STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

FROM: Sean Brown, Deputy Commissioner
Economic Services Division

BULLETIN NO.: 15-02F
DATE: July 22, 2015

SUBJECT: Health Benefits Eligibility and Enrollment (HBEE)

CHANGES ADOPTED EFFECTIVE: 7/15/15

INSTRUCTIONS

X **Maintain Manual - See instructions below.**

MANUAL REFERENCES:

HBEE

Attachments to DCF Bulletin 15-02F:

1. Attachment One - *List of Acronyms in Health Benefits Eligibility and Enrollment (HBEE) Rule*
2. Attachment Two - *Responsiveness Summary and Summary of Changes* (description for decisions on public comments and explanation of other changes to HBEE final proposed rule)
3. Attachment Three - *Explanation of Changes Made to Final Proposed Rule and Approved by LCAR*

Health Benefits Eligibility and Enrollment (HBEE), referenced as "HBEE (B15-02F)" for purposes of this Bulletin, is a final rule that became effective July 15, 2015. HBEE (B15-02F) supersedes HBEE (B14-02F) that was effective from July 30, 2014 until July 15, 2015.

HBEE (B15-02F) is necessary in order to further implement 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, 79 of 2013, and 144 of 2014.

HBEE (B15-02F) is also needed in order to (1) align the rule with federal regulations including ones published since the proposed rule was filed, (2) align the rule with federal guidance from the Centers for Medicare and Medicaid Services and the Internal Revenue Service, (3) align the terminology in the rule with the Department of Disabilities, Aging and Independent Living's terminology for "long-term care services," (4) add clarity and consistency, (5) correct technical and typographical errors, and (6) respond to comments received from stakeholders.

History of HBEE

- HBEE (15-02F), a final rule, became effective July 15, 2015 and superseded HBEE (B14-04F)
- HBEE (B14-04F), a final rule, was effective July 30, 2014 and superseded HBEE Amendment # 3 (B14-02E)
- HBEE Amendment # 3 (B14-02E), an emergency rule, was effective March 31, 2014 and superseded HBEE Amendment # 2 (B13-46E)
- HBEE Amendment # 2 (B13-46E), an emergency rule, was effective January 1, 2014 and superseded HBEE Amendment # 1 (B13-36E)
- HBEE Amendment # 1 (B13-36E), an emergency rule, was effective October 1, 2013 and superseded the original HBEE (B13-12F)
- HBEE (B13-12F), the original final rule, was effective October 1, 2013

Manual Maintenance

Health Care Rules

Remove	**Insert**
HBEE (14-02F)	HBEE (15-02F)

Rulemaking Process

1. The Agency of Human Services (AHS) presented the proposed rule to the Interagency Committee on Administrative Rules (ICAR), and ICAR approved the proposed rule for filing with the Secretary of State on December 8, 2014.

2. AHS filed the proposed rule with the Secretary of State and the Legislative Committee on Administrative Rules on December 19, 2014.

3. AHS 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 December 23, 2014.

4. The Secretary of State published the notice of rulemaking on its website on December 24, 2014. The Secretary of State references this rule as 14P-059.

5. A public hearing was held on January 23, 2015 at 11:00 a.m., at AHS, Conference Room A, 208 Hurricane Lane, Williston, Vermont 05495. There were no public attendees and no comments were made at the hearing.

6. The comment period on the proposed rule closed on January 30, 2015. Vermont Legal Aid and Blue Cross Blue Shield of Vermont submitted written comments on the proposed rule.

7. AHS filed the final proposed rule with the Secretary of State and the Legislative Committee on Administrative Rules on May 21, 2015.

8. AHS presented the rule to the Legislative Committee on Administrative Rules (LCAR) on June 25, 2015 and LCAR approved the rule with an amendment to HBEE 30.05 on the same date.

9. AHS filed the adopted rule with the Secretary of State and the Legislative Committee on Administrative Rules on June 30, 2015.

10. The rule became effective as law on July 15, 2015.

Information about the Rulemaking Process

To get more information about the Administrative Procedures Act and the rules applicable to state rulemaking, see the website of the Office of the Secretary of State (SOS) at: http://vermont-archives.org/aparules/ and/or call the SOS at 802-828-2863. For information about the Legislative Committee on Administrative Rules (LCAR), see the website of the Vermont Legislature at: http://legislature.vermont.gov/committee/detail/2016/39 and/or call LCAR at 802-828-5760.

Attachments to Bulletin

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

The second attachment to this Bulletin is a description for decisions on public comments and explanation of other changes to HBEE final proposed rule. This document is titled *Responsiveness Summary and Summary of Changes* and is incorporated into this Bulletin as Attachment Two.

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

Effective and Repeal Dates to Rule Sections (updates are noted)

Section	Description of Change
4100 Medicaid	Repealed and replaced with HBEE effective 1/1/14
4200 Medicaid SSI	Repealed and replaced with HBEE effective 1/1/14
4300 Medicaid ANFC	Repealed effective 1/1/15. For new enrollees, repealed and replaced with HBEE effective 1/1/14. HBEE will become effective for individuals enrolled on or before 12/31/13 as they reach their annual review date throughout 2014

4400 Medicaid Spenddown	Repealed and replaced with HBEE effective 1/1/14
5300 VHAP	Repealed effective 4/1/14 for individuals enrolled on or before 12/31/13 and choosing to remain enrolled (for new applicants after 12/31/13, repealed effective 1/1/14), *except retain* 5321-5323 for VPharm (5400) and HVP (5700) eligibility)
5400 VPharm **Update**	Remains in place until a point prior to 12/31/16 when information technology support is available; beneficiaries will then convert to HBEE
5500 VHAP Pharmacy	Repealed effective 1/1/14
5600 VScript	Repealed effective 1/1/14
5700 Healthy Vermonters **Update**	Remains in place until a point prior to 12/31/16 when information technology support is available; beneficiaries will then convert to HBEE
5900 Premium Assistance	Repealed effective 4/1/14 for individuals enrolled on or before 12/31/13 and choosing to remain enrolled (for new applicants after 12/31/13, repealed effective 1/1/14)

View HBEE

HBEE (B15-02F) can be viewed electronically at http://dcf.vermont.gov/esd/rules and will be posted at http://humanservices.vermont.gov/on-line-rules/esd.

