflicts with other information obtained by AHS, the following resolution processes shall apply." Otherwise, it's difficult to grasp the context in which these provisions are relevant.

Response: We agree that the title of this section is not explanatory; we thought about it but could not come up with a better title. The addition of a statement such as the one you suggested would be helpful, and we will consider adding a statement in future rulemaking, as well as reviewing the titles of the subsections for clarity.

Comment: We have significant concerns that the Department is not following these rules, and is continuing to request verification in violation of the process specified in 57.00(1) and (2). We would request that the Department immediately revise its procedures to comply with these rules. Specifically, the Department may only request verification after providing an opportunity to explain the discrepancy first. Further, the Department is prohibited from denying an application for lack of verification, if the applicant responds to the verification request, even if the Department believes that the verification was inadequate in some way.

Response: AHS staff has been trained in the new verification procedure, and we will retrain as necessary. Section 57.00(c)(1) states that AHS will contact the application filer to allow an opportunity for any inconsistency to be explained. Such contact could be by mail, email, or phone. AHS reserves the right to follow up with an individual if documents submitted or explanations made are not sufficient to resolve the inconsistency. We have clarified the language at § 57.00(c)(5).

Section 57.00(c): Procedures for determining reasonable compatibility

Comment: Vermont Catholic Charities operates four Level III facilities throughout Vermont. Over 70 of our residents are on Medicaid. We pride ourselves on providing excellent service to

our residents. This potential new health care rule would severely impact our financial viability and operation through increased administrative costs and uncertain Medicaid payments. Our questions/issues/concerns with extending the verification period to 90 days are the following:

What are the main reasons for this proposed change? The current paperwork is not a burdensome process for applicants and can be completed in 30 days. It is unclear why an extension is needed. The provider of services bears the bulk of the financial burden and the applicant will be directly impacted as well.

Response: Federal regulations governing the eligibility and enrollment process for QHPs with APTC require that individuals be given 90 days to provide verification if the individual's attestation is inconsistent with data obtained from federal and state databases. See 45 C.F.R. §155.315 (f). Although federal Medicaid regulations require a 90-day window only for verification of citizenship, we decided to extend the verification period to 90 days for other forms of verification in order to be consistent with the verification process for enrolling in a QHP and receiving APTC.

Comment: Will Medicaid wait the full 90 days before processing an application or begin processing when application is received?

It currently takes an average of 4-6 weeks for Medicaid to process ACCS applications. However, we begin providing care immediately if a resident is admitted. If this law gets passed, we are concerned that approval could take up to 5 months in some cases. This would impact the monthly cash flow to cover expenses. We are providing care we would not be paid for until several months later.

By extending the deadline the provider is at a greater risk for non-payment should the resident be deemed ineligible for Medicaid. More months have gone by due to the 90 day period versus the shorter period currently in practice.

As a provider we are concerned that the 90 days creates a greater spend-down risk than the current system. If a spend down is issued on Day 90, the resident only has a remaining 3 months to pay it off versus the 6 months they have now. This creates an additional financial burden and stress to residents along with the risk of default to the provider.

Response: We understand your concern. Whereas we believe that most applicants will provide verification sooner rather than later, since they are motivated to receive coverage as soon as possible, we will be monitoring this 90-day verification process to determine if applicants are unnecessarily delaying the provision of verification until later in the 90-day period. Depending on what we find as a result of this monitoring, we will consider reducing the verification period to 30 days as the minimum required by federal regulations. We would appreciate your bringing to our attention cases in which the 90-day period has caused non-payment to the facility.

Comment: It appears this new rule may apply to some renewal applications. How will we know which residents this applies for? From a provider perspective, this creates an additional

administrative burden thus increasing the administrative costs. We are very concerned this will increase the number of outstanding monthly Medicaid claims thus impacting the monthly cash flow to cover expenses.

Response: Since coverage at the time of renewal continues until the renewal is completed, a request for verification at renewal will not cause a break in coverage unless the individual fails to provide verification by the end of the 90-day period, in which case Medicaid coverage will terminate.

Comment: The 90 day approval process may force the organization to not accept a resident until their application has been approved by Medicaid, which would unfortunately directly impact the vulnerable population.

Response: As stated above, we will be monitoring the impact of this change in rule and will consider modifying it in a future rulemaking if necessary.

Section 57.00(c)(2)(ii): Procedures for determining reasonable compatibility

Comment: A sentence was added to this provision: "If, because of evidence submitted by the individual, one or more requests for additional evidence is necessary, such additional evidence must be submitted by the individual within the 90-day period that begins with the first verification request."

This does not seem fair to beneficiaries. Applicants should not be subject to multiple and sequential verification requests. If AHS needs verification after following the process set out at 57.00(a) and (b), they can request it, but the request should be done once, in a timely fashion. AHS should then make an eligibility decision based on the applicant's response. The applicant can always submit additional evidence during an appeal, if AHS finds the applicant not eligible. We would prefer the additional sentence be removed.

Response: We will always attempt to be as clear as possible with any request for verification; however, if the individual's response to the verification request is incomplete or otherwise not fully responsive, we must reserve the right to seek additional information. The sentence you refer to in your comment was added to clarify that an additional request for information does not start a new 90-day period. We do not think it is in anyone's best interest, either the individual's or the State's, to keep an application pending, or a renewal incomplete, for longer than 90 days.

Section 57.00(c)(4)(ii)(B) & 57.00(c)(5): Procedures for determining reasonable compatibility

Comment: We believe that an eligibility decision should always be made on the merits of the case, based on the information available to AHS.

The language to which we object does not appear to come directly from any federal regulation. We believe our proposed language, below, is consistent with the regulations at 42 CFR § 435.945(j), 42 CFR § 435.952, 45 CFR § 155.315, and 45 CFR § 155.320.

57.00(c)(4)(ii)(B) should be revised to read, "If AHS cannot determine… that the individual is ineligible for Medicaid, deny the application or disenroll the individual on the basis that the individual cannot be found ineligible for Medicaid."

57.00(c)(5) should be revised to read, "…if…the individual has not responded to a request for additional information, determine the individual's eligibility for Medicaid based on the information available, and notify the individual of such determination, including notice that AHS is unable to verify the attestation."

Response: We have modified § 57.00(c)(4)(ii)(B) to address your concern. However, we cannot make your suggested change to § 57.00(c)(5). Federal regulations at 42 C.F.R. § 435.952 require that, in situations in which the applicant's attestation and income from federal and state data sources are inconsistent, the inconsistency must be resolved before proceeding with the Medicaid eligibility determination. Federal Exchange regulations, however, allow the state to base the APTC eligibility determination on the information from the data sources if the applicant fails to resolve any inconsistency.

Section 58.00: Determination of Eligibility

Comment: This section is called "Determination of eligibility" which is an incredibly broad topic. Further, this topic is touched on in numerous other parts of the rule, which complicates efficient navigation. We recommend changing the name of this section to more precisely define what is intended to be included. Consistent with this suggestion, it is not clear if Section 58.01 applies to QHPs or only Medicaid.

Response: We have changed the title and the language in § 58.01(a) to clarify that this process is for determination of eligibility for health-benefits programs. Individuals who wish only to enroll in a QHP would not be subject to this same process. Rather, their status as a "qualified individual" would be established, which does not involve a MAGI screen.

Section 58.01(a): MAGI screen

Comment: Please clarify that under this rule, a MAGI screen is required for all health benefits applications.

Response: We have modified this section to state that "for each individual who has submitted an application for a health-benefits program (i.e., health benefits other than enrollment in a QHP without APTC or CSR), or whose eligibility is being renewed, and who meets the nonfinancial requirements for eligibility (or for whom AHS is providing a reasonable opportunity to verify citizenship or immigration status), AHS will . . . promptly and without undue delay. . . furnish MAGI-based Medicaid to each such individual whose household income is at or below the

applicable MAGI-based standard." Individuals who wish to request screening under MABD rules may do so by submitting the 202MED application form.

Section 58.01(b): MAGI-based income standards for certain individuals enrolled for Medicare benefits

Comment: This section provides that for certain individuals that are entitled to or enrolled in Medicare "there is no applicable MAGI-based standard…" However, it is not clear what that means? These people are not eligible for any subsidy/health benefit program or a different income calculation method applies to their eligibility analysis? We also note that this section cites an NPRM at footnote 60; it may be that such rules have been finalized.

Response: We have clarified the language in this subsection. Proposed federal regulation at 42 C.F.R. § 435.911 has not yet been finalized.

Section 58.02: Special Rules Relating to APTC

Comment: This section is called "special rules relating to APTC." Again, it's not clear that this the most logical place to include these particular provisions relating to APTC eligibility.

Response: We have changed the title of this section to "Special rules relating to APTC eligibility."

Section 59.00: Special eligibility standards and process for Indians

Comment: This section pertains to special enrollment rights for Native Americans. We understand that the term "Indians" is used in federal law to define a specific population. We suggest a more explicit reference to this law.

Response: We have added the definition of "Indian" and "Indian tribe" to § 3.00.

Section 59.03: Verification related to Indian status

Comment: This section provides specific verification processes for Native Americans. Should this be in the verification processes section of the rule?

Response: Section 59.00 as contained in this rule aligns with the federal regulation at 45 C.F.R. §155.360. We would prefer to leave the provisions in § 59.00 in one section of the rule.

Section 60.00: Computing the premium-assistance credit amount

Comment: This section pertains to computing the premium assistance amount. We recommend including a general reference that the calculation of premium tax credits shall be administered as required by applicable federal law? Furthermore, if this section applies only to QHP

premium subsidies/cost share reduction, we recommend explicitly stating this at the beginning of this section.

Response: We agree that it would be helpful to clarify that this section applies to QHPs, and have changed the language to state this.

Section 60.02(a): Cost of a QHP

Comment: As noted above, we believe use of the term "plan" is inconsistent with the rest of the rule. We are also unclear what is intended to be captured by the concept of "cost of a QHP" – is this the total premium regardless of subsidy amount? If so, it might be clearer to specify.

Response: We agree that the definition for "cost of a QHP" is ambiguous. Because it is not used elsewhere in this section, we are deleting it.

Section 60.03: Coverage month

Comment: This purpose of this section is unclear. From examining the examples, it seems that the section is intended to define what constitutes a "coverage month" such that a person would be entitled to a premium subsidy for that month, except that "coverage month" is defined to include any month where someone is covered for one day of the month, which we understand are the rules applicable to reporting to the IRS about individual's insurance coverage. We recommend more specifically defining why the rules outlined in this section are relevant to VHC enrollees and potential enrollees.

