

## **General Comments (not specific to sections of the proposed rule)**

We would like to thank everyone who submitted comments on our proposed rule. It was obvious that people devoted considerable time and thoughtfulness to reviewing the rule and making constructive suggestions. As a result, we believe the final proposed rule is a much improved product.

### **State Premium Assistance Program**

We received several requests to include the state premium assistance program (passed by the legislature in its 2013 session) in the final proposed rule. We will be filing an emergency rule and a corresponding proposed rule this fall that will incorporate provisions passed by the legislature and signed into law by the governor this year. In addition, the emergency and proposed rule will include any changes made by the Department of Health and Human Services in final rules or guidance issued over the coming months. Not only was there not enough time to incorporate the recently enacted state legislation into this rule, but we also did not want to make substantial changes to the content of this rule without providing opportunity for public comment. The proposed rule to be issued this fall will allow ample opportunity for stakeholders to review the changes and offer comments.

### **Suggested Changes in Language to Improve Clarity**

We received many excellent suggestions from commenters on rewording sections to improve clarity. We very much appreciate those suggestions and have incorporated many of them in the final rule. We have not addressed each of those comments separately in the individual sections below unless the change in language was a substantive, rather than a technical, change.

### **Crosswalks between Current Rule and Proposed Rule**

We received several comments to the effect that it was difficult to compare current rule sections to the proposed rule. We apologize for not providing crosswalks earlier, but we have since developed crosswalks for Sections 4200 (SSI-related Medicaid), 4300 (ANFC-related Medicaid) and 4400 (Spendedown) and have included those as attachments to this public comment and response document.

### **Comments on Formatting**

We received several requests to include more headings, include the names of the parts in the table of contents, and make each part distinct from the next part so that the proposed rule is not one long document. We have incorporated those requests into the final proposed rule.

### **Comments on Sections that are Unchanged from Current Rule**

We received many comments on sections of the rule that were not substantively changed from current rules. We have included those comments under the relevant sections below; however, due to time constraints, we were not able to respond to comments that are outside the scope of this rulemaking process. In light of the considerable effort made by the commenters, we have indicated that we will consider the comments and are willing to discuss them with the commenters at a later time.

## Other General Comments

*Comment: There are places in the proposed rules that simply provide citations to federal law without any explanation of the substance of the federal law. The relevant citations to federal law are very helpful. However, it is not sufficient to simply cite federal law without any explanation of what the federal law says. As examples, see Section 14.00 “Eligibility for enrollment in a QHP that is a catastrophic plan”; Section 28.05(b)(2)(ii), household income for APTC and CSR; Section 49.02(f)(2)i), “procedural rights of employers”.*

Response: Where possible we have added explanatory text rather than merely citing federal law and regulations; however, there are sections for which the cited law or regulation is simply too long to include or even summarize. We have, however, revised section 14.00 to eliminate the tax code reference and, instead, explain its meaning and cross reference our own rule for more information. Section 14.00(b)(2), which addresses exemption from MEC due to hardship, will not be completed until we file the emergency and proposed rules this fall. We have also revised section 28.05(b)(2)(ii) to eliminate reference to federal law.

*Comment: It is impossible to tell what is new and what is changed. A crosswalk comparing the new to the old would be helpful. In the past the AHS indicated changes with solid and dotted lines on the left. A similar method should be used in the future.*

Response: Because this proposed rule replaces most of the sections in the current health care rule, it was not possible to use the traditional methods of highlighting changes; however, we have developed crosswalks (see attachments) that compare the existing 4200 (SSI-related Medicaid), 4300 (ANFC-related Medicaid), and 4400 (Spendedown) sections to the corresponding sections in the proposed rule.

*Comment: It is very difficult to use the rules, especially when using a hard copy, because you can't figure out where you are. It would be helpful to have a heading on every page indicating what sections are on the page. The effective dates and the bulletin numbers for each regulation section should also be included.*

Response: We have added section headings, effective dates, and bulletin numbers to the final proposed rule.

*Comment: The table of contents should be more detailed and every section listed should be a web link. This is done with the current rules online but would be even more useful if the TOC were more detailed. The detailed TOC should include the names of the eight parts.*

Response: Because of word processing issues that have arisen due of the size of this document, to ensure proper formatting and section numbering, we have separated each part of the document, and have created a separate table of contents for each part. It is our intent to have a web link for each section when the final rule is posted online.

*Comment: Include an acronym definition list; there are too many acronyms to be able to easily keep track.*

Response: We have developed an acronym list for the rule and included it in the final proposed rule filing.

*Comment: Because of the combining of Medicaid with the individual and small group commercial markets in the rule, it is not always clear when the rule is pertaining only to Medicaid and when it pertains to both Medicaid and the commercial insurance markets. For example, see section 68 starting on page 279. Also, in various places in the rule the passive voice is used which is problematic because the reader is not sure who is responsible for the task. Please change all passive voice to active voice (for example, see section 74.01).*

Response: We agree and are adding clarification on the relevant program to various sections of the final proposed rule. We are also changing to active voice in sections where it makes sense to do so.

*Comment: Early in the rules process, we were assured that all interpretive memoranda from the current rules would be incorporated into the new regulations. Without a complete crosswalk, it is difficult to verify this. We have noticed several important interpretive memoranda that have not been incorporated into the proposed rules. This concerns us. The state should take steps to ensure that all current interpretive memoranda are incorporated into the regulations.*

Response: We believe that we have incorporated relevant interpretive memoranda into the final proposed rule. If there are specific interpretive memoranda that you believe we have missed, please let us know which ones and we will consider those for inclusion in future rulemaking.

*Comment: The rules need a provision for reopening determinations. CMS provides for this in Section 2904 of the State Medicaid Manual.*

Response: AHS currently provides a supervisory review of a decision whenever an applicant or beneficiary questions the accuracy of the decision, presents new evidence that could affect the decision, or AHS determines that a decision was not appropriately rendered. It is our intention to continue this long-standing practice and do not believe that codification of the practice in the rule is necessary.

*Comment: AHS needs to ensure that the health benefits system is accessible to everyone. The average Vermonter should be able to get assistance including in-person help, whether they have a documented disability or not. This is especially a problem when people are being terminated for failure to fill out recertification paperwork or obtain verification. We are pleased to see that 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: Assistance with verifying citizenship is specifically mentioned in the proposed rule since verification of citizenship can be a relatively challenging process if an individual's citizenship cannot be verified electronically through the federal data hub; however, the reference to assistance in 54.07(f) was not meant to imply that assistance will not be available with other facets of the application/renewal process. AHS will have a robust, statewide system of navigators and application counselors who will be available to any applicant or beneficiary who needs assistance, including in-person assistance, in completing the application or renewal process or in obtaining necessary verification. In addition, all notices to applicants and beneficiaries requiring action provide the toll-free member services number and invite the applicant or beneficiary to call if assistance is needed. Customer Services Representatives are trained to connect individuals needing assistance with navigators/application counselors in their geographic area. We believe that Section 5.00, Eligibility and Application Assistance, provides an adequate description of the types of assistance available.

*Comment: We are concerned with the opaqueness of the federal rules. We understand that many of these AHS-proposed regulations have been directly copied from federal proposed or final regulations. AHS should not adopt federal regulatory language without reviewing for clarity and attempting to convey the meaning of the federal rules in plain English. Much of the federal language is very confusing, and in some cases contradictory. Whenever possible we have made suggestions we think might make the regulations more understandable. However, much more could be done.*

Response: We have attempted wherever possible to make the language in the rule understandable, and have incorporated many of your suggested changes, as well as those from other commenters; however, it was not always possible to explain some of the more complex topics in plain English without straying from the original meaning. We hope you will find the final proposed version improved, though we realize it is not perfect in this respect. This rule must serve both as a general information document and a legal document, and we have done our best to balance those two purposes.

*Comment on use of Carrier versus Issuer: Portions of the rule refer to carriers, whereas other portions of the rule refer to issuers. We recommend that the rule be internally consistent, unless there is a specific intended distinction. If there is an intended distinction, we request such distinction be defined.*

Response: We agree and have eliminated the references to "carrier."

*Comment: When changes are made to this rule that have an impact on stakeholders, additional review may be necessary before they are finalized. The rulemaking process is flexible enough to allow this additional public input, as appropriate. We respectfully recommend that the public be allowed to review changes to this rule before it proceeds to the next step in rulemaking.*

Response: Although we understand the concern, there will not be time for an additional public comment period before the final rule must be filed for an effective date of September 1, 2013. We are, however, reserving most substantive changes for the emergency and proposed rules that we will file this fall. The proposed rule will allow for a public comment period.

*Comment: In general language and terminology are inconsistent with insurance industry language and terminology.*

Response: The language and terminology in this rule are based on federal law and regulations governing Medicaid and Exchanges.

*Comment: As you know, new proposed federal rules were recently published. 78 Fed. Reg. 37032 (June 19, 2013). These proposed rules include many components that are directly relevant to this rule. We strongly recommend the review of various aspects of this rule prior to finalizing the state rules. For example, we recommend a review of the newly proposed 45 C.F.R. § 155.310 (pertaining to procedures for responding to incomplete applications); 45 C.F.R. § 155.340 (refund due to enrollee when Exchange fails to reduce enrollee's premium by APTC); 45 C.F.R. § 155.420 (changes to special enrollment period provisions); and 45 C.F.R. § 156.1240 (mandated acceptance of various payment types). We respectfully suggest that consideration of the issues raised by these proposed rules would best be considered now, as opposed to waiting for an emergency rule making process. As noted, we have expanded on other provisions within the body of this comment letter.*

Response: Given that the federal proposed rule was issued less than a month ago, we have not yet had time for a proper review of the rule; in addition, HHS has scheduled webinars to assist states in analyzing the rule, and it is likely that we will gain a more complete understanding of the rule through these webinars. We will, therefore, incorporate the changes in the federal proposed rule in future rulemaking. We did make a small change to our rule at 52.02(e)(2) based on the federal proposed rule, since it was straightforward and required no analysis.