Acronym List

AABD	Aid to the Aged, Blind, and Disabled
ABP	Applicable Benchmark Plan
ACA	Affordable Care Act of 2010
ACCS	Assisted Community Care Services
ADA	Americans with Disabilities Act
AHS	Agency of Human Services
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
CHIP	Children's Health Insurance Program
CLA	Common Level of Appraisal
CMA	Community Maintenance Allowance
CMS	Centers for Medicare and Medicaid Services
CNMI	Commonwealth of the Northern Mariana Islands
COLA	Cost of Living Adjustments
CPI	Consumer Price Index
CS	Community Spouse
CSR	Cost-sharing Reductions
CSRA	Community Spouse Resource Allocation
CSV	Cash Surrender Value
DAC	Disabled Adult Child
DCHC	Disabled Child in Home Care
DED	Deferred Enforced Departure
DFR	Department of Financial Regulations
DHS	Department of Homeland Security
DVHA	Department of Vermont Health Access
ERC	Enhanced Residential Care
FPL	Federal Poverty Level
GDP	Gross Domestic Product
HDHP	High Deductible Health Plan
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HMO	Health Maintenance Organization
HRA	Healthcare Reimbursement Arrangements
HSA	Health Savings Accounts
HVP	Healthy Vermonter Program
ICF-DD	Intermediate-Care Facilities for the Developmentally Disabled
IIRIRA	Illegal Immigration Reform and Immigrant Responsibility Act of 1996
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 of 1996
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
SEP	Special Enrollment Period
SGA	Substantial Gainful Activity
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
TPS	Temporary Protected Status
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 15-02F

Responsiveness Summary and Summary of Changes - Health Benefits Eligibility and Enrollment Final Proposed Rule (3 V.S.A. § 841)

Responsiveness Summary

Comments by Rule Sections

Part One

Section 3.00 Definitions, Long-Term Care Services and Supports

Comment: This definition of long-term care services and supports here appears to differ from the definition in the Medicaid coverage rules at § 7601. Section 7601 seems to limit home and community based services to Choices for Care services. We continue to have concerns about the consolidation of all of the waiver programs under the rubric of long term care services and supports. We are opposed to the expansion of estate recovery to any waiver program that was not previously subject to estate recovery under Medicaid rule § 7108.3.

Response: The programs that are listed as "home and community-based services" under the definition of "long-term care services and supports" in § 3.00 of the Health Benefits Eligibility and Enrollment (HBEE) rule are the same programs that were listed under the definition of "waiver services" in the former Medicaid SSI Rule at 4201(K), and those waiver services were part of the definition of "long-term care" in the former Medicaid SSI Rule at 4201(G). Thus, there has been no change in the rule to the waiver programs that are under the rubric of long-term care services and supports. In the interest of clarity, this section has been revised so as to relate the list of waiver services to the preceding paragraph.

The Department of Vermont Health Access (DVHA) is currently reviewing the Medicaid coverage rule at 7601C in order to ensure accuracy and consistency, and the coverage rules will be open to comment. As part of its analysis, DVHA will also review which waiver programs are subject to estate recovery under Medicaid coverage rule 7108.3.

Part Three

Section 23.01(c)(5) Continuation coverage

Comment: This provision considers someone as eligible for minimum essential coverage during continuation coverage periods (i.e. COBRA/VIPER) only during the time that someone is covered. Although this is the best policy, it may be impermissible under federal guidance which has indicated that once an individual elects COBRA coverage, they must continue such coverage until open enrollment or other qualifying event. There could be negative impacts on consumers if they are found eligible for APTC by VHC, but are determined ineligible by the Internal Revenue Service.

Response: This provision is intended to explain that, when considering whether an individual is eligible to receive federal tax credits if they enroll in a qualified health plan (QHP), continuation coverage is only considered employer-sponsored minimum essential coverage (MEC) to that individual if the individual actually enrolls in the coverage (i.e. the individual is not considered eligible for employer-sponsored MEC and, therefore, ineligible for a premium tax credit, if they do not enroll in the continuation coverage).

Neither the referenced provision nor any of the other provisions under 23.01 do anything other than identify what is - and is not – considered as "being eligible for" government-sponsored MEC or employer-sponsored MEC for purposes of determining whether someone will be entitled to a premium tax credit if they enroll in a QHP.

Ineligibility for other MEC is only one factor in determining whether someone is eligible for a premium tax credit if they purchase a QHP. Therefore, it is unnecessary to revise this provision to include the circumstances under which a person who disenrolls from continuation coverage could or could not enroll in a QHP and potentially receive a tax credit. Those circumstances are made clear in the enrollment rules in Part Seven.

Part Four

Section 25.01 Transfer penalty

Comment: This section has been reorganized to more clearly specify the individuals that are subject to the transfer penalty evaluation process. We are opposed to any expansion of the transfer penalty to any waiver group that was not previously subject to this penalty.

What is the meaning of the reference to a "special income group (§ 8.05)" in the subsection below?

> *Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MABD and is part of a special income group (§ 8.05) or is medically needy (§ 8.06)*

This reference to a special income group under § 8.05 should be revised to more clearly reference the "special income level" eligibility groups under §§ 28.05(k)(3), (4) and (5) only.

Response: There has been no expansion of the waiver programs subject to transfer penalty analysis. As stated in the former Medicaid Spend Down Rule at 4470, the determination of whether transfers are allowable for purposes of Medicaid coverage of long-term care expenses applies to individuals who qualify for home-based waiver services. The services listed under the definition of "waiver services" in the former Medicaid SSI Rule at 4201K are the same as the services listed as home and community-based services under the definition of "long-term care services and supports" in § 3.00 of the HBEE rule.

The cross-reference to § 8.05 under § 25.01(a)(1)(iii) has been revised in response to the Comment.

Part Five

Section 28.04(a) MCA Medically Needy

Comment: This section is improved, but two issues could still be clarified. First, it should be clear that a responsible person's income will not be double-counted. The individual applicant's MAGI income may include the income of their spouse already, and that should not be counted twice. Second, please clarify how the spouse or other responsible person's income is determined. Is the individual's Modified Adjusted Gross Income used?

Response: Revisions have been made to the language in § 28.04(a) in an effort to improve clarity concerning the income calculation for an individual requesting medically-needy Medicaid for children and adults (MCA),

The income of an applicant's financially responsible family members is not double-counted. The calculation of the applicant's income starts by looking only at their own MAGI-based income, that is, their income calculated using the same methodologies as used to determine MAGI adjusted, if applicable, by the exceptions described in § 28.03(d). The medically needy MCA applicant's income does not include the income of their financially responsible family member until income is apportioned as described in § 28.04(b).

Section 30.00 Spenddown

Comment: Section 30.00(a) has the same issue as § 28.04(a). If the correct reference is to § 28.03 (rather than §28.03(d)), section 28.04 must be amended to prevent double-counting of income.

The spendown rules, including § 30.05 and § 30.06, are inconsistent in their definition of whose medical expenses can be used towards meeting a spenddown. We believe that the rule should consistently state that allowable medical expenses can come from any member of the individual's financial responsibility group. Since the Department is counting the income of the entire financial responsibility group, applicants should be able to count the whole household's medical expenses towards meeting the spenddown. Consistent with this principle, § 30.05 (b): defines allowable medical expenses as "medical expenses of any member of individual's financial responsibility group..."