We also note that final regulations have been recently promulgated on this subject which should be incorporated into this rule to the extent relevant. 79 Fed. Reg. 26113 (May 7, 2014).

Response: The context for the definition of "coverage month" is the computation of premium tax credits, as indicated in 60.01.

We have updated the rule at § 78.00 to reference the new reporting requirements at 26 C.F.R. § 1.36B-5.

Section 60.06: Applicable benchmark plan (ABP)

Comment: This section outlines how to determine what is the applicable benchmark plan for the purposes of calculating a subsidy. We recommend starting Section 60.06 with a simple explanation of the relevance of the applicable benchmark plan. For example: "An individual's subsidy will be the applicable percentage (as described in Section 60.07) of the applicable benchmark plan premium. This section describes how to determine the applicable benchmark plan."

Response: We agree that more explanation should be provided for the ABP. The ABP is the plan that helps determine the total amount of the subsidy, so we have included that explanation here.

Section 61.00(d): Timely determination of eligibility

Comment: The new rules added an extenuating circumstance when the "individual delays providing needed verification or other information." While that is generally a reasonable concept, and was implied under the old rules and allowed under Federal regulations, the additional time to process the application should only apply when the AHS has made a timely request for verification. That request for verification would need to occur within the first week or so after the application; otherwise the delay is attributable to AHS. In the past, we have seen AHS send excessive verification requests for financial information late in the process that do not allow the applicant sufficient time to respond. Revise to:

"An individual delays providing needed verification or other information in response to a timely request from AHS."

Response: We have not changed the language as requested. If an individual delays providing verification, the eligibility determination may take longer whether or not AHS's request was timely.

Section 64.01(i): Premium requirement for partial coverage month

Comment: This section is called "Premium requirement for partial coverage month" and says "The full amount owed must be paid for coverage for all or part of a month." What does this mean?

Response: We have changed the language to clarify that the full premium must be paid to obtain coverage for all or part of a month.

Section 64.01(j): Premium refunds

Comment: It is categorically unjust to have a policy prohibiting refunds of all premium payments. Premiums that are not applied towards an individual's coverage should be refunded upon request from the beneficiary regardless of the scenario. The baseline should not be that premiums are non-refundable, with exceptions. It is entirely unreasonable for the state or an issuer to keep someone's money if it is not going towards past or future coverage. If it is going for future coverage, it must be for a reasonable period, e.g. a few months of advance payment, not years' worth.

The HCA has spoken with several Vermonters for whom this rule was a problem. Individuals called to cancel their VHC coverage shortly after enrolling, or mistakenly sent a check that was too large, and were denied refunds. In one instance the individual accidentally put the wrong check in the premium payment envelope. The check was for $4,000 and not even made payable to VHC; the premium payment was supposed to be only $48. VHC cashed the check and refused to refund it. Initially VHC told the beneficiary that the $4,000 had to be applied to future premiums, which would have covered seven years! The HCA had to fight to get

the money returned, which it finally was. This was an extreme example, but even shorter terms of involuntary advance payment could be a hardship, and are certainly unjust.

When a beneficiary's overpayment does result in hardship, the State should expedite the refund. If the individual can demonstrate the overpayment has created a hardship, the money should be refunded within one week.

The existing rule leads to inequitable results. In addition to lengthy mandatory advance payment, this rule, in conjunction with 70.02(c), could result in a partial payment being allocated to a month in which the individual has no coverage.

Individuals should be entitled to refunds if they overpay. This rule should be amended to allow refunds, and to allow the expedited issuance of refunds if the overpayment causes a hardship.

Response: The limitation on Medicaid premium refunds to certain specific situations is not new. Previous rules under Medicaid Rule 4161 allowed for premiums to be refunded upon termination of Medicaid coverage, but only after 30 days. Overpayments were retained and reflected in the next premium bill. Although we certainly agree that a $4000 check mistakenly included in the wrong envelope should have been promptly returned, we do not believe it is unreasonable to limit premium refunds to coverage periods that have not yet begun. We do not believe that the application of provisions in §§ 64.02 or 70.02(c) would result in the application of a partial payment to a month for which the individual did not receive coverage.

Comment: This section states that premium payments are not refundable (except in a limited situation related to Medicaid). This seems inappropriate. What about overpayments? Incorrect billing? We believe that premium payments will need to be refunded in specific circumstances and the rule should identify those situations. We also believe that premiums need to be retroactively adjusted and refunded in the event of death.

Response: An overpayment of a Medicaid premium is applied to a future month's bill. The death of an enrollee is covered under § 64.11(a), in which case the premium would be refunded.

With respect to QHPs, the State of Vermont currently manages premium payment and related rules through its carrier contract. However, we recognize the importance of including these standards at an appropriate level of detail in the administrative rule. We agree that there are situations in which QHP premiums are refundable and have revised this section to include a non-exhaustive list of examples.

Section 64.03(b): QHP initial enrollment billing

Comment: This section contains invoice and coverage effective dates for December 2013 and January 2014. It should be revised to include the relevant deadlines for the 2015 open enrollment period.

Response: We agree that this provision is no longer applicable. Part (a) references another part of the rule. As such, the provision appears unnecessary and will be deleted.

Comment: This section pertains to QHP initial enrollment billing and was drafted in contemplation of the 2014 coverage year. We suggest updating this to be relevant going forward. We would also suggest deleting (b)(2) and (b)(3). (BCBS)

Response: As noted above, we agree that this provision is no longer applicable and will be deleted.

Section 64.04: Ongoing premium billing and payment

Comment: This section addresses ongoing premium billing and payment. Premiums are currently due on the last day of the month, which creates some operational challenges. We understand that the State is planning on convening a group to exam billing and payment timelines and we look forward to that opportunity to discuss potential options for improvement. We suggest that premiums be due on the 21st of the month (or 21 days past the date of the premium bill), but that payments be accepted within the billing processing system through the end of the month.

Response: We look forward to your input on this process.

Section 64.04(b): Ongoing premium billing and payment

Comment: We recommend separating these two sentences into their own subsections as they are both independently relevant.

Response: We have made your suggested change.

Section 64.05(a): Single-premium obligation

Comment: This section prohibits partial payments. We believe that reasonable partial payments tolerances are necessary, especially if group enrollment is going to be going through Vermont Health Connect. We strongly support revisiting this policy and making it more consumer friendly.

Response: We agree that allowing partial payments in the individual and small group markets may be appropriate under certain circumstances and will take this into consideration for future rulemaking.

Section 64.06: Grace periods

Comment: We applaud AHS for making a one month grace period available for unsubsidized QHP beneficiaries. This is an improvement over the prior rule. However, AHS should extend the Advance Premium Tax Credit (APTC) grace period rule across all categories of VHC

beneficiaries. This includes small businesses and individuals without APTC. A uniform grace period policy will be easier to administer on all sides, and easier for beneficiaries to understand. Medical providers and carriers will not need to keep track of whether someone with a QHP receives APTC.

For years, AHS has struggled with timely and accurate processing of applications and verification documents. If a beneficiary's payment is misplaced or misapplied, one month may not be enough time to sort things out. Or, if a beneficiary experiences a change in circumstances, VHC may need more time to determine whether the person now qualifies for subsidies. Especially where verification of income is required, we are concerned that VHC will not be able to complete its processing before the person's coverage is terminated.

Pending claims for an additional two months does not harm the carriers, since they don't pay claims unless the beneficiary catches up. Providers can also deny service while coverage is pending. Insurers are required to notify providers when coverage is pending.

Response: While we would generally favor a consistent approach across the market, we believe the application of a 90-day grace period to all individuals and small employers would result in an unmanageable claims risk to providers. (In the APTC grace period at § 64.06(a)(2), claims are paid for the first 30 days, and issuers can choose to pend claims for the following 60 days.) However, in the near future, we intend to issue a limited reinstatement policy for the 2014 plan year.

Section 64.06(a): Grace Period

Comment: This section pertains to late payments and grace periods. It appears that it could use some restructuring. We suggest lead in language that states: "The following grace periods apply in the event a premium payment is not received on the date due:" and then outline the grace period applicable for each program.

Response: We believe that the language in the rule is clear that the grace periods apply "when an individual has not paid their monthly premium by its due date."

Section 64.06(a)(3): Grace Period

Comment: We suggest adding the language "during the grace period" to the end of the sentence to make it clear that services rendered must be rendered during the grace period.

Response: We have incorporated your suggestion.

Section 64.06(b)(1): Notice of premium nonpayment

Comment: AHS should add more detail to this section, to ensure that beneficiaries receive sufficient advance notice of their coverage termination date due to nonpayment. We suggest adding paragraph (i)(F) to read, "at least 11 days before the end of the first grace period month,

the issuer will send a closure notice that coverage will end as of the end of that month if full payment is not made by the end of the grace period."

Eleven days is the required period set for Dr. Dynasaur termination notices in 64.06(b)(2)(ii).

Second, it is possible that a beneficiary might dispute the fact of nonpayment. That appeal would presumably be to the HSB. Yet, these notices are being sent by the QHP issuers. Issuer notices under this section must advise beneficiaries of their right to appeal to AHS if they disagree with the allegation of nonpayment.

Response: We believe that the current notification law, which requires carriers to notify enrollees 14 days in advance of termination, provides sufficient notice to enrollees. See 8 V.S.A. § 4091c, Termination for nonpayment of premium or subscription charges. However, we agree this notification should include any appeal rights and will work with carriers to revise dunning and termination notices accordingly.

Section 64.06(b)(1)(ii): Notice of premium nonpayment

Comment: This section provides the issuer shall notify HHS of an individual's nonpayment of premium. As noted on numerous previous occasions, this is not happening and HHS has provided no mechanism for such notification. We request the addition of "if required" at the end of this provision.

Response: We have revised this section to clarify that federal rules will govern any required notification to HHS.

Comment: We request the enactment of reinstatement provisions for all beneficiaries. Currently, the rules lack any reinstatement rights.

An AHS proposal that we reviewed in October 2013 allowed small businesses limited reinstatement rights. Reinstatement was limited to twice per plan year, and was only be available during the one month period following the end of the grace period. In contrast, the federal SHOP allows unlimited reinstatement opportunities. CCIIO, REGTAP FAQ ID 1423, 4/14/14, available at https://www.regtap.info/.