*Comment: Vermont Health Connect needs rules on how IRC 5000A exemptions (from the individual shared responsibility payment) will be applied for and considered, and how adverse decisions regarding those exemptions can be appealed.*

Response: Final federal regulations on this issue were released on 6/26/13. The emergency rule and proposed rule to be issued this fall will address exemptions from the individual shared responsibility payment in a new section 23.06.

*General Comment on Appeals: It is our understanding that AHS is going to be making more changes to the appeals process than are described in these proposed rules in Part Eight. We also know that as of this writing, the final federal rules on appeals have not yet been issued. Because the appeals process for applicants and beneficiaries dealing with Vermont Health Connect will be so critical, we are formally requesting that VLA be invited to participate at the*

*earliest point possible in that rulemaking process. We especially want to be involved early in the process because we understand that it is likely that AHS may have to proceed by emergency rulemaking in order to get the appeals process in place by October 1, 2013. We want to make sure there is a robust discussion early on because the turnaround time for formal comments on emergency rules is so short. Finally, knowing that further changes on appeals are likely made it difficult to comment on these proposed rules*

Response: We are committed to ensuring that the process for appeals is streamlined and consumer-friendly and will certainly work with stakeholders on this every step of the way. We no longer expect to make major changes to the appeals process this year. We are working on setting up an internal review process for appeals (modeled after the process DVHA currently uses for coverage appeals). This internal review process will run parallel to the fair hearing process, but may help appeals get adjudicated earlier. ESD will be setting up an appeals unit to conduct these internal reviews.

*General Comment on dental benefit plans: The proposed rule while referencing stand-alone dental benefit plans, does not address them clearly. It is not clear whether the rules are intended to apply to stand-alone dental benefit plans. At a minimum, related definitions should be added to clarify how and when the rules do.*

Response: Requirements for certification of stand-alone dental benefits are addressed through the form and rate review process through DFR. 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 are cited. We understand that only recently has CMS addressed dental carrier questions about the applicability of federal regulations.

*General Comment on Issuer Customer Service Representatives: The new federal rule proposes that Exchanges may permit an issuer customer service representative to assist individuals in the individual market to apply for insurance affordability programs. 45 C.F.R. § 155.415. These representatives are subject to various standards. 45 C.F.R. § 156.1230. As you know, we, as an issuer, have been engaged in various communication and outreach strategies to help ensure that Vermonters have a positive transition to the new health insurance market they will face in 2014. At this time, we have not intended to provide specific support for individuals applying for affordability programs. However, we are willing to discuss this with the State*

Response: We are considering the proposed rule, 45 C.F.R. § 155.415, 78 FR 37032, June 19, 2013, to allow issuer customer service representatives to assist with eligibility applications. We welcome the opportunity to discuss this matter with issuers. Any codification of the provision would occur through emergency rulemaking.

*General Comment on section 3.00 definitions: Generally, AHS should clarify which rule Parts these definitions apply to. It is a bit unclear which definitions apply to the Parts that come after Part Six, Small Employer Health Benefits Program Rules, because Part Six has its own definitions and is right in the middle of the rules. If every Part except Part Six should use these definitions, we suggest this language: "These definitions apply to all Parts of these rules except Part Six."*

Response: We have removed duplicates and amended definitions to be current with new state law.

*Comment: Vermont Act 171 of 2012, § 34(b), directs AHS to seek a CMS waiver to, in part, “Ensure affordable coverage for individuals who are eligible for Medicare but who are responsible for paying the full cost of Medicare coverage due to inadequate work history or for another reason.” This small group of Vermonters is currently unable to get affordable health insurance. The Act 171 language was inserted to help fix this problem. Our understanding is that AHS is seeking a way to do this through its Global Commitment waiver request, but we could not find the issue addressed in these proposed rules.*

Response: We will be incorporating changes required by Act 171 into the emergency and proposed rule this fall.

*Comment: Beneficiaries just above the poverty level will face a “MAGI cliff” when they reach age 65 or after two years of disability, and become eligible for Medicare. At that point, they would no longer be eligible for MCA and would likely be income or resource ineligible for MABD under those much more restrictive rules. This is contrary to public policy and Vermont’s expressed goal of providing adequate and affordable healthcare coverage to those in need. AHS can reduce the impact of the MAGI cliff by expanding Medicare Savings Program (MSP) eligibility. AHS should allow use of the MAGI methodology, in addition to the MABD rules, to determine income for the MSPs. This could help to maximize eligibility. AHS should also evaluate increasing the income eligibility limits for the MSPs as Maine and other states have done. States have substantial financial interest in MSP expansion and participation, because MSP beneficiaries are categorically eligible for “extra help” with Medicare Part D.*

Response: This comment is outside the scope of this rulemaking process. We will consider it for future rulemaking.

Comment on two new HHS options which could expand coverage  
AHS should pursue two new options provided by HHS: continuous 12-month eligibility for adults and children, and streamlined enrollment of SNAP participants. “Facilitating Medicaid and CHIP Enrollment and Renewal in 2014,” Center for Medicaid & CHIP Services, U.S. Department of Health and Human Services, SHO #13-003, ACA #26, May 17, 2013. HHS is offering states a simple, streamlined request-and-approval process so that states can readily implement the option by this fall.

Response: This request is outside the scope of this rulemaking process. We will consider the request for future rulemaking.

## **Comments Specific to Sections of the Proposed Rule**

## **Section 1.00 Health Benefits Program Administration**

*Comment on Section 1.00: Could you please expand on the description of the span of responsibility for each of the relevant state entities in Section 1.00 and further describe the roles of the Department of Financial Regulation, Green Mountain Care Board and the Vermont Health Connect? For example, see the reference in the definition of QHP to AHS being the entity that officially recognizes that a specific insurance product meets the ACA requirements.<sup>1</sup> Failure to understand each entity's role may pose operational challenges for all involved, in addition to increasing the possibility for unnecessary legal action.*

Response: We have removed all references to specific departments (other than the Agency of Human Services) from Section 1.00. Not only are there too many departments and entities with important roles to play in providing health care to Vermonters, we are reluctant to be specific in all areas of the rule about the department or division that performs a function, since the assignment of responsibility and the names of the departments and divisions can change over time. We would prefer not to go through the rulemaking process to change department and division names.

## **Section 2.00 General Description of Vermont's Health Benefits Programs**

*Comment on Section 2.00: A general description of federal law and the health program landscape would be helpful. In the current rules, Medicaid Rule 4100 Medicaid Program, gives such an overview. Including similar language here would emphasize the broad purpose and scope of the Medicaid program in Vermont. Most individuals looking for rules about Medicaid eligibility are not going to be searching the federal statutes and regulations for how the program works. However, it would be helpful to have language about the purpose and scope in these rules.*

Response: We have added some information in section 2.02 about the Medicaid program; however, we have not included all of the information that was contained in an earlier version of the rule. We do not believe that such information is a necessary part of the rule itself, although we intend to make the information available through other means, such as by posting it on our website.

*Comment on Section 2.02(b): This section states Medicaid is for three groups of people: mandatory categorically needy, optional categorically needy, and medically needy. Mandatory categorically needy, optional categorically needy, and medically needy are non-intuitive terms defined in federal law. Explain what they mean, or add a citation to federal law.*

Response: We have added explanatory language to this section.

---

<sup>1</sup> This is actually inconsistent with our current understanding of the regulatory framework. It was our understanding that the Department of Financial Regulation determines ACA compliance and that DVHA/VHC would choose among compliant plans regarding which plans would be available for purchase on VHC.

*Comment: Medicaid Rule 4100 includes language about the Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions in Title XIX of the Social Security Act. Current DVHA coverage rules refer to Rule 4100, with language such as "... or if otherwise necessary under EPSDT found at 4100." See e.g. Medicaid Rules 7314.4 and 7315.3. Until the DVHA coverage rules can be revised to include general language about the vast scope of EPSDT, that language should be included in these eligibility rules.*

Response: We have added the language on EPSDT back into section 2.02(c). Given that EPSDT is a coverage issue and not an eligibility issue, we will remove the language once DVHA rules at section 7410 have been updated.

*Comment on Section 2.03(b): Why is the CHIP program for those between 225-300% FPL? Should it be simply under 300% FPL?*

Response: In Vermont the CHIP program is technically for uninsured children with incomes between 225% and 300%. Insured children up to 300% and uninsured children under 225% are covered under the Global Commitment waiver. To applicants and beneficiaries (and to the general public), there is no difference, since all these children are covered under the program name of "Dr. Dynasaur."

*Comment on Section 2.04(a): The first sentence of the third paragraph; "QHPs must provide at least essential health-benefit packages." Is there supposed to be a number between "least" and "essential"?*

Response: No, the sentence explains that Qualified Health Plans must offer a benefit package that is at least equivalent to Vermont's chosen benchmark plan, the largest small-employer plan, offered by Blue Cross Blue Shield of Vermont, with the state CHIP plan for pediatric oral care and the FEDVIP plan for pediatric vision care. This decision was made after consulting with stakeholders and comparing all plans. Choosing the Blue Cross Blue Shield plan will mean the least amount of change for Vermonters because already, 77 percent of Vermonters that are expected to use Vermont Health Connect will continue to receive the same benefits they receive today, in addition to added benefits outlined by the federal health care law.