In contrast however, § 30.06 (a) limits the medical expenses those that are the "current liability of the individual." Transportation expenses are also limited to the individual as opposed to the financial responsibility group. (§ 30.06 (c)(2)(B)).

At other places in this Section, expenses are attributed to the whole financial responsibility group.

Health care insurance expenses (§ 30.06 (b)) and expenses not covered by Medicaid. (§ 30.06 (c)) are attributable to the individual or a member of the individual's financial responsibility group. Over the counter drugs can also be attributed to the individual or the individual's financial responsibility group (§ 30.06 (c)(1)(ii)).

It is not clear why the Department would apply different standards to the different types of medical expenses. The rules in this section should consistently count the expenses from the whole financial responsibility group towards the spenddown.

Response: The cross-reference in the second paragraph of § 30.00(a) should be to § 28.03(d) not § 28.03, and the cross-reference has been revised accordingly.

As to income spenddown, the rule is not meant to apply different standards to different types of medical expenses. The income spenddown rules should be consistent with the principle stated in § 30.05(b).

As such, in response to the Comment, the references to "the financial responsibility group" in §§ 30.06(b)(1) and 30.06(c) are being removed thereby allowing the general principle in § 30.05(b) to apply throughout these sections. However, removal of the reference to "the financial responsibility group" in § 30.06(c)(1)(ii)(A) is inappropriate in that the term is needed to provide correct context.

Part Six

General comment

Comment: We continue to struggle with how best to respond to these rules in light of the fact that there is currently no operational VHC operated SHOP. Additionally, it appears that small groups are allowed to direct enroll in a QHP with health plans indefinitely. 33 V.S.A. § 1811(b)(2). As such, it may be beneficial for this portion of the rules to begin to explicitly acknowledge the differences between requirements applicable to enrollments and billing transactions conducted through the VHC web portal (when functional) and those enrollment and billing transactions conducted with the health plans directly.

Response: Direct enrollment in small group QHPs will continue in 2016. Therefore, some of the proposed revisions to this Part related to the obligations of Vermont Health Connect (VHC) when terminating small group coverage are being withdrawn. These provisions will be revisited as VHC small business functionality is developed. At the same time, a number of changes are being made that are necessary in order to align this Part with recently-issued federal regulations related to the Small Business Health Options Program (SHOP).

Section 31.00 Definition: Annual employee open enrollment period

Comment: This section lays out a concept of the annual employee period that does not reflect existing direct enrollment processes. We ask that this definition be clarified to ensure that it clearly is intended to only apply to VHC SHOP enrollment processes.

Response: The definition has been clarified.

Section 32.00(a) Employer's continuing eligibility

Comment: This is a good example of a provision that could be clarified to apply to both a direct enrollment situation and an enrollment through VHC. In the situation where an employer grows to a size that qualifies them as a large employer, is it the intent to allow the employer to choose which market (large group or small group) in which the employer wants to participate? An obvious issue with this approach would be that it will increase adverse selection in the community rated risk pool. An additional issue that arises is when an employer is transitioning in market size at different times during the year; we assume market size is determined based on the previous year and is consistent for the entire 12-month plan year so long as the coverage remains in effect. We would appreciate clarification on these points.

Response: Under this rule, VHC cannot terminate coverage for an employer group solely because it gains additional employees. It would be at the employer's discretion to withdraw from VHC in accordance with applicable rules and move into the large group market.

Similarly, in the context of direct enrollment, an employer would be able to maintain enrollment in the QHP for the duration of the plan year during which it increases size. An employer's size is based on the number of employees during the previous calendar year.

No changes to the language of this section were made in order preserve alignment with the corresponding federal rule.

Section 36.00 Short plan years

Comment: This section could be updated, now that the initial transition period is complete.

For the larger groups that will transition into calendar year plans in 2016 (when they become small groups), BCBSVT would like to have the flexibility to carry the cost share accumulated during the 2015 plan year into the end of the new 2016 plan year and reset the cost share on January 1, 2016, along with the other groups.

As such, we ask that the following language replace the current 36.00(c):

> *(c) Issuers may provide transitional relief to employers renewing during the 2015 plan year which may have a short plan year as a result of becoming a small group, by extending costs share accumulators.*

Response: This section has been revised to remove outdated references and to group the provisions relating to rolling enrollment, calendar plan years, and short plan years. Language has been added to allow for the suggested transitional relief for employers becoming small employers in 2016.

Section 37.00 Employer election period

Comment: With the new small groups (51-100) entering the market in 2016, some acknowledgement of that transition could be helpful in this section (for example, in 37.00(a)).

Response: The small employer transition has been referenced in the previous section. This section has been revised to remove the redundant provisions now located in 36.00.

37.00(a) has also been amended to align with federal rule and to remove the specific timeframe for the annual employer election period in light of Comments received on 38.00(b) that the open enrollment framework is not consistent with current practice in the small group market.

Section 38.00(b)

Comment: This section provides that annual open enrollment for small groups will begin on November 15. In light of the ever changing law, and the difficulties imposed on employers and employees by forcing them into an arbitrary open enrollment period, we recommend deleting this section or making it more flexible. The most important element of the open enrollment rules, as applied to small groups, is that employees have at least 30 days to pick a plan for the upcoming plan year. There are minimal, if any, benefits to the healthcare system to force employees to make this decision between November 15 and December 15. Although we acknowledge the potential limits of federal law, we believe the rule should continue to support the most employer/employee friendly approach which is to allow plan selections once plans are available for purchase at any time prior to December 31. Deleting this provision allows maximum flexibility.[1]

[1] *We also question the applicability of this provision in light of the recently proposed changes to federal regulation. 79 Fed. Reg. 70674 (November 26, 2014) (proposing amendments to 45 C.F.R. 155.725).*

Response: The language of this section has been amended to align with the federal regulations. No matter how they enroll in coverage, qualified employees must be provided an annual enrollment period prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

Section 39.00: Special enrollment periods

Comment: We trust that the special enrollment periods granted in this rule are consistent with other federal rules applicable to group QHP plans. As we have discussed before, we believe that there may be some risk to employees and employers if special enrollment rules are inconsistent with federal law pertaining to Section 125 plans.

Response: This section remains as drafted since it derives directly from the federal rules for special enrollment periods in the SHOP.

Section 40.00(a) Enrollment

Comment: In subsection (1) and subsection (3), periods are missing at the end of the sentences.

Response: Punctuation corrections have been made.