This reinstatement proposal should be enacted for both small businesses and individuals. Uniformity makes for much easier administration and comprehension by all parties involved. Also, the goal of health care reform will be frustrated if some individual beneficiaries cannot get any health insurance until the next open enrollment period. AHS rules should be aimed at providing as much access to health insurance as possible.

As beneficiaries, providers, insurers, contractors, and AHS workers adjust to the new health care system, mistakes and glitches will occur. The rules need to have the flexibility to accommodate and address these bumps in the road without causing serious hardship and defeating the purpose of health care reform. At a minimum, AHS should adopt liberal grace

period and reinstatement rules for the transition period. For example, the rules we propose could sunset after two years.

AHS should take care not to create a system where a minor mistake or a personal crisis causes irreversible hardship. The goals of Vermont health care reform will be best served by extending the APTC grace period rule to all QHP beneficiaries, and by allowing reasonable reinstatement opportunities for individuals as well as small businesses.

Response: As noted above, we intend to issue a limited reinstatement policy for the 2014 plan year.

Section 64.08: Lock-out period

Comment: This rule generally requires that all outstanding premium balances for an individual's household be paid before an individual can reapply and receive premium-based Medicaid. This rule should include an exception for applicants who are children, applicants who are incapacitated, and for applicants who can show good cause why they should not be held responsible for the debts of the other household member.

Response: This rule change is less restrictive than the prior rule, in that it waives all unpaid premium balances after a three-month period, whereas the prior rule required payment of unpaid balances if an individual reapplied within a 12-month period. An unpaid premium balance at time of application would occur only for children, since they have the benefit of the one-month grace period during enrollment, and could therefore terminate Medicaid with the grace period premium still unpaid. Since VPharm enrollees do not have a grace period, they would never terminate with an unpaid balance. VPharm enrollees, however, do have the option for reinstatement if they demonstrate medical incapacity as a good cause reason for failure to pay a premium. We have not made changes to this section of the final proposed rule.

Sections 64.10, 64.11, & 64.13

Comment: These three sections were changed to clarify that they only apply to Medicaid. As far as we can tell, there are no similar rule sections that apply to QHPs.

Response: The State of Vermont currently manages QHP premium payment and related rules through its carrier contract. However, we recognize the importance of including these standards at an appropriate level of detail in the administrative rule, and we will revisit this during future rulemaking.

Section 64.10: Medicaid premium payment balances

Comment: This section states that excess payments will be applied to the beneficiary's next bill. We see no reason to limit this rule to Medicaid beneficiaries.

Response: The State of Vermont currently manages QHP premium payment and related rules through its carrier contract. However, we recognize the importance of including these standards at an appropriate level of detail in the administrative rule, and we will revisit this during future rulemaking.

Section 64.11: Refund of prospective Medicaid premium payments

Comment: This section explains when prospective Medicaid premiums will be refunded. Prospective QHP premiums should also be refunded if the beneficiary is found to have no premium obligation. This can happen as a result of APTC. As we said above, we feel 64.01(j) on premium refunds should be changed. However, in the alternative 64.11 should be extended to QHP beneficiaries.

Response: We have made changes to § 64.01(j) to include situations where QHP premiums may be refundable.

Section 64.13: Appeal of Medicaid premium amount

Comment: The first paragraph of this section should also apply to QHPs. This states that a beneficiary must continue paying her premium at the original level for coverage during an appeal, if the beneficiary is appealing a premium increase or proposed termination of coverage. Section 82.00(g) allows for continuing QHP coverage, APTC, and CSR on appeal, but does not address the premium level. We assume the beneficiary must continue paying the premium in effect prior to the decision being appealed. This should be made explicit in the rules. The second paragraph of section 64.13 is not relevant to QHPs, since excess APTC is recovered on the beneficiary's federal tax return.

Response: We agree that under § 82.00(g) and 45 C.F.R. § 155.525, an individual appealing a QHP premium would continue to pay the amount billed immediately before the redetermination being appealed in order to maintain coverage. As a result, we are adding QHP to this section.

Section 69.00: Corrective action

Comment: This paragraph should be revised to address appeals of initial eligibility applications as well as redeterminations. When an initial Medicaid application is approved, corrective payments are made back to the date of application and sometimes earlier, not just back to the date of the incorrect adverse action. This rule should reflect that possibility.

Response: We have not modified the language in the proposed rule. When an initial application is approved, and when a hearing decision in favor of the applicant is implemented, the beginning date of coverage is the first day of the application month. However, the language in § 69.00 is specific to corrective cash payments made directly to the applicant as reimbursement for out-of-pocket medical expenses paid between the date of the adverse action and the date the hearing decision is implemented. Federal regulations limit cash payments to this period of time. Cash reimbursements are not paid to applicants for services rendered prior to the date an application is

approved; therefore, as a corrective action step when implementing a fair hearing decision, providing cash reimbursement to an applicant for a service rendered on or after the adverse action date puts that applicant on a par with an applicant whose application was correctly approved.

Section 70.02(c): Payment allocation

Comment: This section should provide that partial payments cannot be applied to months prior to the start of coverage. It should not be possible for a beneficiary to pay for part of a month in which she has or had no coverage. Such a partial payment should be refunded, or applied to a future month's premium.

Response: Section 70.02(c) addresses situations in which a premium payment is sufficient to cover a full month. Partial payments will be allocated as described in § 64.05, which does not include an option for applying partial payments to a month for which an individual has no coverage.

Section 71.00: Enrollment of qualified individuals in QHPs

Comment: This section (and its related subsections) of the rule provide some additional details related to QHP enrollment, such as details about open enrollment and special enrollment periods. Consistent with our other comments about the structure of the rule, we question whether this is the best placement for this information. However, if the decision is made to keep it here, we suggest that in other parts of the rule addressing individual market QHP enrollment, the concepts of open enrollment/special enrollment periods be referenced with a cross reference to this portion of the rule. Also, in light of the numerous new guidance related to special enrollment periods, and operational lessons learned, we strongly encourage that this section be reviewed and updated as necessary.

Response: Section 71.00 contains rules related to enrollment in QHPs. We believe this is the appropriate placement for this information. We have updated this section to reflect recent federal guidance.

Section 71.03 Special Enrollment Periods

Comment: The rules on effective dates must reasonably allow consumers to maintain seamless coverage. Vermont must make seamless coverage possible, especially for people with serious medical conditions. We believe there are two serious errors in AHS's current interpretation of the federal rules. Also, AHS should take advantage of a federal option for earlier effective dates.

Recently AHS informed navigators that an individual who is losing coverage, and therefore qualifies for a special enrollment period, cannot apply through Vermont Health Connect in anticipation of their loss of coverage. According to AHS, the soonest a person can apply is the last day their existing coverage is in effect. Also, AHS has informed navigators that coverage is effective the first day of the month following the date the plan is selected.

The state's current interpretations regarding loss of Minimum Essential Coverage (MEC) means that people who lose coverage in the middle of a month have no way to avoid a gap in coverage, and people who lose coverage at the end of a month have only one day to attempt to avoid a gap in coverage. So, for example, if an individual is losing coverage on May 31, they will experience a gap in coverage unless they successfully complete the VHC application and the QHP enrollment process, including premium payment, on May 31. This will be impossible for most people.

This situation is not acceptable and is not required. Section 71.03(b) should be modified to ensure there are no built-in gaps in coverage. Individuals must have a way to seamlessly get onto a QHP when their MEC ends. The HCA has seen multiple problems as a result of the current policy, often with individuals who are in need of medical care, and sometimes in dire need of that care.

Individuals losing other minimum essential coverage must be allowed to apply with VHC up to 60 days before their coverage ends.

45 C.F.R. § 155.420(c) states that "a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP." We read the word "from" to mean "before or after." In the case of loss of employer coverage, § 155.420(d)(6)(iii) explicitly calls for allowing people to enroll as early as 60 days in advance of their loss of MEC: "The Exchange must permit an individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days to access this special enrollment period prior to the end of his or her existing coverage, although he or she is not eligible for advance payments of the premium tax credit until the end of his or her coverage in an eligible employer-sponsored plan." 45 C.F.R. § 155.420(d)(6)(iii). Vermont's current interpretation violates this provision.

Also, recently proposed regulations support our view of HHS's intent. Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Proposed Rule, 79 Fed. Reg. 15808, 15838 (Mar. 21, 2014). http://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf. See proposed §155.420(c)(2) which addresses the situation of an individual who is going to lose MEC or whose eligibility for an employer sponsored plan is ending because the employer is ending or changing the available coverage. It says that a consumer has 120 days to select a QHP. The 120 days starts 60 days prior to the end of the coverage. It specifically says the consumer has a right to select a QHP "prior to the end of his or her existing coverage or eligibility." It goes on to say the consumer is not eligible for APTC until the end of the qualifying coverage. 79 Fed. Reg. at 15875.

Response: We have revised this section to align with the federal rule that individuals may select a QHP up to 60 days in advance of loss of minimum essential coverage and that the coverage effective date following loss of minimum essential coverage may be the first day of the month following the triggering event. 45 CFR § 155.420(b)(2)(iv), (c).

Comment: The special effective date for individuals who lost other minimum essential coverage is based on the date their coverage ended.

AHS now interprets 45 CFR § 155.420(b)(2)(ii)-(iii) to mean that the effective date of coverage when there is a loss of MEC is determined not by the triggering event, but by when plan selection is complete. We believe this interpretation is wrong.

Prompt enrollment is explicitly called for where a person is eligible for this SEP. See 78 FR 421160, 42263-64 (2013) (preamble discussion of effective dates of enrollment for SEPs). In the case of eligibility due to a marriage or loss of MEC, the Exchange must ensure that coverage is effective on the first day of the month following the event. 45 CFR § 155.420(b)(2)(ii)-(iii). The rules do not give the Exchange any discretion to delay the date of enrollment in a QHP. See, e.g., 77 FR 18310, 18393 (2012) (preamble to final rule on SEPs, noting that "in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the Exchange must always ensure coverage is effective on the first day of the following month, consistent with HIPAA rules").

We read the regulation to require retroactive coverage if necessary. This is something that insurance plans routinely provide in the COBRA and birth-of-child context.

In support of its interpretation, AHS cited a draft federal marketplace operations policy manual. This document is not official guidance to state-based marketplaces. Additionally, the manual is just plain wrong about the SEP time (it states 30 days while the regulation provides 60 days). The statement in the FFM manual, "for marriage and loss of minimum essential coverage (MEC), coverage is effective the first day of the month following plan selection" is inconsistent with the federal regulation, which provides for coverage the first day after the month in which MEC is lost. The draft federal marketplace manual is not controlling or even persuasive as to SEP policy.