*Comment on Section 2.04(a): Suggested eliminating language pertaining to QHP requirements and types. Very specific regulatory guidance exists and is enforced by DFR; as such, this section is unnecessary, not clear to the casual reader, and lacks sufficient definition. We suggest eliminating this language or replacing it with something more general.*

Response: This section describes qualified health plans generally, and provides context for federal and state assistance in making private coverage more affordable. Revisions have been made for clarity.

*Comment on Section 2.04(a), catastrophic plans: Catastrophic plans should have a minimum age limit.*

Response: The federal law creating catastrophic plans does not place a minimum age on persons enrolling in a catastrophic plan. Federal regulations specifically provided that if a catastrophic plan covers more than one person (such as a catastrophic family plan), each individual enrolled must satisfy at least one of these two eligibility criteria. 78 FR 13406, 13424, February 27, 2013.

*Comment on Section 2.04(b): Suggested eliminating language pertaining to premium assistance and cost sharing reductions.*

Response: This section describes federal premium assistance and cost-sharing reductions generally, and provides context for federal assistance in making private coverage more affordable. Emergency rulemaking will codify new state law providing for state premium assistance and state cost-sharing reductions.

*Comment on Section 2.04(b): Clarify that the APTC / CSR is for QHPs, and not Medicaid or Dr. Dynasaur.*

Response: We believe this section is clear that APTC and CSR are for insurance purchased through the Exchange. Medicaid and Dr. Dynasaur are not “purchased insurance.”

*Comment on Section 2.04(b): What is meant that the APTC is refundable?*

Response: Individuals found eligible for federal tax credits may choose to receive those credits as a monthly payment (APTC) to the insurance company offering the plan they choose, or they may decide to collect their full annual tax credit at the time they file their income tax return, in which case it is referred to as a tax credit refund.

*Comment on Section 2.04(b): In the last paragraph, we suggest adding a sentence to clarify that legal immigrants who are barred from enrolling in Medicaid are not subject to the income floor. We propose the paragraph end as follows: “Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. are eligible for APTC and CSR. Such immigrants may have income under 133% of the FPL.”*

Response: We have added the suggested language; however, the clarification should be that immigrants may receive APTC and CSR if their income is below 100%. Citizens must have income in the 100%-400% range to be eligible for APTC and CSR.

*Comment on Section 2.05(b)(12): Who can individuals contact? How can they get help? What are the limitations? More information is needed here.*

Response: More detailed information on how the premium tax credit amount is calculated can be found in §60.00 of the rule. In addition, individuals will be able to find information and application assistance through a variety of sources, including the VHC website, the toll-free customer service line, and the robust network of navigators and application counselors described in §5.00 of the rule.

*Comment on Section 2.05(b): A section should be added to this list. 2.05(b)(14): All bases of eligibility and possible programs are considered prior to determining or redetermining eligibility.*

Response: We have not added this language, since individuals may request enrollment in a QHP without an eligibility determination for Medicaid or APTC/CSR. (See Section 63.00(b), which says that a person can request only an eligibility determination for enrollment in a QHP. If such a request is made, other bases of eligibility will not be considered.)

### **Section 3.00 Definitions**

*Comment on “Advance payment of the premium tax credit (APTC)”:* This should be simplified. The federal legal references should be put into the footnotes, especially since Vermont beneficiaries will be eligible for state premium subsidies in addition to the federal tax credits. In the alternative, the current proposed language could be added after our suggested language, which is: “Subsidies provided on an advance basis to an eligible individual enrolled in a QHP to reduce the individual’s required premium payment.”

Response: We have made the requested change.

*Comment on Advance payment of the premium tax credit:* Although we understand that this language tracks the federal rule 45 C.F.R. § 155.20, we suggest that it could be misleading in that it implies that the APTC might be paid directly to the individual. We suggest modifying this definition to make it clear that the APTC is actually paid to the issuer, although an individual may collect any premium tax credit owing at the time he or she files income tax returns.

Response: We agree and have added language to this section to clarify.

*Comment on Appeal/Appeal representative:* This definition refers to the fair hearing and fair hearing representative definition. It is our understanding that VHC will be responsible for hearing appeals from employers who disagree with the VHC’s finding regarding whether an employer plan constitutes affordable coverage providing minimum value. It’s not clear that the definition of fair hearing and fair hearing representative contemplate this process. We would suggest this be more explicit if that is what is intended.

Response: In light of comments received regarding the definitions of “appeal,” “appeal representative,” “fair hearing,” and “fair hearing representative” in this section of the proposed rule, we have determined that those definitions do not convey the information that was intended and have, accordingly, deleted them. All information necessary in regard to fair hearings for individuals and employees can be found in Part Eight of the proposed rule (beginning at Section 80.00). Employers will use a different appeal process as described in §49.00.

*Comment on “Appeal (fair hearing)”:* This proposed definition simply says, “See, fair hearing.” The “fair hearing” in parentheses should be removed. We suggest the following definition:

*Individuals have the right to a review of any action or inaction by AHS through the fair hearing process. See fair hearing.”*

Response: See response above.

*Comment on “Appeal representative”: Rather than saying “See, fair hearing representative,” the definition from “fair hearing representative” should be repeated here. Or consider eliminating all representatives other than “authorized representative.”*

Response: To avoid confusion on the use of these terms, we are removing “appeals representative” and “fair hearing representative” from the definitions section. We believe that Section 80.00, the fair hearings section, makes it clear that individuals may be represented during the fair hearing process.

*Comment on Application date: This definition refers to when the application is “received” but does not specify what entity needs to receive the application. We suggest clarification that the application needs to be received by VHC in order to avoid confusion about what constitutes receipt such that various time frames begin running.*

Response: We have clarified that the application date is the date an application is received by AHS.

*Comment on “Authorized representative” Rather than just “See, section 5.02,” paraphrase at least part of 5.02 in this definition, such as: “An individual designated by another person to responsibly assist that person with his or her application, renewal of eligibility, and other ongoing communications. See 5.02.”*

Response: We agree and have added language to the definition.

*Comment on Section 3.00, broker: We suggest this language be coordinated with current definitions and concepts in Title 8. For example, Vermont issues producer licenses, which may refer to a broker or an agent.*

Response: The definition has been revised to reference licensure as a producer. The term broker is used throughout Chapter 107, Health Insurance, of Title 8, Banking and Insurance, of the Vermont Statutes Annotated.

*Comment on Section 3.00, business day: Defined as days state offices are open to serve the public. In Part 6, Section 31.00, Applicable large employer is defined as 50 full time employees on “business days” during the preceding calendar year. Most businesses have “business days” on days the state offices are not open. See: section 31, Qualified employer uses the term “working days”*

Response: The definition of applicable large employer, adopted from the IRC § 4980H(c)(2) for purposes of determining liability for a responsibility penalty is understood to be narrowly

intended. The use of the term “working days” in the definition of a qualified employer for purposes of eligibility to purchase coverage through Vermont Health Connect accounts for the fact that businesses operate on days other than business days.

*Comment on Cancel: This definition refers to “an applicant who was approved but not yet enrolled \* \* \*.” Does enrollment mean that the coverage is effective or does it refer to the act of becoming enrolled? We suggest this be clarified in this definition.*

Response: We have clarified that “approved” means “approved for health benefits.” The term “enroll” is defined in this section to mean “to initiate coverage to an approved individual.”

*Comment on Section 3.00, catastrophic plan: This definition says catastrophic plans are “available to an individual up to age 30.” AHS should specify that it only applies to adults. We do not believe Congress intended that such limited and incomplete coverage be available for children. Under the proposed rule, parents could purchase catastrophic-only coverage for their children, but not for themselves if the parents are over 30. An age minimum of 18 should be added. This is especially important because many children in Vermont are eligible for coverage through Dr. Dynasaur.*

Response: The federal law creating catastrophic plans does not place a minimum age on persons enrolling in a catastrophic plan. Federal regulations specifically provided that if a catastrophic plan covers more than one person (such as a catastrophic family plan), each individual enrolled must satisfy at least one of these two eligibility criteria. 78 FR 13406, 13424, February 27, 2013. Under the proposed rule, parents over 30 would not be able to purchase a child only catastrophic plan. A child would only be able to be enrolled in a family plan. We do not foresee parents over thirty who have received an exemption from Vermont Health Connect foregoing Medicaid or CHIP coverage for their eligible children.

*Comment on Section 3.00, certified application counselor: The proposed definition, “See 5.05,” is insufficient. We suggest adding this language: “Individuals who are staff or volunteers of state-designated organizations, and who are authorized, registered and trained by AHS to provide assistance to consumers at application and renewal. See 5.05.” Add an explanation of how CACs differ from navigators.*

Response: The duties of certified application counselors will not differ in most respects from Navigator duties. We continue to develop the process by which application counselors will be certified by Vermont Health Connect. Additionally, further guidance is expected from HHS. This rule will be updated through the emergency rulemaking process. In the meantime, we have added language to the definition of certified application counselors.

*Comment on Couple: The reference here to “rules” should probably be a reference to the “laws of the State of Vermont.”*

Response: We agree and have made the suggested change. Given the recent Supreme Court decision, this definition may be modified when we file the emergency and proposed rules this fall.

*Comment: Couple is defined as two individuals who are married to each other or are in a civil union. Historically Domestic Partners have been able to enroll for health insurance as a couple by both small group insurers in VT, will this continue? If so, this definition should be adjusted.*

Response: This rule defines “couple” relevant to eligibility for Medicaid or tax credits, and will not in any way prevent domestic partners from enrolling in private health insurance coverage; however, if a domestic partner couple applies for Medicaid or APTC, they would be treated as two separate households.