Section 40.00(b) New Enrollments

Comment: This provision allows employees until the last day of the month prior to the effective date of coverage to choose a plan. BCBSVT supports this proposal. We would like some language in the rule,

however, acknowledging that if the decision is communicated to an issuer after the effective date of coverage, there will be a delay in the effectuation of coverage and the sending of materials. We suggest: "For plan selections received by VHC within the last five days of the month, VHC shall transmit the plan selection and issuers shall effectuate coverage without undue delay, although qualified employees may not have coverage effectuated by the first of the month, although such coverage shall be retroactively effectuated."

We also suggest examining the desirability (and capacity) for VHC to support employer selected coverage effective dates. Not all employers provide coverage effective on the first day of the month and more generous benefits ideally would be supported by VHC as they are supported in the direct enroll small group market today.

Response: This section has been revised to align with recently-modified federal rules related to effective dates of coverage for newly qualified employees. The proposal that QHP selection can be received up until the last day of the month prior to the effective date has been preserved. Language has been added to allow for later and retroactive effectuation for enrollments received in the latter part of the prior month.

Section 41.00(a) Coverage effective dates, Generally

Comment: We suggest changing "when full payment is received by the due date" to "provided full payment is received by VHC by the due date" so that it is clear that a prerequisite of effective coverage is the receipt of payment and that such payment needs to be received by VHC, not necessarily the issuer.

Response: The rule has been clarified.

Section 41.00(b) Coverage effective dates for plan years beginning on or after January 1, 2015

Comment: This section provides that coverage shall be effective by January 1, if the plan selection is received by November 30. We understand that VHC rules do not prohibit a more generous effective date process than that provided for by rule. However, we suggest adding the following language to make that explicit: "Nothing in this subsection shall prevent issuers to effectuate January 1 coverage effective dates for plan selections received after November 30."

Response: Language clarifying that coverage may be effectuated in a shorter timeframe for those directly enrolling in QHPs has been added.

Section 43.00(a) Terminations

Comment: We believe that enrollment and billing timeframes should be incorporated into the HBEE rule. Alternately, AHS must develop a system for notifying the public of operational guidance and other subregulatory guidance when it is issued. Also, any guidance relating to the HBEE rule should be available to the public on the AHS website where the HBEE rule is posted.

Response: This reference has been removed pending development of VHC small business functionality.

Section 43.00(a)(2) Terminations, In general

Comment: This provision notes that VHC shall publish an operational document describing enrollment and premium billing timelines for QHPs. Although ultimately, we believe enrollment and billing timelines should be in the rule, we understand the operational challenges associated with specifying them in the rule at this time. We note that billing and enrollment deadlines are likely to be different in the group market than in the individual market. Finally, we note that it is imperative that issuers be involved in the enrollment and billing timelines development. The failure to involve the issuer community in the development of the previous timelines led to numerous operational challenges. We ask that the following language be added to the end of 43.00(a)(2): "Such enrollment and billing timelines shall be developed with meaningful participation from interested stakeholders, including small businesses and issuers."

Response: This reference has been removed pending the development of VHC small business functionality.

Section 43.01(a)(2) Employer withdrawal

Comment: This section provides that VHC shall notify issuers "promptly" of an employer withdrawal from the SHOP. We request that this notification occur within 3 days of receipt, as there are numerous steps that must occur in order to terminate group coverage in an orderly manner. Long delays put both small groups and their employees at risk, as well as issuers.

Response: This reference has been removed pending the development of VHC small business functionality.

Sections 43.01(b) and 43.02(c) SHOP notices to employees

Comment: If an employer withdraws from a QHP, or if an issuer terminates an employer's QHP coverage, the proposed rule requires 30 days' advance notice to the employees. We are concerned that this timeframe is not sufficient to allow employees to apply for and enroll in a new QHP through VHC without a gap in coverage. Individuals must select a plan by the 15th of the month in order to get coverage for the following month. Because of this, under the proposed rule employees really are getting about two weeks' notice. We believe the required notice period in these rule sections should be 60 days.

Response: With respect to noticing in the case of employer withdrawal from VHC at 43.01(b), the specific timeframe has been removed pending the development of VHC small business functionality.

With respect to noticing in the case of nonpayment of premium at 43.02(c), this was displaced by recently-released federal guidance which has been incorporated at 43.06. Roles, responsibilities, and timing for this noticing requirement will be addressed upon development of VHC small business functionality.

Section 43.01(b)(1) Employee notice of termination

Comment: This should read "Each QHP issuer terminates" instead of "Each QHP terminates."

Response: This typographical error has been corrected.

Section 43.01(b)(2) Employee notice of termination

Comment: We support these new provisions as being consistent with current practice and current Vermont law. However, in the event that, at the employer's directive, VHC coverage is being replaced by new coverage (i.e. employees are not facing a gap in coverage) we do not believe the provisions of 43.01(b)(2) are as applicable. We suggest adding a new section (b)(3) providing "In the event an employer is replacing coverage with new coverage, the provisions of (b)(2) above shall not apply. In the event of replacement of coverage, issuers shall notify employees and employers of the effective date of the termination of the current coverage."

Response: The Comment will be considered during the process of developing VHC small business functionality.

Section 43.01(b)(c) Termination Effective Date

Comment: This provides that the last day of coverage is the last day of the month provided that employees have received 30 days notice. However, if notice of termination can't go out on the 1st day of the month due to issues outside of the issuers (or VHC's) control, employees could be entitled to almost two months of coverage without corresponding premium. We believe coverage should be terminated 30 days following the date of the notice. Otherwise, employees could receive up to two months of coverage. Note that the existence of this coverage could prevent employees from getting other coverage or subsidies.

Response: This provision has been removed and the addition of the language will be revisited during the process of developing VHC small business functionality.

Section 43.02(a)(1) Conditions under which QHP issuer may terminate coverage

Comment: This provision states that VHC will notify issuers "promptly" about an employer failing to pay its premiums. We ask that this be changed to 48 hours. Long delays will create undue financial strain on the system and "promptly" is too vague.

Response: This provision has been removed and the addition of the language will be revisited during the process of developing VHC small business functionality.

Section 43.02(d)(2) Reinstatement

Comment: This section provides that employers cannot reenroll after two terminations for non-payment until the next open enrollment period. However, new federal regulations may allow for employers to enroll throughout the year, even in a merged market. As such, maybe this should say "until the next calendar year" instead of "during the next open enrollment period."

Response: The text has been revised accordingly.

Section 43.03(a)(2) Termination due to loss of eligibility

Comment: This section provides that coverage being terminated for loss of eligibility shall be on the last day of the month in which VHC receives notice of the loss of eligibility. However, this may not be true in all situations (such as death or termination of employment). Note that an employer is responsible for premium for coverage until such coverage is terminated. The coverage should be terminated on the date of the loss of eligibility or such later date as provided for by the employer.

Response: This provision has been removed and the addition of the language will be revisited during the process of developing VHC small business functionality.