Response: We have revised this section to align with the federal rule that individuals may select a QHP up to 60 days in advance of loss of minimum essential coverage and that the coverage effective date following loss of minimum essential coverage may be the first day of the month following the triggering event. 45 C.F.R. § 155.420(b)(2)(iv), (c).

Comment: AHS should work with QHP issuers to implement earlier effective dates for individuals who lose other MEC in the middle of a month.

Even under our interpretation of the federal regulations discussed above, individuals who lose MEC in the middle of a month will have a gap in coverage. However, federal regulations at 45 C.F.R. §155.420(b)(3) allow an exchange to set earlier effective dates for the SEPs in section 71.03(b)(2)(ii), if all participating QHP issuers agree. AHS should work with QHP issuers to implement this option. Ideally, consumers would be able to choose the day their coverage starts, including selecting the day after their qualifying event, all the way up to the normal coverage effective date.

Response: We believe the revisions to this section will be sufficient to avoid gaps in coverage. At this point, the rule does not allow for mid-month effective dates for loss of minimum essential coverage, but this may be revisited in future rulemaking.

Comment: AHS should implement additional Special Enrollment Periods.

States must provide the SEPs that are included in the federal regulations, but nothing prevents a state exchange from providing additional enrollment opportunities. See, e.g., 78 FR 42159-42322 at 42264 (July 15, 2013) ("a state may establish additional special enrollment periods to supplement those described in this section as long as they are more consumer protective than those contained in this section and otherwise comply with applicable laws and regulations.").

We have several suggestions for additional special enrollment periods that we believe VHC should implement. Some of our suggestions are included in the proposed federal rules published on March 21, 2014. We understand that AHS's preference is to wait until proposed federal rules are finalized. However, waiting does not make sense here. As explained above, VHC has the authority to implement more generous SEPs than the federal marketplace. VHC should implement our proposed changes to SEPs and effective dates because it is the right thing to do, regardless of whether the federal proposed rule becomes finalized.

Response: We have updated this section to reflect recent federal guidance related to Special Enrollment Periods (SEP).

Comment: The IRS issued guidance on March 26, 2014 providing that domestic violence victims who use the "married filing separately" filing status can qualify for Premium Tax Credits (PTC) in the Marketplace in 2014. Notice 14-23, http://www.irs.gov/pub/irs-drop/n-14-23.pdf. The notice indicates that a proposed rule will be forthcoming.

In a related development, guidance from the Centers for Medicare & Medicaid Services (CMS) created a special enrollment period through May 31, 2014 for domestic violence victims who thought they were ineligible for PTC because of the joint tax return requirement. See, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf.

The SEP appears to be under the authority of 45 C.F.R. § 155.420(d)(9), which would require State Based Marketplaces to affirmatively adopt it.

Response: The State of Vermont adopted this temporary SEP for victims of domestic violence. However, the language is not included in this rule because the SEP has now expired. See http://www.cms.gov/CCIIO/Resources/Regulations-and Guidance/Downloads/victims-domestic-violence-guidance-3-31-2014.pdf.

Comment: Vermont should offer continuous open enrollment for lower income individuals.

Massachusetts grants a special enrollment period to any individual newly determined eligible for a ConnectorCare plan. 956 Code of Mass. Regs. 12.11(5)(b) (eff. Jan 1, 2014), available at www.mahealthconnector.org. This effectively gives individuals under 300 percent of the federal poverty line a continuous enrollment period.

AHS should adopt an SEP for individuals who are determined newly eligible for a Vermont premium reduction. A continuous special enrollment period for this income group could be critical for many Vermonters this year, as they adjust to moving from VHAP and Catamount Health to QHPs. The income limit for receiving Catamount with premium assistance was 300% FPL. VHAP and Catamount did not have designated enrollment periods, and people frequently moved on and off the programs during the course of a year. It will be a rude shock to many this year to learn that they will have to wait until the next open enrollment if they fall off their QHP.

Response: We recognize the importance of this issue. We asked CMS for permission to allow individuals who are newly eligible for APTC by virtue of submitting a first-time application to be granted a special enrollment period to enroll in coverage outside of open enrollment, and CMS has advised us that this approach is not permissible under 45 C.F.R. § 155.420(d)(6). We welcome comments on how we might address this situation under the current rules.

Comment: AHS should create a SEP for people whose health plans renew outside of marketplace open enrollment. Consumers should have an option not to renew noncalendar year policies and instead to receive a special enrollment period in VHC.

The HCA has already seen one situation where this was a problem for a consumer. The individual's grandfathered plan renewed outside of open enrollment, with a significant premium rate increase.

Affected individuals should be able to apply to VHC in advance and get coverage with no gap. Individuals should be able to report to VHC that they will not renew their plan up to 60 days before the renewal date. Also, consumers should have 60 days after their renewal date to enroll in a QHP. Coverage should be effective the day following the renewal date, unless the consumer elects a later effective date.

The federal marketplace implemented a similar SEP for individual market consumers on May 2, 2014. CCIIO, Special Enrollment Periods and Hardship Exemptions for Persons Meeting Certain Criteria, May 2, 2014, available online at http://www.cms.gov/CCIIO/Resources/Regulations-and-guidance/Downloads/SEPand-hardship-FAQ-5-1-2014.pdf.

Additionally, HHS proposes to include this SEP in a permanent rule change. Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Proposed Rule, 79 Fed. Reg. 15,808, 15,838 (Mar. 21, 2014).

Response: We agree that individuals whose health plans renew outside of marketplace open enrollment should have the opportunity to receive a SEP and have updated the rule to align with 45 C.F.R. § 155.420(d)(1)(ii).

Comment: Historically student health plans have offered limited coverage in order to maintain low premium rates. An individual on a student health plan should be eligible for an SEP if they wish to disenroll from a student plan and get coverage through a QHP. VHC's 4/1/14 navigator Q&A states: "We are awaiting clarification on whether a student can dis-enroll from a student plan mid-year and be eligible for a special enrollment period." Vermont does not need permission to create a new SEP for these students.

Furthermore, student health insurance plans are not subject to all ACA requirements. For example, they are not subject to the guaranteed availability and renewability requirements of the ACA. Carriers may also develop school specific community rates. See Vermont Department of Financial Regulation Insurance Bulletin No. 181, http://www.dfr.vermont.gov/reg-bul-ord/student-health-insuranceplans.

A new section should be added allowing individuals on student health plans to disenroll and get an SEP to purchase a QHP.

Response: This section is consistent with federal law in that individuals who voluntarily terminate coverage do not have a SEP. See 45 C.F.R. § 155.420(e). We are exploring options around special enrollment periods and may be able to address this issue in the future.

Comment: COBRA coverage is very expensive. It can be much more expensive than a QHP, especially if the beneficiary qualifies for QHP subsidies. Consumers should be allowed to drop COBRA at any time and enroll in a QHP instead, as long as their COBRA premiums are paid through the date of coverage termination. The HCA has frequently heard from consumers who expected to be able to need COBRA for only a brief period because they thought they would find a new job quickly. When they don't find new employment, they often can't afford to continue their COBRA benefits. To be unable to get onto a QHP in those circumstances seems very harsh.

An individual with COBRA should be able to drop it at any time for either a subsidized or an unsubsidized QHP. The phrase, "and is otherwise newly eligible for APTC" should be deleted from section 71.03(e)(1).

As explained above, Vermont can make this change to the special enrollment periods even if the federal marketplace is not allowing individuals to have a SEP upon dropping COBRA.

Response: We believe federal rules are clear that loss of MEC does not include voluntary termination of coverage. See 45 C.F.R. § 155.420(e). However, we have revised this section to clarify that eligibility for COBRA does not preclude the availability of a special enrollment period upon loss of MEC.

Section 73.01: Eligibility redetermination during a benefit year; General requirement

Comment: Language about seamless transitions should be added. In the Catamount Premium Assistance regulations, Section 5926 required that the state provide seamless coverage for individuals who experience changes in eligibility for DVHA programs.

For example, if a family was on Dr. Dynasaur and Premium Assistance for Catamount Health (CHAP), and their income decreased, the state would "seamlessly" transition the parents onto VHAP after the income change was reported. This principle of seamless transition to other health benefit coverage should be more clearly incorporated into these rules and explicitly stated because it is such an important concept in a complicated system.

We suggest adding this language from the prior rule § 5926 on Seamless Coverage to §73.01: "From time to time, a beneficiary's changed circumstances may require a change from one health-care program to another. AHS will ensure that individuals retain coverage during program transitions brought about by changed circumstances."

We understand that VHC is currently trying to avoid coverage gaps due to delays in redetermination through a process called "access to care." (VHC 4/1/14 navigator Q&A). We applaud VHC for this, but we are concerned that the current rules do not require such efforts. The principle of seamless transitions should be acknowledged and clearly stated in the rules.

Response: The State of Vermont shares the goal of providing seamless transitions to Vermonters as they move between programs. This is a strategic goal for AHS and drives associated policy decisions. We believe that the State's strategic plan, rather than the administrative rule, is the appropriate place to address this goal. However, we also look forward to working with stakeholders on identifying specific processes that can be put in place to ensure seamless transitions.

Section 76.00: Termination of QHP coverage

Comment: In section 76.00(b)(2), the numbering seems off. Paragraphs (ii), (iii), and (iv) should be (C), (D), and (E). They are all circumstances under which an individual's QHP coverage may terminate.

As explained above, the termination provisions need more detail regarding advance notice to beneficiaries.

76.00(b)(2)(i)(A) should provide that AHS may initiate termination of coverage upon 30 days' notice when an individual is no longer eligible for coverage in a QHP. Less than this gives the individual insufficient time to remedy the reason for the termination or to arrange for other health care coverage.

76.00(b)(2)(i)(B) should specify that the issuer may terminate coverage for nonpayment of premiums, upon notice to the beneficiary consistent with section 64.06.

76.00(b)(2)(ii) – (iv). These provisions all need to specify who will give notice to the beneficiary and how much time is required. We suggest 11 days' notice, under the general standard in section 68.02.

Response: We have corrected the numbering issues identified in § 76.00(b)(2).

The State of Vermont currently manages QHP premium payment and termination rules through its carrier contract. However, we recognize the importance of including these standards at an appropriate level of detail in the administrative rule, and we will revisit this during future rulemaking.

In the case of termination for premium nonpayment, we believe that the current notification law, which requires carriers to notify enrollees 14 days in advance of termination, provides sufficient notice to enrollees. See 8 V.S.A. § 4091c, Termination for nonpayment of premium or subscription charges.