*Comment on Coverage month: Section (b) refers to the individual’s premium being paid in full. This definition should clarify how that concept applies when the individual receives APTC and is in the first month of the 90 day grace period (where claims are paid regardless of whether the premium is ever paid).*

Response: We have clarified that a coverage month includes the first month in a premium grace period for a person enrolled in a QHP with APTC. We have also added a cross reference to Section 64.06(a)(1) for purposes of describing the grace period since the grace period for individuals enrolled in a QHP with APTC is different from the grace period for individuals enrolled In Dr. Dynasaur.

*Comment on Enroll: We believe this might more appropriately read “initiate coverage for” an approved individual. However, consistent with our previous comments, we believe it is necessary for the rule to be clear about whether someone can be considered “enrolled” prior to the effective date of their coverage. We note that the definition of “enrollee” would imply that someone cannot be “enrolled” prior to their coverage effective date, but this should be explicit. We would also recommend that if one cannot be enrolled absent effective coverage, we may need a term to describe someone who is signed up for a specific type of coverage, but that coverage is not yet effective. Any changes to this definition would need to be aligned with the proposed definition of “grace period” which incorporates an enrolled individual who may be subject to a retroactive termination of coverage.*

Response: We have changed the language in this definition to your suggested language: “initiate coverage for.” We don’t believe a new term is needed for someone who is signed up, but for whom the coverage is not yet in effect, since the definition of “eligible” is sufficient for that situation.

*Comment on Grace Period: We are unclear about the referral to “suspended” coverage in this definition. Could you please clarify?*

Response: We have removed the reference to “suspension in coverage” since it is not necessary to the meaning of the definition.

*Comment on Grandfathered health plan: This definition refers to approval by “the state entity with approval authority” for a health plan to continue with current benefit structure. We do not believe that there is currently a proactive grandfather approval process, by product type, in place. Further, since the grandfather status analysis can be complex and sometimes raises federal preemption issues, we would recommend that this definition specifically refer federal law.*

Response: We have changed the term “grandfathered health plan” to “grandfathered health plan coverage” and have revised the definition in a way that addresses your concern.

*Comment on Health Benefits Program -- (c) What is “A program that assists in the enrollment in a QHP”?*

Response: We included enrollment in a QHP in this section to ensure that the definition of “health benefits program” was in alignment with its use in other sections of the rule. Since enrollment in a QHP is not technically a program, we have changed the definition to include “a system that facilitates the purchase by qualified individuals of health insurance coverage in QHPs.”

*Comment: Definition of health insurance coverage on page 26 is odd. It references “hospital or medical service policy”, which is the Vermont statutory reference for Blue Cross and Blue Shield. It appears to leave out the definition of a health insurer that is not BCBS or an HMO. Health insurance definitions should mirror those in Vermont law (Title 8, chapter 107).*

Response: The definition of “health insurance coverage” is from federal regulations at 45 CFR 144.103; however, we believe that issuers licensed in Vermont are covered under the second sentence, which is broader than the first sentence.

*Comment: Definition of health insurance issuer or issuer on page 27 states it does not apply to group health plans (meaning employer sponsored plans). Why? It appears you are defining issuer for individual market plans only.*

Response: We agree and have removed the reference to group health plans from the definition.

*Comment on Section 3.00, health insurance coverage: In the federal definition of health insurance coverage there is a reference to short term, limited duration insurance, which is generally not available in Vermont and unavailable in the small group and nongroup market.*

Response: We have removed the reference to short term, limited duration insurance.

*Comment on Section 3.00, health insurance issuer or issuer: recommend incorporating specific Vermont law references in this definition.*

Response: We have incorporated the specific Vermont law in the footnote.

*Comment on Section 3.00, Level of coverage: “Creditable coverage” is a HIPAA continuation of coverage concept (of questionable relevance after the removal of pre-existing condition exclusions) and may not be the appropriate concept applicable to bronze coverage. We suggest removal of the reference. We also note that de minimus thresholds allow a variation of the actuarial value percentages referenced and, as such, these values may not be technically accurate.*

Response: We are removing the reference to creditable coverage and adding a reference to the minimal variations permitted under federal guidelines.

*Comment: “Limited English proficiency” is defined as “an inadequate ability to communicate in the English language.” This definition is overly vague. Here is some suggested language: LEP means a limited ability to read, speak, write or understand English for someone whose primary language is not English. This is paraphrased from the LEP.gov webpage at [www.justice.gov](http://www.justice.gov).*

Response: We agree and have modified the definition.

*Comment: “Minimum essential coverage” (MEC) simply says, “See, §23.00.” This is an important concept for these rules and more information in the definition section would be useful.*

Response: We agree and have added language to the definition section.

*Comment on Section 3.00, Navigator: The proposed definition does not actually describe what a navigator is supposed to do. We suggest changing this to “a state designated private or public entity or individual that is qualified and certified to provide consumer assistance to individuals or employers and to engage in the activities and meet the standards described in 5.03, including assistance with enrollment in Medicaid programs and qualified health plans. There should also be an explanation of how navigators differ from certified application counselors. .*

Response: We have added language to the definition of Navigator. See also prior response to comment regarding certified application counselors.

*Comment on Premium: We believe the rule should be clear as to whether APTC is “premium” (we do not believe that it would be).*

Response: We agree that the term “premium” in this context does not include APTC. We have clarified that it is the charge an individual must pay.

*Comment on Section 3.00, Premium due date: We are currently very concerned about the current proposed premium due date. It appears from the proposed rule that the premium due date is not intended to go through rule making and will be published at some yet to be determined location. Although we appreciate the operational challenges, we advocate that the State include a published premium due date in the rule. As repeatedly requested in other*

*forums, we currently propose a premium due date of the 21st of the month prior to the month in which coverage is to be effective.*

Response: The premium due date for health benefits is the 21<sup>st</sup> of the month prior to the month of coverage. Potential carriers were engaged in discussions regarding enrollment and premium billing timelines for plans sold on Vermont Health Connect. The timelines are documented in the State of Vermont, Department of Vermont Health Access, Vermont Health Connect's "Individual and Small Business Enrollment and Billing timelines, Final, Version 2.0, June 2013." A premium due date of the 21<sup>st</sup> of the month prior to the month in which coverage is to be effective was agreed. We intend to publish a summary of the document in a consumer friendly format and post it to Vermont Health Connect.

*Comment on Section 3.00, Qualified Health Plan (QHP): This definition is inconsistent with our understanding of the current regulatory framework. It is our understanding that the Department of Financial Regulation, not the Agency of Human Services, is responsible for determining whether a health plan is consistent with the ACA requirements.*

Response: We have corrected this section. The Vermont Department of Financial Regulation will certify, decertify, and recertify qualified health plans. Prior to contracting with a health insurer to offer a certified qualified health plan on Vermont Health Connect the Commissioner of DVHA shall determine that making a qualified health plan available through Vermont Health Connect is in the best interest of individuals and qualified employers in Vermont. As an active purchaser, Vermont Health Connect issues an annual request for proposals (RFP) soliciting health plans within specific parameters to be certified by DFR as QHPs and selected by the Commissioner of DVHA to be offered on Vermont Health Connect.

*Comment on Section 3.00, Qualified Health Plan Issuer: This definition references a certification process from AHS. We respectfully request that the rule include more detail about this process and also how such process does, or does not, align with regulatory activities of the Department of Financial Regulation.*

Response: We have corrected this section. The Vermont Department of Financial Regulation will certify, decertify, and recertify qualified health plans. Prior to contracting with a health insurer to offer a certified qualified health plan on Vermont Health Connect the Commissioner of DVHA shall determine that making a qualified health plan available through Vermont Health Connect is in the best interest of individuals and qualified employers in Vermont. As an active purchaser, Vermont Health Connect issues an annual request for proposals (RFP) soliciting health plans within specific parameters to be certified by DFR as QHPs and selected by the Commissioner of DVHA to be offered on Vermont Health Connect.

*Comment on Reasonable compatibility: This definition refers to a "collection of standards" that will be used to verify an individual's information. Are these standards published? If so, where? Will they be written? We believe this should be explicit in the rule.*

Response: “Reasonable compatibility” is defined in detail in §57.00(a), which addresses inconsistencies between an individual’s attestations and information obtained from other sources. To avoid any confusion with respect to the meaning of “reasonable compatibility,” we are removing the definition from Section 3.00 and, in its place, cross-referencing Section 57.00(a).

*Comment on Reenroll: We are concerned that this definition may not take into account all of the various scenarios to which it might apply. For example, as noted above, it is not clear whether “enrollment” constitutes the receipt of effective coverage. However, we also note that it appears that the definition of “closure” refers to eligibility<sup>2</sup> but eligibility for all health benefits (public and/or private). Is the term “reenroll” only supposed to refer to the situations in which a person ceases to have any effective coverage through VHC or publicly funded programs (for example, because they are uninsured or they are covered in the large group market)? If so, we may need an additional concept that refers to “new” enrollments as people move among programs based on their income and employment status.*

Response: The term is intended to refer to reinitiating coverage in a plan through VHC, not initiating coverage through VHC after losing coverage through a non-VHC plan, such as a large employer plan or a government-sponsored MEC.

*Comment on Reinstate: We note that the definition of reinstate refers to the restoration of eligibility, but not necessarily of benefits. We want to confirm that this is the intended meaning as the concept “reinstate” in the private health insurance lexicon typically means the reinstatement of benefits, not just eligibility.*

Response: The term “reinstate” is intended to refer to eligibility.

*Comment on Renew: This definition may need to be broadened. In the group market, and even in the direct pay nongroup market, the act of renewal does not relate to a redetermination of eligibility, but rather to the beginning of a new plan year, without any eligibility determination.*

Response: Within the context of the AHS rule, the term “renewal” refers to the annual process by which an individual is recertified by AHS as eligible for Medicaid, APTC, or enrollment in a QHP. QHP enrollment “timing” is covered under the section for annual open enrollment periods (71.02 - 71.02(d)), which states that AHS will send notification in September each year regarding the annual open enrollment period and the provisions under 75.02(b).