Part Seven

Section 64.00(i) Premium requirement for partial coverage month

Comment: This section clarifies how premium shall be calculated when coverage is provided for a partial month. Does this same formula apply to APTC or VPA? Clarifying this would be helpful.

Response: The prorating rules apply to the advance premium tax credits (APTC) and the Vermont Premium Reduction for partial months of coverage, and the text of the rule has been clarified to reflect that.

Section 64.04(d) Enrollment and billing timelines

Comment: We believe that enrollment and billing timeframes should be incorporated into the HBEE rule. Alternately, AHS must develop a system for notifying the public of operational guidance and other subregulatory guidance when it is issued. Also, any guidance relating to the HBEE rule should be available to the public on the AHS website where the HBEE rule is posted.

Response: Comment will be solicited on billing and enrollment guidance.

Section 64.04(d) Ongoing premium billing and payment

Comment: This section notes that AHS periodically publishes an operational document describing enrollment and premium billing timelines for QHPs. However, we believe that it is unfair to stakeholders to have billing processes and related changes made without any public process. We respectfully request that AHS commit in these rules to some public input process prior to the publication of such guidelines.

Response: Comment will be solicited on billing and enrollment guidance.

Section 64.05(a) Single-premium obligation

Comment: The new proposed language reads: "When there is only a single premium obligation, payment of the full amount due is required to maintain coverage and eligibility. A payment of less than the full amount will be considered by AHS as nonpayment." We have two comments.

First, what is a "single premium obligation"?

Second, as we have stated numerous times previously, we believe that some partial payment tolerance should be allowed. Currently, a discrepancy of one penny can result in a disastrous results for a consumer. With bills not reliably accurate and consumers caught in the middle, we believe a reasonable partial payment tolerance amount best serves all involved.

Response: In response to the first part of the Comment, a single premium obligation means that only one type of premium is owed. It may be a premium for coverage in Medicaid's Dr. Dynasaur program or it may a premium for coverage in a QHP, but it will not be both. When there is more than one type of premium owed (for example, both a premium for Dr. Dynasaur coverage and a premium for QHP coverage), that is a "multiple-premium obligation."

As stated in the HBEE rule at § 64.05(a), in a situation when there is only one type of premium owed (a "single premium obligation"), an individual must pay the full amount due in order to maintain their coverage. Any payment that is less than the full amount due is considered non-payment.

Section 71.03 Special Enrollment Periods

Comment: An individual should be entitled to a special enrollment period (SEP) to purchase a catastrophic plan if he or she is newly eligible for a catastrophic plan due to receipt of an exemption certificate from HHS. We believe individuals in this situation are currently being offered an SEP, but this policy should be explicit in the rule at § 71.03(d)(9).

Response: The rule has been clarified in response to the Comment.

Section 75.02 Renewals

Comment: We appreciate that VHC attempted to determine 2015 APTC eligibility as accurately as possible when making renewal determinations this past fall. We support that approach in the future, and we urge VHC to commit its renewals process to that goal rather than leaving the rules vague. The proposed rule does not inform the public or beneficiaries of the renewal process that may be used. VHC currently has no sub-regulatory guidance system by which to inform the public when it makes such a decision.

VHC should check all data sources available when making renewal determinations. VHC should send out notices (at least to current APTC beneficiaries) with the latest eligibility information available, with a response form. Notices must give consumers enough information to know if VHC has incorrect or outdated information.

Response: Federal rules give state exchanges the flexibility to propose a state-specific renewals process for approval by the U.S. Department of Health and Human Services (HHS). Any such proposal will be shared with stakeholders. Irrespective of an alternative renewals process, these rules require that eligibility be redetermined annually using the most recently-reported enrollee information.

Section 76.00(b)(1)(i) Enrollee-initiated terminations

Comment: This section provides that enrollees can terminate their coverage at any time by notifying VHC or the QHP issuer. This is inconsistent with other guidance from VHC to issuers. Issuers are only allowed to terminate coverage for nonpayment of premium. Issuers cannot effectuate a termination for other reasons. Both from an IT perspective and from an operations perspective, there is no infrastructure in place to support this provision and, as such, this is misleading to consumers and problematic for issuers. Please remove the reference "or the QHP issuer." If VHC would like such a process to exist, BCBSVT is willing to work with VHC and other stakeholders to create a procedure, although IT costs would need to be examined.

Response: The rule has been revised in response to the Comment.

Section 76.00(c)(3) Termination of coverage tracking and approval

Comment: This section requires QHP issuers to make reasonable accommodations to individuals with disabilities prior to terminating coverage. However, VHC controls terminations. Does this mean that QHP issuers are not supposed to process VHC terminations without additional investigation? This is not operationally feasible, nor does it make good policy sense. Further, it's entirely unclear what this provision is intended to accomplish. We ask that this provision be stricken or that it be applicable to VHC, not issuers. We understand that this provision comes from federal law; however, with VHC assuming all termination responsibilities except for non-payment (unlike the federal model), this provision doesn't apply to issuers. VHC needs to assume ADA accommodations responsibility in the event of a termination as it is the entity that has this authority. As an alternative, this could be amended to provide "for nonpayment" after "terminating coverage" in the final line of the section. We do note, however, that we continue to be uncertain what expectations are pertaining to this section even if a termination is for nonpayment.

Response: There is no flexibility to waive the federal requirement. As stated in the preamble for the corresponding federal rule, "QHP issuers must create standards to accommodate all individuals with disabilities when terminating such individuals' coverage." Individuals with disabilities are defined as "those groups identified under the Americans with Disabilities Act." 77 FR 18310, 18395.

Moreover, VHC does not follow a different terminations model than the Federally-facilitated Marketplace. (To date, VHC terminations have largely been related to non-payment, but this rule contemplates the broader universe of terminations, including those due to lack of eligibility.) Consistent with federal rules, VHC will transmit termination information to the QHP issuer. 45 CFR 155.430(c)(2). The QHP issuer must then make reasonable accommodations, if necessary, when terminating the individual from coverage.

Section 77.00(f) Reduction of individual's portion of premium to account for APTC

Comment: This section generally provides that a premium bill shall be reduced by selected APTC. We have a few comments on this section.

First, this section provides that the premium bill will be reduced if "a QHP issuer or stand-alone dental plan has been notified it will receive APTC". However, AHS makes this determination and AHS determines what the bill will reflect. As such, the trigger for a bill reduction should be an AHS determination of the

eligibility for a premium tax credit and then individual's decision to accept some or all of it in advance. Notice to the issuer is not relevant to the need for a bill reflecting the tax credit.

Second, we recommend adding references to Vermont premium assistance in this section; such amounts are also reflected on the premium bills.

Response: The rule has been revised in response to the Comment.