Section 76.00(b)(2): AHS or issuer-initiated termination

Comment: The numbering/structure of this provision should be corrected. The lead in (b)(2)(i) applies to all of the subsections, yet (b)(2)(ii) through (b)(2)(iii) are structured as if unrelated and without the lead-in language, these provisions lack meaning.

Response: We have renumbered the section appropriately.

Section 77.00: Administration of APTC and CSR

Comment: VHC should implement the option of granting retroactive PTC and CSR in certain circumstances. See 45 C.F.R. § 155.545(c); CMS Bulletin to marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances, February 27, 2014, available online at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf.

This federal guidance allows retroactive QHP coverage and retroactive subsidies for individuals who did not receive timely eligibility decisions during 2014 open enrollment, due to technical problems experienced by an exchange. As we commented above, this guidance should be implemented immediately.

Even though this guidance pertains only to the 2014 open enrollment period, it should be noted in the rules at 77.00. The Vermont rules should say that AHS may provide retroactive coverage when authorized by federal law, and note this example.

Response: We have adopted this guidance and are allowing retroactive QHP coverage and APTC/CSR payments for individuals for whom technical issues prevented a timely eligibility determination during 2014 open enrollment.

Part Eight: Fair Hearings/Appeals

Section 80.02(b): Requesting a fair hearing

Comment: We disagree with the proposal to provide expedited appeals only in MAGI and QHP cases. We understand that this is all the federal rules currently require, but we believe Vermont should voluntarily extend the process to other Medicaid applicants.

It seems counterproductive and unfair to have an expedited process that the elderly and disabled cannot use. As you know, in Vermont the exchange and the state Medicaid agency are both contained within AHS. There is generally no distinction in the Vermont rules between "exchange" cases and "non-exchange" cases.

Differentiating between these cases here will likely confuse beneficiaries, authorized representatives, and providers. We strongly favor a unified application process for all applicants, including appeals. We believe this would further Vermont's goal of maximizing health coverage.

Furthermore, section 58.01(a) appears to require AHS to perform a MAGI screen on all applications for health benefits, so AHS should be evaluating and making an MCA eligibility determination for all MABD applicants. Thus, applicants denied MABD would also have been denied MCA, blurring any clear distinction between applicants for purposes of considering an expedited appeal.

We understand that AHS has concerns regarding a lack of resources to handle additional appeals, especially in relation to the complexity of LTC decisions. We gather that AHS prefers to wait and see how the process works, and whether CMS will finalize a rule on Medicaid expedited appeals. We do not agree with that approach. All individuals should have the same rights to appeals for all Medicaid programs.

Response: All applicants have the right to request an expedited appeal for a denial of MAGI Medicaid or QHP eligibility. We think it is prudent to wait until CMS finalizes its proposed Medicaid regulation on expedited appeals before we develop a process for expedited appeals on denials of MABD eligibility. By waiting until the federal regulation is finalized, we are following our general practice of not implementing federal regulations that are not final. We will make efforts to ensure that the expedited appeals process is not confusing to individuals. We believe that the most common way of filing all appeals, by calling the toll-free hotline, is working well. We welcome feedback if there are ways to make the appeals process friendlier to individuals.

Section 80.05(a): AHS Secretary review of fair hearing decisions

Comment: Section 80.05(a)(1)(i)(A) should be stricken. The federal regulations at 42 CFR § 431.10(c)(3)(iii) limit the grounds for reversal of Medicaid fair hearing decisions to application

of law or rule. The secretary should not be reversing based on a difference of opinion about the facts before the HSB. Our prior comment is reproduced below.

The federal "single state agency" rule was significantly revised in July 2013 to allow delegation of certain appeals to the exchange. The Medicaid agency is permitted to review fair hearing decisions of the exchange, but the review is limited. The permissible scope of review is narrower than that set out in §80.05. 42 CFR §431.10(c)(3)(iii) states:

"If authority to conduct fair hearings is delegated to the Exchange or Exchange appeals entity under paragraph (c)(1)(ii) of this section, the agency may establish a review process whereby the agency may review fair hearing decisions made under that delegation, but that review will be limited to the proper application of federal and state Medicaid law and regulations, including sub-regulatory guidance and written interpretive policies, and must be conducted by an impartial official not directly involved in the initial determination.

Therefore, the Secretary's review must be limited to the proper application of Medicaid law. The rule should be changed to reflect this narrower scope.

Response: We disagree. 42 C.F.R. § 431.10(c)(3)(iii) limits the grounds for reversal and modification of appeal decisions to certain issues of law only if the single state agency delegates authority for appeals of denials of MAGI-based eligibility to "the Exchange or Exchange appeals entity." Vermont has not delegated authority to a separate Exchange appeals entity. Vermont's single state agency, AHS, retains all authority for eligibility appeals. Since this federal regulation is not applicable in Vermont, our rule is accurate in using the review authority set out in 3 V.S.A. § 3091(h).

Section 80.06(b)(1): Implementation of appeal decisions

Comment: This paragraph should be revised to include appeals of initial eligibility applications as well as redeterminations. When an initial Medicaid application is approved, corrective payments are made back to the date of application and sometimes earlier, not just back to the date of the incorrect adverse action. This rule should reflect that possibility.

Response: See our earlier response to this comment at § 69.00. We believe that the existing language is correct according to federal regulation.

Section 80.07(a): Expedited appeals; in general

Comment: We agree with the general framework, particularly placing the burden on AHS to gather the information necessary to decide the expedited appeal request.

There should be a way for applicants to contact the decision-maker at the first stage of their expedited appeal. Applicants will need to provide a medical provider's contact information when they request the expedited appeal, or they will need to have their doctor fax information in.

Response: We agree it is important that the individual have an opportunity to timely provide information to the agency about his/her medical providers, contact information, etc. An individual has an opportunity to do this, including providing the information mentioned in your comment and getting needed fax numbers, when s/he calls the toll-free hotline to appeal. The rule places an obligation on AHS to act promptly and in good faith to obtain the information needed to resolve the appeal.

Section 80.07(c)(1): Denial of expedited appeal requests; Notice of denial of request

Comment: The oral notice of eligibility for an expedited appeal should include all the same information as the written notice. This should include who DVHA spoke with, what evidence they relied on, and the HCA's phone number.

Response: When given oral notice, the individual will have an opportunity to ask for more specific information about the reason for the denial. We are not changing the rule to require the oral notice to contain the same information as the written notice. The oral notification is intended to provide the individual with notice of whether his/her appeal will be heard on an expedited basis. More detailed and individualized information will be sent to the individual no later than two business days after oral notification. We agree that it is important to give people the Health Care Advocate (HCA) number as soon as possible, and we are amending our rule to state that AHS will give the individual the phone number to the HCA during the oral notification.

Section 80.07(c)(2): Denial of expedited appeal requests; Content of written notice

Comment: We have two comments on this section. First, the notice should include what evidence AHS gathered (e.g. who DVHA spoke with), and what evidence they relied on. The current language ("the reason for the denial") is not specific enough.

Applicants deciding whether to continue their appeal will want to know if DVHA spoke to a certain doctor, etc.

Second, sometimes DVHA will not be able to get enough information within two days. A doctor might be on vacation, for example. If a request for an expedited appeal is denied, the applicant should have some period of time (perhaps a week) to submit additional information and talk to the DVHA employee who made the decision. Meanwhile, the appeal should be sent to the HSB to be docketed as a regular appeal.

Response: The requirement of the rule is the same as the requirement in 45 C.F.R. § 155.540(b)(2)(ii). We are not amending the proposed rule to require the notice to include the evidence AHS gathered, the persons spoken to, and what evidence AHS relied upon. The requirement that AHS provide the "reason for the denial" necessarily requires that the notice be individualized to the extent needed in order for the notice to be meaningful.

As to the second part of the comment, we believe that the process set forth in the rule is fair and reasonable. The rule requires that AHS act in good faith to obtain information needed to

determine if the expedited appeal standard has been met; however, there will no doubt be situations in which the information cannot be obtained within the required timeframe, in which case we agree AHS should refer the appeal to the Human Services Board pending receipt of the information.

Section 80.07(d)(3): Resolution of expedited appeals; Hearing

Comment: We request that AHS incorporate the procedural rights set out in 45 C.F.R. § 155.535(d). Inter alia, this section gives the applicant the right to review his or her appeal record and the right to question or refute any testimony or evidence. These are important rights.

Also, we believe the rule should specify that the decision will be based on the evidence reviewed or noted at the hearing. This can include evidence gathered by AHS, if the applicant has a chance to review it and respond to it. The decision maker could make a decision based on the available evidence if the applicant does not attend the hearing. But, the decision-maker should not be able to hold a hearing, subsequently gather additional information, and then make a decision without giving the applicant a chance to respond to the additional information.

We understand that AHS does not envision a truly contested hearing, in that the agency will not have a representative at the hearings, or be represented by counsel. Nevertheless, the applicant must have the ability to be fully involved in the process, and the process must be fair. The applicant should have the opportunity to respond to any evidence gathered by AHS, before a decision is made.

Response: We have amended the proposed rule to state that AHS must give the individual an opportunity to review his/her appeal record, including all documents and records considered by the decision-maker, and the right to present argument.

To the extent the comment raises the concern that the decision-maker, in making a decision unfavorable to the individual, may rely on evidence that the individual has not had an opportunity to review, we agree this should not occur. It is our intent that the individual have an opportunity to review all evidence considered by the decision-maker. We believe the modification to the rule addresses this concern. Additionally, we have modified the rule to identify the information and evidence that may be considered by the decision-maker.

Comment: Additionally, we would strike the last sentence of this section, "hearing decisions have no precedential value." We believe expedited appeal decisions should be treated like HSB decisions. They are confidential in that they are redacted, but they are available to the public and they are used as persuasive (if not controlling) authority in subsequent cases. Vermont has chosen to implement expedited appeals in an internal process, but this is not required by the federal rules, and indeed the federal rules (at 45 CFR Part 155, subpart F) do not distinguish between the appeals entity for fair hearings, and the appeals entity for expedited appeals. There is no legal basis for treating the decisions differently.

Response: Please see the response to the next comment.

Section 80.07(d)(4): Resolution of expedited appeals; Notice of decision

Comment: Rule 80.07(d)(4) says, "Written notice of the hearing decision is confidential and is not a public document." What is the intent of this provision? As explained above, it seems to us that expedited hearing decisions should be treated like HSB decisions, i.e. available to the public in redacted form. We would strike, "and is not a public document."