*Comment on Section 3.00, small employer: We do not believe this language is consistent with the newly amended 33 V.S.A. § 1811(a)(3). Furthermore, after January 1, 2016, we believe this definition of small employer (specifically the method of calculation) would be preempted by*

---

<sup>2</sup> Closure is not currently defined, but “close” is defined as “To determine that an enrollee is no longer eligible to receive health benefits.”

*federal law. See 45 C.F.R. § 155.20, 78 Fed. Reg. 15410, 15532 (March 11, 2013), see also 77 Fed. Reg. 73118, 73186 (December 7, 2012).*

Response: We have removed the small employer definition from this section. Small employer is defined in Part Six.

*Comment on “Substantial gainful activity”: This definition does not include any reference to federal law or regulation. This is a term of art used extensively in federal Social Security disability determinations, and typically is tied to a specific earning level with periodic adjustments. Is there a reason why this definition is not tied to the federal SGA definition? The proposed language is quite broad, and we would not want it to be used to impose stricter definitions of SGA than those currently used by the Social Security Administration. If the intent is to have a parallel definition to the federal definition, the proposed rule should say so.*

Response: This definition is not a substantive change from existing policy (Rule 4213.1) so this comment is beyond scope of this rulemaking effort. However, in an effort to provide clarity, we have made some modifications to the definition.

*Comment on “Tax dependent”: Definition simply says, “See, § 28.02(h).” This is a typo; it should be § 28.02(f). As explained below, the language of § 28.02(f) needs to be revised for consistency with federal Exchange rules. If the final rules contain multiple definitions of this term, that should be noted and explained here.*

Response: Unfortunately there is a difference between the Medicaid and Exchange federal rules in defining “tax dependent,” in that the Medicaid rule includes a spouse as a dependent, and the Exchange rule follows the tax code in not including spouses as dependents. For now we will need to have two definitions in our rule. At some point HHS may bring the two definitions into alignment, in which case we can drop one definition in future rulemaking.

#### **4.00 General program rules**

*Comment on Section 4.01: This section notes that an individual receiving health benefits from another state is not eligible for such benefits in Vermont. However, it is our understanding that an individual might be on two employer plans (including an employer plan from out of state) and such employer plans constitute “health benefits.” The rule should clarify if that is permissible.*

Response: We are taking the comment into consideration and may address it in future rulemaking.

*Comment on Section 4.02: This section appears to lack clarity as to what entity is bound by them. We also request clarifying language in Section 4.02 specifying that these rights are applicable to State processes (since the State is responsible for eligibility).*

Response: We have changed the titles of 4.02 and 4.03 to respond to your concern.

*Comment on Section 4.02(h): Add language clarifying that an individual's attorney or representative may inspect the case file on an individual's behalf.*

Response: We believe that §5.02(b) describes the scope of authority for authorized representatives broadly enough to cover inspection of the case file. We would prefer not to insert language in every section that could potentially apply to authorized or legal representatives, as well as to individuals.

*Comment on Section 4.02(j): The description of the right to interpreter services should specifically note that the services are available to people who are Deaf and Hard of Hearing. Not everyone will know what 'sensory impairment' means. Interpreter services should also include the availability of video interpretation services.*

Response: We have added clarifying language.

*Comment on Section 4.03: This section includes responsibilities of individuals. We recommend including a similar section that outlines the responsibility of employers and, where different from individuals, employees.*

Response: We are considering similar sections applicable to employees and employers.

*Comment on Section 4.03(b)(4): This section notes that a QHP enrollee that did not request an eligibility determination for APTC or CSR does not need to report changes that effect eligibility. We request clarification as to whether this applies to individuals that requested subsidies, but were denied and are not receiving any assistance.*

Response: We have added clarification that the language in 4.03(b)(4) applies to an individual who is not requesting, or is not receiving, subsidies.

*Comment on Section 4.04(a): Case records must include all information relevant to the individual's case. The proposed definition is too narrow. For example, AHS 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: We believe the phrase "including but not limited to" in (2) and (3) of that section sufficiently indicates that the list is illustrative and not exhaustive.

*Comment on Section 4.06(a): The source of the quoted language should be identified.*

Response: We agree and have added a footnote to indicate the source.

*Comment on Section 4.06(e)(1): We would like to suggest that this section include this specific example: "The individual misrepresents his condition, residency status or dependent*

*relationship or status in order to receive benefits to which he or she would not otherwise be eligible.”*

Response: We have modified this section to include the following language: “The individual misrepresents a material fact, such as residency status or dependent relationship or status in order to receive benefits to which he or she would not otherwise be eligible.” We have not included “condition” in the modification, since an individual’s condition is not an eligibility factor (other than for specific categories of Medicaid).

*Comment on Section 4.07: Recovery of improperly-paid benefits. Current rules allow for recovery of benefits when the beneficiary commits fraud (Medicaid Rule 4105) or gets continuing benefits pending the outcome of a fair hearing but either loses the hearing or withdraws it (Medicaid Rule 4153). The proposed rule expands the possibility of recovery to include situations where the beneficiary may not be at fault. Such recovery sought from an individual who was not at fault, and who may not have known or understood the state’s regulations, could wreak serious hardship on frail and vulnerable individuals and their families. We object to this unwarranted expansion of the state’s power to recover Medicaid benefits. The stated purpose of these changes is to implement Medicaid and establish exchanges under the ACA. These changes required by the ACA should not be used to make major changes in beneficiaries’ rights and protections unrelated to the ACA.*

Response: We appreciate the commenter bringing this to our attention. It was not our intention to expand the state’s recovery rights. We have deleted this section.

*Comment on Section 4.08: We are concerned this section, outlining individual privacy and security rights, is not nearly as robust as would be expected in light of the incredibly sensitive nature of the data collected and received by VHC. We are also concerned that the footnote makes no explicit reference to HIPAA or to any applicable state laws. We understand that HHS recently proposed to amend 45 C.F.R. § 155.280 and that, as such, this is an area in flux. Nonetheless, we request additional written guidance regarding this important issue.*

Response: Your reference to 45 CFR 155.280 appears to be incorrect; we presume you meant 45 CFR 155.260, the Privacy and Security of Personally Identifiable Information for which Vermont Health Connect will adhere to. We are not aware of recent HHS proposals to amend 45 CFR 155.260. Many of the exchange privacy and security policies, procedures, and documents are currently under development and review and will be made publicly available upon completion. As of May 1, 2013, we completed and submitted to CMS a Privacy Impact Assessment (PIA). The PIA facilitates the identification of systems that contain personally identifiable information and satisfies the system compliance with all relevant privacy laws, regulations, and guidance. System privacy and security measures outlined in the State's contract for cloud computing services include: National Institute of Standards & Technology 800 Series Requirements, Health Insurance Portability and Accountability Act (HIPAA), Health Information, Technology for Economic and Clinical Health Act (HITECH), Payment Card Industry (PCI) Data Security Standards, IRS 1075 Requirements, State of Vermont Security

Policies and Standards, Federal Information Processing Standards (FIPS), and Federal Information Security Management Act (FISMA).

## **Section 5.00 Eligibility and enrollment assistance**

*Comment on Section 5.01: 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. The State has an affirmative obligation to provide this assistance. .*

Response: We agree. That is what this section provides. Nothing in this section should be interpreted to mean otherwise.

*Comment on Section 5.01(b)(2)(ii)(E): This notes that the website will include quality ratings as contemplated by the ACA. It is our understanding that such ratings are on hold for 2014. Please clarify.*

Response: Quality ratings will be available for health plans in 2015. We have revised this section.

*Comment on Section 5.01(c)(2): It would be helpful to include examples of auxiliary aids and services, such as videorelay and in-person ASL interpreter services.*

Response: We are reluctant to add specific examples here, since the language from the CFR is intended to be all-inclusive.

*Comment on Section 5.01(e): Include who the Outreach and Education will be conducted by (DVHA, Navigators, Brokers, etc.) but leave it open for others to participate as well.*

Response: Section 5.01 is specifically referring to assistance offered through AHS. Outreach and education activities conducted by navigators and DVHA staff must meet the referenced accessibility standards.

*Comment on Section 5.01(f): Americans with Disabilities. The language should be changed to, "reasonable accommodation or modification." Also, "when necessary to avoid discrimination on the basis of disability" is not the only reason that accommodations or modifications may be necessary under the Americans with Disabilities Act. The language should be, "to provide equal access to programs, services, and activities, or when necessary to avoid discrimination on the basis of disability." The Rule should also refer to Section 504 of the Rehabilitation Act of 1973 and the Vermont Fair Housing and Public Accommodations Act, which also require government agencies receiving federal funds to provide accommodations. 9 VSA §4502(c)(5).*

Response: We have considered this comment and have made some modifications to the final proposed rule.

*Comment on Section 5.02: This section refers to authorized representatives. We suggest that this section address whether authorizations are intended to extend to communications with issuers. If such authorizations are so intended, we request that additional detail be provided regarding how that process will work and what issuers and individuals should expect from that process.*

Response: The authorization extends only to communications with AHS as stated in 5.02(a).

*Comment on Section 5.02(a): A requirement for written authorization is potentially problematic for some organizations that assist people because we often try to resolve our clients' issues quickly and over the phone. It would greatly reduce our efficiency if we have to get written authorization from our clients in every case. We always get oral authorization to act on behalf of our clients, but almost never get written authorization because time is usually of the essence. This has been allowed for many years, and was formalized with the Assistant Attorneys General through an Interpretive Memorandum opposite Welfare Assistance Manual ESD All Programs Rule 2000 on January 24, 1997. This interpretive memorandum has not been explicitly incorporated into the proposed rules.*

Response: This rule does not repeal the rules under section 2000, so the interpretive memorandum you are referring to will still be in effect.