Section 77.00(g) Failure to reduce individual's premiums to account for APTC

Comment: This section provides that if AHS failed to accurately account for a tax credit on the premium bill, AHS will notify the individual of the failure within 45 days of the discovery of the error. This seems to be an excessively long period of time, particularly when individual billing errors can be quite dramatic. We strongly recommend that AHS commit to a much shorter time frame, such as ten calendar days.

We also recommend that this section also refer to Vermont premium assistance.

Response: The federal 45-day timeframe will be maintained as an outside limit. The suggested reference to the Vermont Premium Reduction has been made.

Part Eight

Section 80.02(b) Requesting a fair hearing and 80.07(a) Expedited appeals

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. Distinguishing the appeal process based on benefits as proposed will likely confuse beneficiaries, authorized representatives, and providers. We strongly favor a unified application process for all applicants, which should include an across-the-board appeals process. We believe this would further Vermont's goal of maximizing health coverage.

For those same reasons, we also disagree with the proposed change to exclude cases dealing with MCA coverage of long-term care services and supports.

Response: The suggestion that expedited appeals be made available in cases of Medicaid for the aged, blind and disabled (MABD) is outside the scope of the revisions being proposed to the HBEE rule at this time. Further guidance on the issue may be obtained if the Centers for Medicare and Medicaid Services (CMS) finalizes its proposed Medicaid regulation on expedited appeals. At the moment, however, the Comment does not address directly the rule being proposed.

The replacement of "QHP or MAGI based Medicaid" with "QHP or MCA, other than coverage of long-term care services and supports under MCA" is for clarification and reflective of pre-existing policy that expedited appeals are only available in QHP and MCA-based community Medicaid cases.

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

Comment: We would strike the last sentence of this section: "These 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, and they are often fact-specific, 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: The Comment is outside the scope of the revisions being proposed to the HBEE rule at this time. Expedited appeal decisions are not precedent within the rule of *stare decisis* or as persuasive authority.

Summary of Changes

In addition to the changes being made in Health Benefits Eligibility and Enrollment (HBEE) final proposed rule in response to public comments, additional changes are being made 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 following is a list of these additional changes and the reasons for them. All changes being made in the HBEE final proposed rule are identified in gray highlight in the annotated version of the final proposed rule being filed contemporaneously herewith.

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

PART ONE

Section 2.01(a) – To correct technical error, delete "," after "circumstances"

Section 3.00/definition of "Long-term care" – To provide clarification, replace "authorizations, go to:" with "governing terms and conditions, see:"

Section 3.00/definition of "Long-term care services and supports" – To provide clarification, replace "and" with "or in" at end of first paragraph of text and "authorizations, go to:" with "governing terms and conditions, see:" in last paragraph of text

Section 5.01(c)(3)(iv) – To align with federal regulation, add "website translations" as a fourth language service

Section 5.04(b) – To correct technical error, delete second "," after "assistance" on third line of text

PART TWO

Section 6.00(b)(5) – To correct technical error, add "and" at end of text

Section 7.03(a)(5)(i) – To correct technical error, delete "," after "individual"

Section 8.05(k)(6) – To correct technical error, change "An" to "A" at beginning of text

Section 9.03(b)(2)(i) – To correct technical error, change cross-reference from 17.02 "(c)" to 17.02 "(d)" at end of text

PART THREE

Section 16.01 – To correct technical error, delete second cross-reference in footnote

Section 16.01(b)(1) – To correct technical error, change cross-reference from paragraph "(a)" to paragraph "(a)(1)"

Section 16.01(b)(1)(iii) – To align with federal regulation and improve clarity, add provision to end of text to explain meaning of "well-established religious objection"

Section 16.01(b)(2) – To improve clarity, insert "Medicaid" before "identification number" at beginning of text

Section 23.01(b)(1)(i) – To improve clarity, add language to end of text and cross-reference to related HBEE rule provision explaining that an individual's eligibility for Medicare part A is not eligibility for government-sponsored MEC for purposes of APTC eligibility if the individual must pay a premium for their part A coverage and chooses not to enroll

Section 23.01(b)(1)(ii) – To align with federal regulation and guidance, add language to end of text (via paragraphs (A) through (D)) listing the types of Medicaid coverage eligibility for which is not considered eligibility for government-sponsored MEC for purposes of APTC eligibility

Section 23.01(e)(5) – To align with federal guidance, add new provision, including footnote with cross-reference to IRS's notice, identifying Medicaid coverage for a pregnant woman enrolled in a QHP as government-sponsored MEC, for purposes of APTC eligibility, only if the woman is enrolled in the coverage

Section 23.06(b)(7)(iv)(B) – To correct technical error, change "(vi)" to "(iv)" at end of first line of text

Section 23.06(b)(7)(iv)(D) – To align with federal regulation, add new provision to allow an individual to claim exemption through IRS instead of from AHS

Section 23.06(b)(7)(v) – To provide clarification, delete existing text in its entirety since the IOEP has passed

Section 23.06(b)(7)(v) – To align with federal regulation, add new provision to allow an individual to claim a "filing threshold" exemption through IRS

Section 23.06(b)(7)(vi) – To align with federal regulation, add new provision to allow an individual to claim an exemption through IRS for "self-only coverage in an eligible employer-sponsored plan"

Section 23.06(b)(7)(vii) – To align with federal guidance, add new provision to allow an individual to obtain an exemption from AHS if the individual becomes eligible for Medicaid coverage as medically needy only after meeting a spenddown

Section 23.06(c)(4)(iii) – To provide clarification, delete existing text in its entirety since October 15, 2014 has passed

Section 23.06(d)(3)(ii) – To correct technical error, add "." at end of text

Section 23.06(d)(6)(iii) – To correct technical error, change "(vi)" to "(iv)" at end of third line of text and in middle of fifth line of text

Section 23.06(h)(1) – To provide clarification, revise provision to explain the appeal process when an eligibility determination is made by HHS

Section 23.06(h)(2) – To provide clarification, revise provision so it applies to eligibility determinations made by AHS

PART FOUR

Section 24.01(a) – To align with revisions being made to Section 25.01(a)(1)(iii) in response to comment, change "as part of" to "under" on third line of second paragraph, add "coverage" between "income" and "group" on fourth line of second paragraph, and narrow cross-reference to Section 8.05 by adding "(k)"

Section 25.01(a)(1)(iii) – To correct technical error, change ":" to "." at end of text

PART FIVE

Section 29.15 – To correct technical error, change effective date and rule number in title (since revisions were made to this section in the proposed rule, the effective date and rule number in the title should have been "04/28/2015, 15-02P")

Section 30.05(d)(3) – To correct technical error, add "," after "§ 30.06" on first line of text

PART SIX

Section 33.00(a) – To align with federal regulation and clarify related citations, add language to text at (a)(1) and to footnote