Response: We have deleted the language stating that the decision notice is not a public document. Although the public may have access to these decisions in redacted form, they will not be reported, published, or posted on-line. We have retained the language in the rule stating that expedited hearing decisions do not have precedential value and do not bind the agency in any future cases.

Explanation and Summary of Other Changes

The following is a list of additional changes made in order to (1) bring the rule into alignment with recently issued federal regulations and guidance, (2) provide clarification, (3) add clarity and improve consistency, and (4) correct technical and typographical errors.

The changes, in order by section number, are as follows:

Part One

Section 2.03(b) – To align with CMS guidance, add language to end of section stating that Section 28.01(d) does not apply to individuals enrolled in Children's Health Insurance Program (CHIP)

Section 3.00 – Definition of "community spouse" – to align with other rule provisions, replace home "or" community-based with home "and" community-based

Section 3.00 –Definition of "initial open enrollment period" – to provide clarification, delete definition since the Initial Open Enrollment Period (IOEP) has passed

Section 3.00 – Definition of "institutionalized individual" – to align with other rule provisions, replace "the community" with "a home and community-based setting"

Section 3.00 – Definition of "Medicaid services" – to improve clarity, add "services" after "long-term care;" replace "incorporated into Global Commitment" with "as specified in relevant waiver authorizations"

Section 3.00 – Definition of "special enrollment period" – to provide clarification, delete reference to the IOEP since the IOEP has passed

Section 3.00 – Definition of "tax filer" – to align with IRS guidance, add cross-reference to newly-created provision under Section 12.03(b) which states the exception to a married person being required to file a joint tax return for purposes of the federal premium tax credit if the person is a victim of domestic abuse

Section 4.02(b) – To improve clarity, insert footnote to cross-reference to applicable federal regulation

Section 5.01(g) – To align with federal regulation, add new provision on "non-discrimination"

Section 5.03(c)(1) – To correct technical error, change cross-reference from "(e)" to "(f)"

Section 5.03(d) – To align with federal regulation, add new paragraphs (5) through (9) following paragraph (4)

Section 5.03(f) – To align with federal regulation, insert language at end of first sentence in paragraph (5); add new paragraphs (10) and (11) following paragraph (9)

Section 5.05(b) – To align with federal regulation, add new paragraph (8) following paragraph (7)

Section 5.05(d)(1) – To align with federal regulation, insert language at end of text

Section 5.05(e)(1) – To align with other rule provisions, delete "and beneficiaries"

Section 5.05(e)(2) – To align with federal regulation, insert "in a form and manner as determined by AHS" following "authorization" on first line; add language at end of text

Section 5.05(f) – To align with federal regulation, delete all language following "not" on first line and replace with new paragraphs (1) through (5)

Section 5.05(g) – To align with federal regulation, add new provision on "non-discrimination"

Part Two

Section 7.03(a)(2)(i) – To correct technical error, add "for the applicable family size" to end of text (provision was inadvertently omitted from prior versions)

Section 7.03(a)(3)(i) – To correct technical error, add "for the applicable family size" to end of text (provision was inadvertently omitted from prior versions)

Section 7.03(a)(5)(ii) – To improve clarity, delete "dependent" in front of "children" in title and in front of "child" in text

Section 7.03(a)(6) – To align with federal requirements in light of Congress's extension of Transitional Medical Assistance (TMA) until March 31, 2015, insert a new paragraph "(a)" to state the regulations for TMA under Section 1925 of the Social Security Act; re-designate current provisions in section as paragraph "(b)" and re-format paragraph (b) as necessary to align with new paragraph "(a)"

Section 7.03(a)(7) – To align with the formatting of revised Section 7.03(a)(6), above, re-format section by moving "(i)" to a footnote, moving "(ii)(A)" to new "(ii)," and embedding "(iii)" into new "(A)" and new "(B)"

Section 7.03(a)(9) – To align with federal guidance, add new provision stating the additional eligibility requirements for an individual eligible for MCA seeking Medicaid coverage of long-term care services

Section 8.05(k)(1)(ii) – To align with other rule provisions, insert "home and" in front of "community-based"

Section 12.03(b) – To align with IRS guidance, add provision stating the exception to a married person being required to file a joint tax return for purposes of the federal premium tax credit if the person is a victim of domestic abuse

Section 14.00 – To align with other rule provisions, insert "as specified in Section 11.00," following "QHP,"

Part Three

Section 17.02(a) – To align with federal regulation, add provision to end of section to make it clear that for purposes of QHP enrollment, an individual must expect to be a citizen/national for the entire period for which QHP enrollment is sought; to improve clarity, move subparagraphs (2) and (3) to newly-created paragraph (b)

Section 17.02(b) – To improve clarity, create new section to apply to enrollment in Medicaid for non-citizens; add explanatory language at beginning of text

Section 17.02(c) (former Section17.02(b)) – To align with federal regulation, add provision to end of section to make it clear that for purposes of QHP enrollment, an individual must expect to be lawfully present for the entire period for which QHP enrollment is sought

Section 17.02(d) (former Section 17.02(c)) – To improve clarity, re-order (2) and (3); restate in newly-designated (2) the content previously stated under (3)(i) and (ii); replace in newly-designated (3) "are not related to either an" with "do not include;" to provide clarification, replace "eligible for but unenrolled" with "enrolled" in footnote

Part Four

Section 24.01(a) – To align with other rule provisions, replace home "or" community-based with home "and" community-based; add "see" in front of cross references to Sections 8.05 and 8.06

Section 24.03 – To align with other rule provisions, insert "services" after "long term care"

Section 24.04(c)(2) – To align with other rule provisions, replace home "or" community-based with home "and" community-based – in two places

Section 24.04(e)(1)(i)(A) – To align with other rule provisions, replace home "or" community-based with home "and" community-based – in three places

Section 24.05(a) – To align with other rule provisions, replace home "or" community-based with home "and" community-based

Section 24.05(c) – To align with other rule provisions, replace "waiver" with "home and community-based" in title

Section 24.05(c)(1) – To align with other rule provisions, replace home "or" community-based with home "and" community-based

Section 24.05(c)(2) – To align with other rule provisions, replace home "or" community-based with home "and" community-based

Section 24.05(d) – To align with other rule provisions, replace "waiver" with "home and community-based" in title; replace home "or" community-based with home "and" community-based

Section 25.01(a) – To align with other rule provisions, replace home "or" community-based with home "and" community-based – in two places

Section 25.03(e)(4)(ii) – To align with other rule provisions, insert "home and community-based" in front of "long-term care" and delete "in the individual's home or community-based setting"

Section 25.03(e)(5)(i) – To align with other rule provisions, insert "home and community-based long-term care" in front of "services" and delete "in the individual's home or community-based setting"

Section 25.03(h)(2) – Correct auto-numbering error ((iii)(A) and (B) should be (C) (I) and (II), and (iv)(A) through (E) should be (D)(I) through (V))

Section 25.04(a)(1)(iii) – To provide clarification for establishing category under MCA, insert cross-reference to Section 7.03

Section 25.04(a)(1)(vi) – To provide clarification, insert "if applicable" at end of provision since there is no resource test for MCA

Section 25.04(a)(1)(vii) – To provide clarification for determining income eligibility for MCA, insert cross-references to Sections 28.03 and 28.04

Section 25.04(a)(3) – To improve clarity**,** delete auto-numbered "(3)" preceding "Examples:" (examples apply to paragraph (2))

Section 25.04(e) – To align with other rule provisions, insert "services" at end of title

Section 25.04(e)(3) **–** To align with other rule provisions, insert "services" at end of title

Section 25.04(e)(5) **–** To align with other rule provisions, insert "services" at end of title

Section 25.05(f)(7) **–** To align with other rule provisions, insert "services" at end of title

Section 25.05(f)(10) – To provide clarification**,** insert "services" after "long term care"

Part Five

Section 28.01(d) – To align with CMS guidance, add language to end of text to state that the one-time extension of Medicaid coverage does not apply to individuals enrolled in CHIP; to improve clarity, replace "whose eligibility for Medicaid began on or before" with "who was enrolled in Medicaid;" to provide clarification, insert "fail to pay a premium" in front of "or are deceased."

Section 28.05(d) – To align with IRS guidance, add cross-reference to newly-created provision under Section 12.03(b) which states the exception to a married person being required to file a joint tax return for purposes of the federal premium tax credit if the person is a victim of domestic abuse

Section 29.04(d)(2) - To align with other rule provisions, replace home "or" community-based with home "and" community-based

Section 29.10(e)(1) - To align with other rule provisions, replace home "or" community-based with home "and" community-based

Section 29.14(h) – To align with other rule provisions, replace "their home or community-based setting" with "a home and community-based setting" in title and text

Section 30.01(d) - To align with other rule provisions, replace home "or" community-based with home "and" community-based

Part Six

To provide clarity, some of the sections in Part Six have been moved and incorporated into existing sections or have been deleted in their entirety. These changes are described below in addition to the other technical changes that have been made to Part Six in the final proposed rule.