*Comment on Section 5.02(a)(3): Will Navigators need a release signed? This is important information for the Navigator Organizations.*

Response: Vermont Health Connect will provide releases, if any, to navigators at the conclusion of the certification process.

*Comment on Section 5.02(b): Scope of authority. Add "request a fair hearing or a grievance" as one of the enumerated powers of a representative.*

Response: We have added this power to the list.

*Comment on Section 5.02(c)(2): Duration of authorization. We have some concern that a person can only terminate the authority of an authorized representative in writing. Some beneficiaries may not be able, on their own, to put this statement in writing. If a beneficiary indicates a desire to end a representation, there should be a mechanism for providing assistance to a person who is unable on their own to put this intent in writing. This section could cite to other sections of the rule regarding providing accommodations and assistance with communication to facilitate this process.*

Response: Proposed changes to 42 CFR 435.923(c) require that requests for termination be in writing; however, the Exchange regulations allow termination requests to be made by a variety of methods, including by phone. We will adopt the more liberal method as allowed by Exchange

federal regulation at 45 CFR 155.405(c). We are adding a cross reference to section 52.02(b)(2) under (c)(1)(i) and modifying (c)(2) accordingly.

*Comment on Section 5.02(e): Condition of representation. What is intended by “a provider or staff member or volunteer of an organization”? It is not clear whether this is intended to apply to every representative or only a subset. Attorneys should not be required to sign a separate statement since they are already bound by conflict of interest and confidentiality rules.*

Response: We have revised this section to make its applicability clearer.

*Comment: A new section, 5.02(j), should be added to incorporate the interpretive memorandum facing rule 2000 (1/24/1997) regarding disclosure of information without a signed release. This is important when we are assisting individuals with an emergency problem. Sometimes individuals have very limited phone access, or limited funds to put minutes on their phone. Advocates should be able to get information in urgent situations even if a written release cannot be immediately obtained.*

Response: None of Rule 2000 is being repealed. All existing policy contained therein is still effective. We do, however, intend to add a provision to Rule 2000 to make it clear that to the extent there is any conflict between provisions under Rule 2000 and provisions under this proposed rule, the provisions of this proposed rule control. The Interpretive Memorandum facing rule 2000 is not one of those provisions

*Comment on Sections 5.03 Navigator Program and 5.05 Certified Application Counselor*  
*The proposed rules are confusing about how the Navigator Program is set up. The rules should be clear that Navigator organizations are “state-designated organizations” and that the Navigator program includes certified application counselors. The differences between Navigator organizations, individual Navigators, and Certified Application Counselors are not clear.*

Response: Navigators may be individuals or organizations, as stated in 5.03(a), who are certified by AHS upon meeting certain standards and requirements. Navigator individuals and organizations will enter into grant agreements with AHS and will provide assistance to individuals as described in 5.03(e). Certified application counselors, as described in 5.05, will be staff or volunteers in specific organizations, and who will be trained and authorized by AHS to help individuals with the application and renewal process. There will be no grant agreements attached to application counselors, and their duties will be somewhat more limited than those of navigators. Application counselors will provide the same core application assistance service that is also available directly through the Exchange, as well as through Navigators; the distinction between these entities is that application counselors are not funded through the Exchange, through grants or directly, or licensed by states as agents or brokers. CMS has said that they are referring to “application counselors” as being the same as the long-standing concept of “application assisters.”

*Comment on Section 5.03: This section refers to the Navigator program. Section 5.03(b) refers to “a set of standards” applicable to Navigators that is maintained and disseminated by the Agency of Human Services. We request that the rule include additional detail about where these standards are available and how they are disseminated.*

Response: These standards were included in the request for applications to which all navigators replied. We intend to reproduce the standards and post them publicly on VermontHealthConnect.gov.

*Comment on Section 5.03(a): There should be some descriptive overview of the navigator program. Consider adding language like: “Navigators provide information and education about qualified health plans and Vermont’s public health benefit programs, and assist consumers with enrollment.” It would also be helpful to explain their relationship to certified application counselors. There should also be a footnote citing 33 V.S.A. §1807, which requires a state navigator program.*

Response: We have added descriptive overview language from 33 V.S.A. §1807 to address the concern. As to the relationship between Navigators and CACs, see earlier response.

*Comment on Section 5.03(d): My understanding is that Navigators do not have to receive copies of patient notices (5.02, b, iv), but this section makes it sound like they have to. Please clarify this section so that it is clear that Navigators do not have to receive copies of the individual’s notices and other communications if a) they do not have the capacity to serve in this function (which is essentially an Alternate Reporter), or b) if the patient does not wish the Navigator to receive these communications on their behalf.*

Response: We do not see in 5.03(d) where navigators would be required to carry out the duties of authorized representatives or alternate reporters.

*Comment on Section 5.03(e): The duties of a navigator also should include: “Provide accurate information about, and assistance with applications for, premium tax credits and cost-sharing reductions available with qualified health benefit plans.” See 33 V.S.A. §1807(b)(2). The advanced premium tax credits (APTCs) and cost-sharing reductions (CSRs) are critical components of the affordability of qualified plans offered by VHC. Without them many individuals will not be able to afford insurance. Navigators must be required to explain them to consumers. Brokers can help individuals apply for APTCs and CSRs (see 504.(a)(2)), and navigators should be required to do so. One example of the importance of this assistance is that individuals will not be allowed to get CSRs unless they are enrolled in a silver level plan. If they enroll in a bronze plan, which would have a lower premium, they will not be entitled to CSRs, even if they are income eligible for them. Navigators must make sure consumers know this before they select a plan.*

Response: We agree and have added the language from 33 V.S.A. §1807(b)(2).

*Comment on Section 5.03(g)(2): I would disagree with this slightly; not sharing applicable and needed information with an authorized representative would hamper the individual’s ability to enroll if assistance is needed. A Navigator/Broker/Call Center Rep cannot assist an individual*

*with enrolling if the individual refuses to tell them income information, and other pertinent information needed for enrollment.*

Response: We interpret this comment to refer to 5.02(g)(2). In light of recently released federal final regulations regarding authorized representatives, further revisions and clarifications to this section will be considered as part of emergency rulemaking as needed. Because of the important public interest in rules for authorized representation we invite concerned Vermonters to engage us in drafting the revisions.

*Comment on Section 5.04: Reiterating our comments relating to the definition of broker, we recommend that this section be aligned with current Vermont law and concepts. We also note that the new rule contains provisions that may be relevant. See, e.g., 45 C.F.R. § 155.220.*

Response: The definition of broker is revised. Provisions regarding brokers are aligned with state law, and federal regulations, specifying that brokers enrolling individuals or employees in a QHP through an exchange must comply with state law, and enter into agreements with the exchange.

*Comment on Section 5.04(b): This section is a little difficult to follow. We suggest the following replacement language:*

*“Prior to assisting individuals or employers to enroll in QHPs or apply for APTCs or CSRs, a broker must have a signed agreement with AHS, which includes at least the following requirements:*

- (1) The broker must be registered with AHS;*
- (2) The broker must have significant training on APTCs, CSRs, Vermont’s health benefit programs, and the full range of QHP options;*
- (3) The broker must comply with AHS’s privacy and security standards pursuant to 4.08; and*
- (4) The broker must comply with all relevant policies and procedures established by AHS, including payment mechanisms and standard fee or compensation schedules.”*

Response: We have revised 5.04(b) for clarity.

*Comment on Section 5.04(c): It appears that AHS will publish a compensation schedule and additional rules and/or procedures relating to brokers. When will this information be available? Will it be subject to public comment?*

Response: The compensation schedule terms and conditions of participation will be defined in a standard broker registration agreement and conditions of participation. When finalized we intend to publish these standard agreements on VermontHealthConnect.gov.

*Comment on Section 5.05: This section seems to be focused on AHS’s obligations, rather than the CAC’s. There should be more information about what it means to be certified, and what the*

*requirements of certification are. See also the section on the definition of a certified application counselor, above.*

Response: The duties of certified application counselors will not differ in most respects from Navigator duties. We continue to develop the process by which application counselors will be certified by Vermont Health Connect. Additionally, further guidance is expected from HHS. This rule will be updated through the emergency rulemaking process.

*Comment on Section 5.05(a): This section should clarify how CACs differ from navigators. Are they expected to be a subset of navigators? Are the “state-designated organizations” the same as navigators? Or different organizations?*

*There should be an additional requirement that CACs demonstrate their knowledge, perhaps through some regular testing. Who is supposed to do the “effective” training mentioned in §5.05(a)(2)? AHS or the “state-designated organization?” We assumed in the CAC definition section above that AHS is doing the training. Training by AHS makes sense, since AHS has to certify the CACs.*

*The last phrase in (2), “as implemented in the state,” seems redundant and thus unnecessary.*

Response: Vermont Health Connect will train and certify application counselors. We do not feel “as implemented in the state” is redundant. Additionally, further guidance is expected from HHS. This rule will be updated through the emergency rulemaking process.

*Comment on Section 5.05(a): CACs can be from other organizations as well; do not limit it to just “state designated organizations” or it will seriously hamper access to enrollment assistance, and will put some individuals who do this work full-time out of a job*

Response: While we agree that having the most enrollment assistance from trained professionals is desirable, current guidance requires CACs to be from state designated organizations. We will evaluate recently finalized federal regulations for any flexibility and may revise the provision during emergency rulemaking if permitted.