Section 35.00 – To provide current authority, update citation in footnote

Section 36.00(b) – For clarity and to group related provisions together, move provision formerly at Section 37.00(c) to Section 36.00(b)

Section 38.00(d) – To align with federal regulation, add language to text clarifying the timing of the enrollment period for newly qualified employees

Section 40.00(b) – To align with federal rule, add language to (b)(1)

Section 41.00 – To align with federal rule, update citations in footnote

Section 41.00(a) – For clarity, add (a)(3) to reference revised 40.00(b)(1)

Section 43.02 – To align with federal regulation, remove subsections (b) and (c) and cross-references thereto (noticing requirements are now located in 43.06)

Section 43.02(e) – To align with federal regulation, add subsection (e) on payment for COBRA continuation coverage

Section 43.06 – To align with federal regulation, add new provision establishing requirements for notice of termination

PART SEVEN

Section 56.03(b)(3) – To align with federal regulation, replace the "individual attests" with the "individual's attestation indicates" on first line of text

Section 56.06 – To correct technical error, replace "is" with "are" at end of second line of title

Section 56.07 – To correct technical error, replace "is" with "are" in title

Section 56.08(a) – To correct technical error, replace "indicates" with "indicate" in title

Section 57.00(e) – To correct technical error, replace "is" with "are" on third line of title

Section 64.06(b)(1)(ii)(B) – To correct technical error, add "." at end of text

Section 65.01(a) – To correct technical error, change cross-reference from § 1916 "(c)" to § 1916 "(e)"

Section 65.02(a) – To clarify policy, revise provision to narrow the population of long-term care Medicaid enrollees from whom copayments are never required (population is limited to enrollees living in long-term care facilities since copayments may be required from individuals living in home and community-based settings)

Section 68.01(b)(3) footnote – To correct technical error, add ")" at end of footnote

Section 71.03(b)(2)(i) – To align with federal regulation, add provision at end of text that allows an individual to elect a regular effective date

Section 71.03(b)(2)(iii) – To align with federal regulation, delete cross-reference to "(d)(10)" (as identified below, to align with federal regulation text of (d)(10) is being merged with text of (d)(4) and (d)(10) is being deleted)

Section 71.03(b)(2)(v) – To align with federal regulation, add new provision stating special effective date for enrollment in cases involving court orders

Section 71.03(b)(2)(vi) – To align with federal regulation, add new provision stating special effective date for enrollment in cases involving the death of enrollees or their dependents

Section 71.03(b)(2)(vii) – To align with federal regulation, add new provision stating special effective date for enrollment in cases involving permanent moves

Section 71.03(c)(2) – To align with federal regulation, replace "Advance" with "Advanced" in title

Section 71.03(c)(2) – To align with federal regulation, combine text from prior (i) and (ii), add cross reference to "(d)(7)," replace "loss of coverage" with "triggering event" and delete (ii) in its entirety

Section 71.03(c)(3) – To align with federal regulation, delete cross-reference to "(d)(10)" (as identified below, to align with federal regulation text of (d)(10) is being merged with text of (d)(4) and (d)(10) is being deleted)

Section 71.03(d)(1)(ii) – To align with federal regulation, revise provision to eliminate reference to non-calendar year policies that expired in 2014

Section 71.03(d)(1)(iii) – To improve clarity, delete provision in its entirety (since pregnancy-related Medicaid coverage is MEC, (d)(1)(i) is the applicable triggering event for loss of this coverage)

Section 71.03(d)(2) – To improve clarity, add title and divide text into 2 parts – (i) and (ii) – as identified below

Section 71.03(d)(2)(i) – To align with federal regulation, add provision at end of text to include gaining a dependent through child support order or other court order; to improve clarity, add footnote cross-referencing to state statute

Section 71.03(d)(2)(ii) – To align with federal regulation, add new provision to include loss of dependent through divorce, legal separation or death.

Section 71.03(d)(4) – To align with federal regulation, add language to text from 71.03(d)(10) (text of (d)(10) is being merged with (d)(4) and (d)(10) is being deleted)

Section 71.03(d)(9)(i) – To align with federal regulation, delete provision in its entirety (provision is being merged with (d)(4))

Section 71.03(d)(10) – To align with federal regulation, delete provision in its entirety (provision is being merged with (d)(4))

Section 71.03(d)(11) – To align with federal regulation, delete provision in its entirety (provision, including footnote, is being merged with (d)(2)(i))

Section 71.03(e)(1) – To align with revisions under Section 71.03(d)(1), replace cross-reference to (d)(1)(ii) "through (iv)" with (d)(1)(ii) "and (iii)" on third line of text

Section 76.00 – To align with federal regulation, insert "enrollment or" before "coverage" in title

Section 76.00(a) – To align with federal regulation, replace "coverage" with "enrollment" on first line of text

Section 76.00(b)(1)(i) – To align with federal regulation, insert "or enrollment" after "coverage" on first line of text

Section 76.00(b)(1)(ii) – To align with federal regulation, replace "coverage" with "enrollment" on next to last line of text

Section 76.00(b)(1)(iii) – To align with federal regulation, add new provision for AHS to establish a process for someone to report the death of an enrollee

Section 76.00(b)(2) – To align with federal regulation, replace "coverage" with "enrollment" on first line of text, and insert "or enrollment" after "coverage" on second line of text

Section 76.00(c) – To align with federal regulation, insert "or enrollment" after "coverage" in title

Section 76.00(c)(1) – To align with federal regulation, replace "coverage" with "enrollment" at end of text

Section 76.00(c)(3) – To align with federal regulation, replace "coverage for" with "enrollment of" in last line of text

Section 76.00(d) – To align with federal regulation, add "or enrollment" at end of title

Section 76.00(d)(2) – To align with federal regulation, replace "coverage" with "enrollment" on second line of text

Section 76.00(d)(3) – To align with federal regulation, replace "coverage" with "enrollment" on second line of text

Section 76.00(d)(4) – To align with federal regulation, replace "coverage" with "enrollment" on second line of text

Section 76.00(d)(5) – To align with federal regulation, replace "coverage" with "enrollment" on second line of text

Section 76.00(d)(6) – To align with federal regulation, delete last sentence of text in its entirety (text being moved to its own provision at (d)(8))

Section 76.00(d)(7) – To align with federal regulation, replace "coverage" with "enrollment" on second line of text

Section 76.00(d)(8) – To align with federal regulation, add new provision (being moved from last sentence of (d)(6))

Section 76.00(e)(1) – To align with federal regulation, replace "coverage" with "enrollment" on second line of text, and replace "covered by the issuer" with "enrolled in coverage through VHC" at end of text

Section 76.00(e)(2) – To align with federal regulation, replace "coverage" with "such enrollment" at beginning of third line of text, replace "coverage" with "enrollment' at end of third line of text, and delete "with the QHP" at end of text

PART EIGHT

Part Eight – To improve clarity, add "expedited administrative" before "appeals" in title to part

Section 80.00 – To improve clarity, add "administrative" before "appeals" in title

Section 80.01/definition of "Fair hearing request" – To improve clarity, delete "appeal" after "fair hearing request" in title, replace "fair hearing entity" with "the AHS Human Services Board" at end of first sentence of text, and add "administrative" before "appeal" in fifth line of text

Section 80.01/definition of "Fair hearings entity" – To improve clarity, add "The Human Services Board, the" at beginning of text, add "by law" after "designated" in first line of text, add "administrative" before "appeals" in fourth line of text; to remove redundancy, delete "AHS's fair hearing entity for eligibility issues is the Human Services Board."