Former Introduction – The introduction referring to direct enrollment and the MOU has been removed as CMS has since clarified the requirements for direct enrollment

Section 31.00 – Definition of "annual employee open enrollment period" – remove language around a standard enrollment period of not less than 30 days to reflect recently-issued federal regulations; consolidate definition with language from Section 38.00(b) (former Section 40.00(b)) "Open enrollment periods, generally" to provide greater clarity and improve consistency

Section 31.00 – Definition of "annual employer election period" – remove language around 30 day election period to reflect recently issued federal regulations; consolidate definition with language from Section 38.00(b) "Decisions during election period" to provide greater clarity and improve consistency

Section 31.00 – Definition of "applicable large employer" – remove definition to provide greater clarity and improve consistency (the term "applicable large employer" refers to IRS provisions that are not administered by VHC or AHS)

Section 31.00 – Definition of "dependent" – remove reference to applicable large employer (the term "applicable large employer" refers to IRS provisions that are not administered by VHC or AHS)

Section 31.00 – Definition of "full-time employee" – remove current definition and update to definition from recently-issued federal regulations; include examples from preamble to recent federal regulations to help provide clarity; clarify how full-time employee is defined in the context of defining small employer versus qualified employer

Section 31.00 – Definition of "qualified employee" – replace "by the receiving of" with "through" for clarity

Section 31.00 – Definition of "qualified employer"– remove definition of small employer within the definition for greater clarity and consistency

Section 31.00 – Definition of "seasonal employee" – update definition with definition from recently-released federal regulations for determining full-time employees for purposes of offering coverage and provide context for usage for greater clarity

Section 31.00 – Definition of "seasonal worker" – add federal definition of seasonal worker and context for usage for greater clarity

Section 31.00 – Definition of "small employer"– incorporate language from Section 34.00 "Method for counting employees for purposes of determining employer eligibility" for greater clarity and consistency

Section 32.00(b)(1) (former Section 32.00(a)(1)) – Remove limitation to 2014 and add "to the extent permitted by HHS" (federal guidance has extended the exception to beyond 2014)

Section 32.00(c)(2)-(3) – Remove provisions for greater clarity and consistency

Section 32.00(c)(4)-(5) – Remove provisions due to recent federal guidance (VHC is not required to collect information referred to in provision)

Section 32.00(g) – Update to reflect recent federal guidance

Section 33.00(b) (former Section 33.00(c)) – Remove paragraphs (2)-(3) for greater clarity and consistency

Section 33.00(f) (former Section 33.00(g)) – Remove current language and incorporate recent federal guidance around eligibility determinations for employers and employees in VHC

Former Section 34.00 – Remove section "Method for counting employees for purposes of determining employer eligibility" for clarity and consistency (this section was incorporated in definition of "small employer")

Section 34.00(c) (former Section 35.00(c)) – Add language to include recent federal guidance for employer choice after the 2014 plan year

Former Section 38.00(a) & (b) – Remove "Employer election period, generally" and "decisions during election period" (paragraphs were incorporated into definition of "annual employer election period")

Former Section 38.00(c) – Remove "timing of initial election period for plan years beginning January 1, 2014" to avoid confusion and provide greater clarity. Small employers were directly enrolled into QHPs for 2014 plan year.

Section 37.00(c) (former Section 38.00(e)) – Clarify that group and non-group plans are on a calendar year, but new qualified employers can come into VHC any time during the year in which they qualify

Former Section 39.00 – Remove section "Employer contributions to cost-sharing through HSAs or HRAs" for purpose of clarity and consistency (subject matter is enforced by IRS, not AHS)

Former Section 40.00(b) – Remove "open enrollment periods, generally" (language was incorporated into definition of "annual employee open enrollment period" for clarity and consistency); replace with former 40.00(e)

Section 38.00(c) & (d) (former Section 40.00(c) & (d)) – Remove for clarity (small employers were directly enrolled into QHPs for 2014 plan year)

Section 39.00(a) (former Section 41.00(a)) – For clarity and consistency, remove language describing special enrollment provisions and refer to citation in rule

Section 39.00(c) – (e) (former Section 41.00(c) – (e)) – For clarity and consistency, remove language describing loss of minimum essential coverage and refer to citation in rule

Section 40.00(a)(3) (former Section 42.00(a)(3)) – Remove language referencing the effective date for January 2014 coverage and replace with "employee coverage shall be effective for the coverage date agreed upon by the employer and the carrier" to create greater clarity and in accordance with federal guidance around direct enrollment

Section 40.00 (former Section 42.00(b)) – Remove sub-paragraph titled "Late initial enrollment" to provide greater clarity (all small employers were directly enrolled for 2014)

Section 40.00 (former Section 42.00(c)) – Remove sub-paragraph titled "Non-enrollment" to provide greater clarity (VHC is revisiting its policy on non-enrollment)

Section 40.00(b) (former Section 42.00(d)(2)) – Remove reference to retroactive coverage for greater clarity

Section 44.00 – Remove majority of this section for now for clarity (VHC is currently revising its policy on cancellation)

Section 42.00 (former Section 45.00) – Clarify section title to indicate renewal of coverage as opposed to QHP discontinuation and renewal

Section 42.00(a) (former Section 45.00(a)) – Remove reference to rule regarding termination (as this rule was removed)

Section 44.00 (former Section 48.00) – Remove all provisions in this section for now except sub-paragraph (a) (VHC is revising its policy on terminations; implementation under federal law is not required until after January 1, 2015); clarify sub-paragraph (a) to allow QHP issuers to terminate coverage for non-payment of premiums; reserve sub-paragraph (b) for a later date

Section 45.00 (former Section 49.00) – Add "and employee eligibility" to title to be consistent with federal law

Section 45.00(a) (former Section 49.01(a)) – Clarify provision with reference to relevant rule

Section 45.00(b) – Add employee right to appeal to be consistent with federal law

Section 45.00(c)(2) (former Section 49.01(b)(2)) – Add "or employee" to be consistent with federal law

Section 45.00(d) (former Section 49.01(c))—Add AHS to comply with federal law

Section 45.00(e) (former Section 49.01(d)) – Replace "appeals entity" with "AHS" for clarity

Section 45.00(e)(3) (former Section 49.01(d)(3)) – Replace "appeals entity" with "AHS" for clarity; add "employee" to be consistent with federal law; remove "including" to comply with federal law

Section 45.00(f) (former Section 49.01(e)) – Replace "appeals entity" with "AHS" for clarity; add "employee" to be consistent with federal law

Section 45.00(g) (former Section 49.01(f)) – Replace "appeals entity" with "AHS" for clarity; add "employee" to be consistent with federal law

Section 45.00(h) (former Section 49.01(g)) – Replace "appeals entity" with "AHS" for clarity; add "employee" to be consistent with federal law

Section 45.00(i) (former Section 49.01(h)) – Add "employee" to be consistent with federal law

Section 45.00(k) (former Section 49.01(j)) – Replace "appeals entity" with "AHS" for clarity

Section 46.00(a) – Add notice requirements to comply with federal law

Section 46.00(b) (former Section 49.02(a)) – Add language to clarify that employers will appeal to the HHS appeals entity or other entity as directed by VHC

Former Section 49.01 – Remove for clarity

Former Section 49.02(b)-(k) – Remove provisions for clarity and to reflect current VHC policy of appeals going to HHS

Section 47.00 (former Section 50.00(c)-(f)) – Remove provisions for clarity (VHC is revising its policy on premium processing)

Part Seven

Section 54.01 – To improve clarity, replace content with cross-reference to Section 17.00

Section 54.05(a)(1)(i) – To improve clarity**,** revise text to explain how this section differs from 57.00(c)

Section 54.05(a)(1)(ii) – To improve clarity, add "In addition to the reason described in Section 57.00(c)(3);" delete "or obtain any necessary documentation"

Section 54.05(a)(2) **–** To be consistent across all health benefits, eliminate application of this section to Medicaid only and re-number section accordingly

Section 54.05(c)(2) - To correct technical error, replace cross-reference to "Sections 57.00(c)(5) and (6)" with "Section 57.00(c)(4)(ii)"

Section 54.06 – To provide clarification, insert "for Medicaid" in title

Section 54.07(b)(4) – To correct technical error, delete footnote

Section 54.08 – To provide clarification, insert "for qualified non-citizens" in title; insert "If verification of immigration status cannot be obtained through the process described in Section 54.04" at beginning of text; insert "as a qualified non-citizen" after "health benefits"

Section 54.09 – To provide clarification, insert "for determining the Medicaid five-year bar for qualified non-citizens" in title

Section 54.09(a) – To provide clarification, insert "for qualified non-citizens" after "five-year bar"

Section 54.10 – To provide clarification, insert "qualified non-citizen" at end of third sentence; delete "for purposes of Medicaid" at end of fourth sentence; insert "Medicaid" in front of "eligibility criteria" and delete "of a health-benefits program" in fifth sentence;" to align with new formatting under Section 17.02, replace cross-reference to "17.02(c)" with "17.02(d)"

Section 54.11 – To provide clarification, insert "ineligible for Medicaid" in title; insert "for purposes of Medicaid eligibility," at beginning of text

Section 57.00(c)(5) – To provide clarification, add text following "the individual has not responded to a request for additional information;" insert explanation at end of section that Medicaid cannot be granted to a new applicant until verification of attestation is received unless the verification is for purposes of citizenship/immigration status

Section 58.02(b)(2) – To align with IRS guidance, add cross-reference to newly-created provision under Section 12.03(b) which states the exception to a married person being required to file a joint tax return for purposes of the federal premium tax credit if the person is a victim of domestic abuse

Section 63.00(b) - To improve clarity, insert “if an individual is requesting an eligibility determination for a health-benefits program” after “However” in second sentence

Section 66.04(c) – To align with CMS guidance, delete reference to “hospital admission” for the frequency of presumptive Medicaid eligibility periods and replace with statement that individual may only have one presumptive Medicaid eligibility period in a calendar year; add provision to end of text that a pregnant woman may only have one presumptive Medicaid eligibility period for each pregnancy even if she has not otherwise already had a presumptive eligibility period during the calendar year

Section 71.02 - To provide clarification, delete “Initial and” from title since the IOEP has passed

Section 71.02(a)(1) – To provide clarification, delete reference to the IOEP since the IOEP has passed

Section 71.02(a)(2) - To provide clarification, delete reference to the IOEP since the IOEP has passed

Section 71.02(b) – To provide clarification, delete section since the IOEP has passed

Section 71.02(c) – To provide clarification, delete section since the IOEP has passed

Section 71.02(d) – To align with federal regulation, reword text by replacing “September 1, and no later than September 30” with reference to the “month before the open enrollment period begins”

Section 71.02(e) – To align with federal regulation, reword text to apply only to benefit year 2015; replace “October 15” through “December 7” with “November 15, 2014” through “February 15, 2015;” to provide clarification, insert provision at end of text to explain that for benefit years beginning on or after 2016, the AOEP will be in accordance with federal regulation

Section 71.02(f) – To align with federal regulation, reword text to apply only to benefit year 2015; replace text that states that coverage will be effective as of the first day of the following benefit year with text explaining the month of effective coverage depending on the date of plan selection; to provide clarification, insert provision at end of text to explain that for benefit years beginning on or after 2016, coverage will be effective in accordance with federal regulation

Section 71.03(b)(2) – To align with federal regulation, revise paragraphs (ii) and (iii); insert cross-reference in (iii) to newly-created Section 71.03(d)(10); add new paragraph (iv)

Section 71.03(c) – To align with federal regulation, insert “Availability and” in title; redesignate current rule as new paragraph (1) and add title “General rule;” add new paragraph (2) on “Advance availability;” add new paragraph (3) on “Special rule”

Section 71.03(d)(1) – To align with federal regulation, replace existing subparagraphs (i) and (ii) with subparagraphs (i) through (iv)