*Comment on Section 5.05(b): Only (1) involves certification, but it does not state what individuals need to do to become certified. Also, it is not clear what CAC “certification agreements” with AHS might entail. 5.05(b)(2) appears to contain requirements on AHS related to CACs and not specifically related to certification, so it should be in a separate section.*

Response: At a minimum certification agreements will include a requirement that CACs participate in all training that is required by Vermont Health Connect, including guarding the privacy of the personally identifiable information that individuals will share with them. CACs will also promise to follow other applicable state and federal consumer protection laws. Further details will be included in the certification agreements. We intend to post those standard agreements on VermontHealthConnect.gov when they are finalized.

## **Section 7.00 Medicaid for children and adults (MCA)**

*Comment on Section 7.03(a)(5): “Adult” is defined as an individual who is not entitled to Medicare. For beneficiaries who have not paid sufficiently into the Medicare system, they may have an entitlement to Medicare, but the cost of the Medicare Part A premium is prohibited, often a substantial portion of their monthly income. AHS should limit the impact on this subset of beneficiaries as provided for by the state General Assembly in Vermont Act 171 of 2012.*

Response: We will take this comment into consideration; however, we will not respond to this comment at this time since it is beyond the scope of this rulemaking effort.

*Comment on Section 7.03(a)(6): This section refers to what is currently called Transitional Medicaid in Vermont, and is described in current Medicaid ANFC Rule 4312.1 Eligible Except for Earnings. We are hoping that the state intends to continue Transitional Medicaid as it now operates. It 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. This reduces the so-called benefits cliff and encourages families on Reach Up to work.*

Response: Transitional Medicaid Assistance (TMA) under §1925 of the Social Security Act is scheduled to sunset unless Congress acts this fall to extend it. The four-month extension language will take effect if Congress allows existing TMA authority to sunset. Given that the federal government has issued no guidance on TMA, we do not have enough information to determine the impact on Vermont’s current TMA program should Congress decide to extend it. We will need to resolve this issue in future rulemaking.

*Comment: 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: You are correct that the language in 7.03(a)(6)(ii)(B)(II)(ii) is 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. We have removed the reference to “increased hours.”

*Comment on Section 7.03(a)(6)(iii): Income limit for potential extended eligibility. The income limit would seem to nullify the entire section. However, since we submit that the State should*

*retain its current Transitional Medicaid program which goes up to 185% FPL, we are hoping this particular section of the proposed rule can be adjusted to reflect the current benefits.*

Response: Absent federal guidance on transitional medical assistance (TMA), we cannot answer this question at this time. The TMA section will be revised in future rulemaking.

*Comment on Section 7.03(a)(7)(iii): Income limit for extended eligibility. As mentioned in the above comment on §7.03(a)(6)(iii), this language appears to nullify the extension, which is mystifying. This section also tracks the proposed federal regulation word for word.*

Response: See answer to question above. We will revise the TMA section in future rulemaking.

*Comment: Section 7.03(b): Why is this section on resource tests reserved? AHS should not impose any resource tests on MCA populations. This is stated below in Rule 28.03(e). Add a cross reference to that section.*

Response: This section is reserved because there is an unresolved issue pertaining to the whether or not there is a resource test for the medically-needy MCA population due to a conflict in the Affordable Care Act (ACA). Due to a presumably inadvertent omission, the ACA did not extend the elimination of the resource test to the section of the Social Security Act authorizing medically needy Medicaid eligibility. We have been in discussion with the Centers for Medicare and Medicaid Services about this and other issues, and we understand that we may be permitted to waive the resource test by State Plan Amendment. If so permitted, it is our intent to waive the resource test. We are waiting for a final decision on this point and will update this section in the emergency and proposed rules this fall.

## **Section 8.00 Medicaid for the aged, blind, and disabled (MABD)**

*Comment on Section 8.04(b): Procedures for obtaining a determination of disability or blindness. This rule simply states, “AHS will explain the disability determination process to individuals and help them complete the required forms.” This is good and we agree with that language. However, it is overly vague for a rule entitled “procedures for obtaining a determination...” There are in fact no procedures contained in this rule. AHS should add more text or a reference to another rule which explains the actual process.*

Response: The language in this section was not changed from current policy at 4215 and so is outside the scope of this rulemaking process; we have, however, modified the language to clarify that it is not intended to describe procedure.

*Comment on Section 8.07 Medicare Cost Sharing: AHS should eliminate verification requirements for the MSP programs to the fullest extent permissible, including automatic enrollment, self verification of income, and no interviews. As explained in our general comments above, we are concerned about the “MAGI cliff” facing beneficiaries who become eligible for*

*Medicare, and we suggest several ways Vermont could use MSPs to lessen the cliff's impact on needy populations.*

Response: We will take this comment into consideration; however, we will not respond to this comment at this time since it is beyond the scope of this rulemaking effort.

## **Section 9.00 Special Medicaid Groups**

*Comment on Section 9.03(c)(3): Categorical and financial criteria. States there is "no unique" Medicaid income standard that applies. This phrase is confusing. Instead of using this term, the rule should cite to the applicable income standard. "No unique Medicaid income" standard is repeated in several sections including 9.03(f)(4). This comment applies to each of those sections.*

Response: The word "unique" was used to make clear that there is no separate income test for someone in one of these groups. Individuals are screened for eligibility by an entity outside of the Department for Children and Families' Economic Services Division (ESD); ESD, therefore does not apply any "unique" Medicaid standard. However, we have removed the word "unique" from this section since it was causing confusion.

*Comment on Section 9.03(e)(2)(iii): Categorical and financial criteria. This section states that the rule is triggered if a child was in foster care at the time of either (A) turning 18; or (B) "such higher age at which the state's or foster care assistance ends under Title IV-E of the Act." This was taken from the ACA. Vermont should update the language to reflect Vermont law and specify the age at which Vermont's state or foster care assistance ends.*

Response: We agree and have removed references to "tribe" and have added that foster care in VT under Title IVE ends at age 18.

*Comment on Section 9.03(g)(3): Categorical and financial criteria. The post-ICAR version of the proposed rules removed language that stated that only the income of the applicant and not the partner would be considered for family planning services. This principle is included later in the rules in 28.03(i), but it would be better to leave the clarification in this section. At the very least, this section should refer to 28.03(i).*

Response: Section 9.03(g)(3) does refer to 28.03(i).

## **Section 12.00 Advance payments of the premium tax credit (APTC)**

*Comment on Section 12.02: This would make it so that folks who don't file taxes are not eligible for APTC, which is not what DVHA told me would happen. I was informed that folks who didn't file taxes could get the APTC, but they would need to file a tax return the following year.*

Response: To be eligible for APTC, an individual must file a tax return for the benefit year in which they are applying for APTC. So, if an individual is applying for APTC for one or more

months in 2014, he or she must be intending to file a tax return for 2014 and must attest to that intention before APTC can be authorized. The individual must follow through and file the return for 2014 or potentially be liable for repayment of all or some of the APTC received. See Section 58.02(b).

*Comment on Section 12.03(a): the reference to 28.03(b) is not correct; it should be 28.05(b). 28.03 is Medicaid MAGI and contains a different definition of household income than the APTC section, which is 28.05(b).*

Response: We agree and have made this correction.

*Comment on Section 12.03(b): Please include same-sex couples as recognized under state law.*

Response: Although Vermont recognizes marriages between same-sex couples, federal law has not. Married same-sex couples under current federal law must file separate tax returns. However, due to the recent Supreme Court decision on the Defense of Marriage Act, we expect further guidance on how that decision will affect various provisions as set forth in this proposed rule.

### **Section 13.00 Cost-sharing reductions (CSR)**

*Comment on Section 13.01(a)(3): The reference to 28.03(b) is not correct; it should be 28.05(b). 28.03 is Medicaid Magi and contains a different definition of household income than the APTC section, which is 28.05(b).*

Response: We agree and have made this correction.

*Comment on Section 13.03: Because this section applies to multiple tax households on a single QHP, the phrase "one of the applicants in the tax household" is confusing and ambiguous. Examples would be helpful. It is difficult to envision exactly how this would work in different situations.*

Response: We are revising this section to reflect proposed federal regulation changes that we believe make the language more understandable; in addition, in the emergency and proposed rules to be filed this fall, we plan to add an example to this section.

*Comment on Section 13.03: This section contemplates what will occur when APTC is awarded to multiple tax households. We believe this is consistent with federal law. However, we note that in our discussions with State representatives, we have been told that APTC will only be awarded at the insurance household level. We strongly encourage you to ensure that this complex topic be accurate in both the rules and operational plans as failure to implement this consistent with federal and Vermont law could be harmful for certain Vermonters, such as spouses in same sex marriages.*

Response: This section applies to situations in which two or more tax households are enrolled in a single QHP, in which case CSR for the plan will be awarded at the lowest level for which one of the tax households is eligible. We do not expect this situation to occur often, and should not occur with same-sex marriages due to the recent Supreme Court decision; however, it could occur if, say, a parent has enrolled a child under age 26 in the parent's QHP, and the child is his or her own tax household. As stated in the above comment, proposed federal regulations, which we have included in the final proposed rule, provide clearer language.

#### **Section 14.00 Catastrophic Plan**

*Comment on Section 14.00: Several commenters suggested including a minimum age, one commenter suggested 19, so that catastrophic coverage is available only to adults under age 30.*

Response: The federal law creating catastrophic plans does not place a minimum age on persons enrolling in a catastrophic plan. Federal regulations specifically provided that if a catastrophic plan covers more than one person (such as a catastrophic family plan), each individual enrolled must satisfy at least one of these two eligibility criteria. 78 FR 13406, 13424, February 27, 2013. Under the proposed rule, parents over 30 would not be able to purchase a child only catastrophic plan. A child would only be able to be enrolled in a family plan. We do not foresee parents over thirty who have received an exemption from Vermont Health Connect foregoing Medicaid or CHIP coverage for their eligible children.