Section 80.02 – To improve clarity, delete "fair" before "hearing" in title

Section 80.02(a) – To improve clarity, replace "Appeals, except expedited appeals pursuant to § 80.07," with "Fair hearings" at beginning of text; to provide consistency, replace "V.S.A." with "VSA" in last line of text

Section 80.02(b) – To correct technical error, delete "by" in fifth line of text; to improve clarity add "administrative" before "appeal" in tenth line of text and before "appeals" in thirteenth line of text

Section 80.02(c) – To improve clarity, add "and their right to request an expedited administrative appeal pursuant to § 80.07" at end of text

Section 80.03(a) – To improve clarity, delete "fair" before "hearing" in first line of text

Section 80.03(c) – To improve clarity, add "or an expedited administrative appeal" after "hearing" in first line of text and replace "fair hearing request" with "appeal" in fourth line of text

Section 80.05 – To correct technical error, replace "secretary" with "Secretary" in title

Section 80.05(a) – To correct technical error, replace "secretary" with "Secretary" in title and in first, third, fourteenth, fifteenth, seventeenth, and twentieth lines of text

Section 80.05(b) – To correct technical error, replace "secretary's" with "Secretary's" in title and in fifth and seventh lines of text, replace "secretary" with "Secretary" in third line of text and replace "supreme court" with "Supreme Court" in third, fifth, and seventh lines of text

Section 80.05(c)(1) – To correct technical error, replace "secretary's" with "Secretary's" in fourth line of text

Section 80.05(c)(1)(ii) and (iii) – To correct technical error, delete "and" at end of (ii) and insert "and" at end of (iii)

Section 80.06 – To improve clarity, replace "appeal" with "fair hearing" in title

Section 80.07 – To improve clarity, add "administrative" before "appeals" in title

Section 80.07(a) – To improve clarity, add "administrative" before appeals in first line of text

Section 80.07(a)(1) – To provide consistency, replace "shall" with "will" in first line of text; to improve clarity add "administrative" before "appeal" in second line of text

Section 80.07(a)(2) – To provide clarification that this text applies to expedited administrative appeals, add new subsection to state, "AHS will assist the individual requesting the expedited administrative appeal, if asked, and will not limit or interfere with the individual's right to appeal."

Section 80.07(a)(3)(former 80.07(a)(2)) – To provide consistency, replace "shall" with "will" in second and seventh lines of text; to improve clarity, add "administrative" before "appeal" in second and fifth lines of text

Section 80.07(a)(4)(former 80.07(a)(3)) – To improve clarity, add "administrative" before "appeal" in second, fourth, and fifth lines of text

Section 80.07(a)(5) – To provide clarification that this text applies to expedited administrative appeals, add new subsection to state, "AHS will treat the scope of the expedited administrative appeal as set forth at § 80.04(d)."

Section 80.07(b) – To improve clarity, replace "expedited appeals" with "an expedited administrative appeal" in title and add "administrative" before "appeal" in second, third, fifth and last lines of text; to provide consistency, replace "shall" with "will" in fourth line of text

Section 80.07(c) – To improve clarity, replace "expedited appeal requests" with "an expedited administrative appeal request"

Section 80.07(c)(1) – To improve clarity, add "administrative" before "appeal" in second, seventh and tenth lines of text and before "appeals" in fifth line of text; to clarify that oral communications are by telephone, replace "oral" with "telephonic" in sixth, twelfth and thirteenth lines of text

Section 80.07(d) – To improve clarity, replace "expedited appeals" with "an expedited administrative appeal" in title

Section 80.07(d)(1) – To improve clarity, add "administrative" before "appeal" in second, fifth and sixth lines of text; to clarify that oral communications are by telephone, replace "orally" with "telephonically" in fifth line of text and "oral" with "telephonic" in the eighth and tenth lines of text

Section 80.07(d)(1)(iv) - To improve clarity, add "administrative" before "appeal" in first, fourth and last lines of text

Section 80.07(d)(2) - To improve clarity, add "administrative" before "appeal" in second line of text

Section 80.07(d)(2)(i) - To improve clarity, add "administrative" before "appeal" in second and third lines of text

Section 80.07(d)(2)(ii) - To clarify that oral communications are by telephone, replace "orally" with "telephonically" in first line of text; to improve clarity, add "administrative" before "appeal" in second line of text

Section 80.07(d)(2)(iii) - To clarify that oral communications are by telephone, replace "orally" with "telephonically" in second line of text; to improve clarity, add "expedited administrative" before "appeal" in third line of text

Section 80.07(d)(2)(v) - To improve clarity, add "expedited administrative" before "appeal" in second line of text

Section 80.07(d)(3) – To improve clarity, add "expedited administrative" before "appeal" in second and eleventh lines of text, "administrative" before "appeal" in fourteenth line of text and replace "pursuant to" with "within the meaning of" before "3 VSA § 3091"

Section 80.07(d)(5) - To improve clarity, add "administrative" before "appeal" in first and third lines of text

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Amendment to the Health Benefits Eligibility and Enrollment Final Proposed Rule
June 30, 2015

The Legislative Committee on Administrative Rules (LCAR) approved the Health Benefits Eligibility and Enrollment (HBEE) final proposed rule with one amendment that the Agency of Human Services presented to LCAR.

The amendment to the final proposed rule is based upon discussions with stakeholders and is intended to provide clarification to HBEE 30.05(b) of what medical expenses can be used to meet an individual's income spenddown for purposes of Medicaid eligibility.

Section 30.05(b) of the final proposed rule states, "Medical expenses of any member of the individual's financial responsibility group, whether they are paid or incurred but not paid, may be used to meet the individual's income spenddown requirement." The amendment does not change this language but it adds a clarifying clause at the end of the sentence that states, "references in § 30.06 to the medical expenses of the "individual" include the medical expenses of any member of the individual's financial responsibility group."

The amendment does not have any effect on the Economic Impact Statement.