Section 71.03(d)(6)(iii) – To align with federal regulation, delete last sentence

Section 71.03(d)(10) – To align with federal regulation, add provision to state new triggering event for special enrollment period

Section 71.03(e) – To align with federal regulation, add language at the end of paragraph (1) (formerly paragraph (2)); to improve clarity, move language from Part Six to new paragraph (3) (to consolidate information on loss of coverage)

Section 73.02 – To provide clarification, move (b) from Section 73.02 to Section 73.03 (the limitation described in (b) does not apply only to the verification process for reported changes); re-number Section 73.02 accordingly

Section 73.03 – To provide clarification, insert "for Medicaid enrollees" in title; re-number provision as (a); insert "for a Medicaid enrollee because of a change in the individual's circumstances" after "benefit year;" insert cross-reference to new paragraph (b) (moved from Section 73.02); retitle (b) to explain that it applies to limitations on "AHS's ability to request additional information"

Section 73.05(a)(1) – To correct technical error, replace cross-reference to Section 58.00 with Section 61.00 and insert "timeliness" in front of "standards"

Section 73.05(a)(2) – To provide clarification, replace cross-reference to Section 61.00 with Section 68.00

Section 73.05(a)(3) – To improve clarity, revise language to parallel language in Section 75.02(f)(1)(iii)

Section 75.01(b) – To provide clarification, delete "MAGI-based" (section also applies to non-MAGI-based income and MAGI income)

Section 75.01(d) – To provide clarification, replace "continues" with "discontinues"

Section 75.02(a) – To improve clarity, insert at beginning of section "For renewal of an individual's eligibility for enrollment in a QHP"

Section 75.02(f)(1)(i) – To correct technical error, replace cross-reference to Section 11.00 with cross-reference to Section 61.00; insert "timeliness" in front of "standards"

Section 75.02(f)(1)(ii) – To provide clarification, replace cross-reference to Section 68.02 with cross-reference to Section 68.00; insert "regarding the redetermination" after "individual"

Section 75.02(f)(1)(iii) – To align with renumbering in Part Six, replace cross-reference to "49.02" with cross-reference to "46.00"

Section 75.03(b)(1)(iii) – To provide clarification, insert language after "Notice" to explain that notices will be issued in a timely manner in accordance with timeliness standards in Section 61.00

Section 76.00(d)(6) - To align with federal regulation, add language to end of text on retroactive enrollments and retroactive termination dates

Section 76.00(e) – To align with federal regulation, add new provision defining termination, cancellation, and reinstatement

Section 77.00(c) – To provide clarification, replace cross-reference to "78.00(a)" with "78.00"

Section 78.00(a) – To align with federal regulation, reword section to separately identify annual and monthly reporting requirements to IRS; revise cross-reference in footnote

Section 78.00(b) – To align with federal regulation, replace "of" with "for" in title; replace "[Reserved]" in text with language stating the timing for the IRS annual and monthly reports

Section 78.00(c) – To align with federal regulation, add new provision to state the timing and content for notices to individuals; redesignate current paragraph (c) as paragraph (d) and revise language; delete footnote

Part Eight

Section 83.00(a) – To improve clarity, insert at beginning of text explanation that, regarding issues of Medicaid coverage, an individual may utilize DVHA's internal Managed Care Organization (MCO) appeals process (from former Medicaid Rule 4151, third paragraph)

Explanation of Changes Made to Final Proposed Rule and Approved by LCAR

Text below that is underlined is text that has been added since the final proposed rule. Text that has a strike-through is text that has been removed from the final proposed rule.

Section 5.01(a) Assistance offered through AHS/In general

Clarify that all individuals, not just individuals with known disabilities, can get assistance with the application or renewal process if needed.

(a) In general[1]	AHS will provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient. Eligibility and enrollment assistance that meets the accessibility standards in paragraph (c) of this subsection is provided, and referrals are made to assistance programs in the state when available and appropriate. These functions include assistance provided directly to any individual seeking help with the application or renewal process.

Section 31.00 Definitions

Definition of Employer: Remove reference to associations to reflect current Vermont law.

Employer[2]	(a) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan~~; and includes a group or association of employers acting for an employer in such capacity~~. (b) Such term includes employers with one or more employees, and (c) All persons treated as a single employer such as a controlled group of corporations; partnerships, proprietorships, etc., which are under common control; affiliated service groups; and other arrangements such as separate organizations and employee leasing arrangements.[3]

Definition of Full-time Employee: Remove "factors to consider" to avoid confusion. In federal law, these factors are used to determine full-time employee for the purpose of qualified employer.

[1] 42 CFR § 435.908; 45 CFR § 155.205(d). Note: While the consumer-assistance responsibilities of Medicaid agencies and Exchanges may be distinct, "[s]ome aspects of [the Medicaid agency's] applicant and beneficiary assistance may be integrated with the consumer assistance tools and programs of the Exchange." See, CMS "Summary of Proposed Provisions and Analysis of and Responses to Public Comments," 77 Fed. Reg. 17144, 17166 (Mar. 23, 2011). Vermont has opted to operate one health-benefits assistance call center, serving the needs of all applicants and beneficiaries of health benefits.

[2] 45 CFR § 155.20. [Applies the definition in PHSA §2791, 42 U.S.C. 300gg-91(d)(5) which applies the definition in 29 U.S.C. §1002(5).]

[3] 45 CFR § 155.20 referencing 26 U.S.C. § 414.

Full-time employee[4]	An employee who is employed on average at least 30 hours of service per week, for effective plan years beginning on or after January 1, 2014. ~~Factors to consider when determining whether a new employee is a full-time employee include:~~ (a) ~~Whether the employee is replacing an employee who was or was not a full-time employee;~~ (b) ~~The extent to which employees in the same or comparable positions are or are not full-time employees; and~~ (c) ~~Whether the job was advertised, or otherwise communicated to the new employee or otherwise documented as requiring hours of service that would average 30 or more hours of service per week or less than 30 hours of service per week.~~[5] For purposes of the definition of small employer, full-time employee does not include seasonal workers. For purposes of the definition of qualified employer, full-time employee does not include seasonal employees.

Section 32.00 Employer eligibility

Clarify current standards around eligibility determinations.

(b) Employer eligibility requirements[6]	~~(1)~~ To the extent permitted by HHS: (1) VHC shall permit small employers to purchase QHPs directly from a health insurer under contract with VHC. (2) Upon request, VHC must provide a small employer with an eligibility determination as to whether it is a qualified employer with a notice of approval or denial of eligibility and the employer's right to appeal such eligibility determination. ~~(2) Before permitting the purchase of coverage in a QHP, VHC must determine that the employer who requests coverage is eligible in accordance with the requirements of §§ 31.00, and 32.00(b), except to the extent permitted by HHS~~ ~~(i)~~ VHC may accept an employer's attestation of eligibility as eligibility is defined in §§ 31.00 and 32.00(b) instead of determining the employer's eligibility.~~; and~~ ~~(ii) employers may purchase coverage in a QHP before VHC makes an eligibility determination or receives the employer attestation of eligibility.~~

[4] 45 CFR § 155.20.
[5] 79 FR 8544, 8555 (Feb. 12, 2014).
[6] 45 CFR § 155.710(b)(2), § 155.715(a); "A Direct New Path to SHOP Marketplace Coverage" viewed on Dec.11, 2013, http://www.hhs.gov/healthcare/facts/blog/2013/11/direct-new-path-to-shop-marketplace.html .

Section 34.00(c) Employer choice

Clarify that after 2014 plan year issuers must provide employers full choice within one issuer.

Two models of employer choice	(a) Except as provided for in 34.00(c), a qualified employer may offer QHPs on VHC to its employees and at the employer's option to the employees' dependents[7] in one of the following ways: (1) Permitting the qualified employee to select any plan from among all QHPs offered on VHC; or (2) Permitting the qualified employee to select any QHP offered on VHC by one issuer of the employer's choice; (b) A qualified employer may choose to offer in addition to QHPs any stand-alone dental plans offered on VHC to its eligible employees and at the employer's option to their dependents. (c) For employers who direct enroll with the issuers <u>for the 2014 plan year</u>, issuers may limit the choice based on consistent standards. <u>For employers who direct enroll with the issuers after the 2014 plan year, issuers must provide the option listed in (a)(2).</u>

Section 37.00 Employer election period

Modify notice requirement to provide greater flexibility for more efficient, less confusing notices.

(b) Notice of election period[8]	VHC shall ~~notify a qualified~~ <u>ensure that</u> employer<u>s are notified</u> of the annual election period 30 days in advance of the start of the employer election period for the 2015 plan year and subsequent plan years.

Amend to federal requirement to provide greater flexibility to employers.

(c) Rolling enrollment[9]	VHC must permit a qualified employer to purchase coverage for its small group ~~beginning on the first of any month~~ <u>at any point</u> during the year ~~in which the employer becomes a qualified employer.~~.

Section 57.00(c)(1) Inconsistencies/Procedures for determining reasonable compatibility

Clarify that the opportunity for individuals to provide statements reasonably explaining discrepancies is not limited to Medicaid applicants or enrollees.

[8] 45 CFR § 155.725(d).
[9] 45 CFR § 155.725(b).

(c)Procedures for determining reasonable compatibility	In circumstances described in paragraph (b) of this section, AHS will: (1) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer, and~~, for purposes of Medicaid eligibility,~~ by allowing the individual, or the application filer on the individual's behalf, the opportunity to provide AHS with a statement that reasonably explains the discrepancy.

Section 57.00(c)(5) Inconsistencies/Procedures for determining reasonable compatibility

Clarify the basis for the Agency to deny an application or disenroll an individual if the individual has not responded to a request for additional information or has not provided information sufficient to resolve an inconsistency, or the agency otherwise remains unable to verify an individual's attestation at the end of the 90-day verification period.

(c)Procedures for determining reasonable compatibility	In circumstances described in paragraph (b) of this section, AHS will: (5) In connection with the verification of an attestation for Medicaid eligibility, if, after the period described in paragraph (c)(2)(ii) of this section, the individual has not responded to a request for additional information or has not provided information sufficient to resolve the inconsistency, or AHS otherwise remains unable to verify the attestation, deny the application or disenroll the individual on the basis <u>that there is insufficient information to determine the individual's eligibility for Medicaid</u> ~~of the individual's noncompliance with the verification request~~. Medicaid coverage cannot begin for a new Medicaid applicant until verification of the attestation is received, unless the verification is for purposes of establishing citizenship or immigration status as described in § 54.05(b).