*Comment on Section 14.00: This section refers to catastrophic plans. Please note that the lead-in language refers to "QHP that is a catastrophic plan" but it is our understanding that a catastrophic plan is not a QHP (see, for example, the definition of catastrophic plan included in the proposed rule). Section 14.00(b) states that an individual must have a "certification" but does not state how one receives such certification or what entity is responsible for issuing certifications. We request that these items be specified in the rule.*

Response: We agree that catastrophic plans are not QHPs and have removed the references to a QHP from this section and all other sections in which it appears. We will incorporate rules for the issuance of certifications of exemption in the emergency and proposed rules to be filed this fall. HHS issued a proposed rule on February 1, 2013, that would divide responsibility for issuing certifications between states and the federal government depending on the reason for the exemption.

#### **Section 16.00 Social Security Number**

*Comment on Section 16.02: This section provides that an individual "apply for QHP-related health benefits and who has a Social Security number must provide it." Does this apply even if the individual is not seeking any government assistance? If so, the rule should clearly specify.*

Response: Yes, individuals who have an SSN must provide it, even if they are not seeking APTC or CSR. We have clarified this in the final proposed rule.

## **Section 17.00 Citizenship**

*Comment on Section 17.00: Does enrollment and eligibility (citizenship status) apply to employer sponsored plans? Employers already obtain this information for I9s. Also these all appear to be indications of US citizenship, what about VT resident status for individual coverage through the VT exchange (non-employer sponsored insurance)? It appears in 55.01 residency will be determined solely by attestation?*

Response: Verification of citizenship or lawful presence is the responsibility of employers. VHC will not verify citizenship status for employees enrolling in QHPs. Residency will be determined by attestation unless there is other information available that conflicts with the individual's attestation.

*Comment on Section 17.01(d)(10): This subsection is confusing. "An American Indian, born outside of the U.S. and who enters and re-enters and resides in the U.S. ..." What is the meaning/purpose of "enters and re-enters"? Why is it not sufficient to say it applies to an American Indian who was "born outside of the U.S. and resides in the U.S."?*

Response: This section is not a substantive change from existing policy, and while we appreciate the concern raised by the commenter regarding the language, it is beyond the scope of this rulemaking effort.

## **Section 18.00 Assignment of Rights and Cooperation Requirements**

*Comment on Section 18.00: This section refers to assignment of rights and cooperation requirements. It is not entirely clear which of these sections apply to Medicaid only and which apply to all assistance programs and which apply to even those individuals who do not receive assistance. We request that this be clarified in each section.*

Response: This entire section applies only to Medicaid. We have clarified this in the section title.

*Comment on Section 18.04: Good cause for noncooperation. A new subsection (c) should be added to incorporate the provisions of P-2235.5 Review of Good Cause Waivers (02/04/2012, 11-04) concerning documentation required at eligibility reviews. The procedure reads, "A review of the continued existence of good cause circumstances upon which the waiver was granted is required no less frequently than at each redetermination of eligibility for those cases in which determination of good cause is based on a circumstance that may change. A formal decision based upon resubmission of evidence shall not be required, however, unless the eligibility*

*worker determines that significant change of circumstances relative to good cause has occurred.” This language is good and should be incorporated here.*

Response: Because there has been no change to the language in current policy at 4138-4138.4, this comment is beyond the scope of this rulemaking process.

## **Section 20.00 Living Arrangements for Medicaid Eligibility Purposes**

*Comment on Section 20.03: Broaden to include other facilities similar to Brattleboro Retreat.*

Response: This section did not change current rules at 4218 and 4382 and so is outside the scope for this rulemaking. We have determined, however, that to better align with current rules, since there has been no substantive change, Section 20.03 should be made a subsection under Section 20.01; Brattleboro Retreat is an example of a private facility that meets the living arrangement requirement for individuals who are living there and are under the age of 21 or age 65 or older. That change has been made.

## **Section 21.00 Residency**

*Comment on Section 21.03: Question re state residency requirement for VHC programs.*

Response: We interpret the question referred to in 21.03 to be the question at the 21.13(c). See below.

*Comment on Section 21.03: This section specifies who is a Vermont resident, but it appears to be limited to certain scenarios, with a primary focus on qualifying for public programs. We strongly recommend clear regulatory guidance on who shall be considered a Vermont resident for all VHC programs. Failure to clearly specify applicable rules opens the door for inconsistent application of residency requirements to people in the same situation.*

Response: We believe that section 21.00 applies to all VHC programs, except as specifically indicated in sections 21.12 and 21.14, which apply to QHPs and Medicaid, respectively. 45 CFR 155.305 defines residency for enrollment in QHPs for two scenarios, but then refers to the residency requirements defined in 42 CFR 403 for all other scenarios.

*Comment on Section 21.06(c)(1-3): The rule provides three different ways to determine an institutionalized individual’s state of residence. More than one of these may apply to the same individual. In that case, which rule governs? Can the individual choose?*

Response: We do not believe that more than one condition can exist simultaneously. A child’s state of residence is the current state of residence of the parent applying if the child is institutionalized in the same state as that parent ((c)(3)). If the child is not institutionalized in the same state as the parent applying and the child has two parents who live in separate states from each other, the child’s state of residence is the state of the parent applying ((c)(1)). If the child is not institutionalized in the same state as the parent applying and both parents live in a

different state than the state of the child, the child's state of residence is the state of residence of the parent at the time the child was institutionalized.

*Comment on Section 21.08(c): This section shows two ways of determining residency. Which trumps in cases where both apply?*

Response: We do not believe that both conditions could apply simultaneously to one institutionalized individual. If the individual is institutionalized in the same state in which the individual's parent is currently living, the individual is a resident of that state; otherwise, the state of residence for the individual is the state in which the parent lived at the time of placement.

*Comment: Some language on residency was not carried forward, and should continue to be in the regulations: Former 4217.5D: "Failure to have a fixed or permanent address is not a reason to deny Medicaid." This is an essential protection for homeless individuals.*

Response: We believe that the state of homelessness is adequately covered by the language in 21.06 (a)(1), which states that an individual's state of residence is the state where the individual is living and intends to reside, "including without a fixed address."

*Comment on Section 21.13(c): In reference to residency, an absence is not temporary if another state or Exchange verifies that the individual meets the residency standard of such other state or Exchange. What about adult children under the age of 26 who wish to remain on their parent's insurance?*

Response: Following public comment, HHS has struck the exception language from the final federal regulation with respect to exchanges, 45 CFR §155.305(a)(3)(v), 78 FR 42160. We intend to revise 21.13(c) in the emergency and proposed rules to be filed this fall to limit it to Medicaid.

*Comment on Section 21.14: Residence as Payment Requirement. This section carries forward language from the previous regulations (4217.4), but drops a crucial clause: "the service however does not have to be rendered in Vermont". This clause should be included, as in appropriate circumstances, Vermont pays for out-of-state treatment.*

Response: We have added the clause back in, but with the clarification that payment is subject to certain restrictions as specified in 42 CFR Section 431.52.

## **22.00 Pursuit of Potential Unearned Income for Medicaid Eligibility**

*Comment: The interpretive memorandum facing 4137 (03/19/1996) needs to be incorporated into the proposed regulations. It states, "Individuals are not required to apply for Medicare Part B as a condition of eligibility for Medicaid."*

Response: We agree with the commenter and have revised the proposed rule accordingly.

## **Section 23.00 Minimum Essential Coverage**

*Comment: The 23.00 Minimum Essential Coverage (MEC) section is very confusing for those not familiar with the ACA. A general introduction explaining the impact of being found “eligible for MEC” would be helpful. For example, “MEC is an important concept for two main reasons under the ACA. First, MEC is important in the context of the federal shared responsibility payment, the so-called individual mandate. Under the ACA, individuals must have MEC, qualify for an exemption, or pay a penalty on their federal income tax return. Second, MEC is important for APTC eligibility. As set out in §12.02(b), one of the criteria for APTC is that the individual “Is not eligible for MEC (within the meaning of § 23.00) other than individual coverage offered through VHC.” The rules in §23.00 will therefore be used to determine whether an individual meets the APTC criterion in 12.02(b).”*

Response: We agree and have added an introductory paragraph.

*Comment on Section 23.00: This section covers minimum essential coverage. It is unclear exactly what sort of regulatory authority the Exchange or AHS would have over a minimum essential coverage determination. It would be helpful to specify in this section of the rule what specifically VHC or AHS (or other State entity) will be primarily responsible for in the context of this federal tax penalty framework.*

Response: Based on federal proposed rules, we believe that determinations of minimum essential coverage, affordability, and minimum value will be a shared responsibility between states and the federal government. The final federal rule on determining MEC was issued on 6/23/13 and we have not yet had time to analyze it. We will be clarifying this section in future rulemaking.

*Comment on Section 23.00(a): This section defines minimum essential coverage, which is the coverage a person must have in order to avoid paying a federal tax penalty. We note that this section does not explicitly include individual (nongroup) VHC coverage. We recommend that this section more closely track the federal law as the federal law controls. See, e.g., 26 U.S.C. § 5000A(f)(C).*

Response: Our definition is the same as the definition in 26 CFR 1.36B-2c; however, we will add individual plans to §23.00(a).

*Comment on Section 23.01(a): Explaining that affordability and minimum value are required for any plan to constitute MEC for APTC eligibility purposes would make clear that a person can qualify for APTC if their grandfathered plan is not affordable.*

Response: We have clarified that grandfathered group plans are eligible employer sponsored plans. Only eligible employer sponsored plans as defined in IRC 5000A(f)(2) as provided for in 26 CFR 1.36B-2(c)(3) are subject to the affordability and minimum value tests for purposes of MEC eligibility in relation to APTC eligibility.

*Comment on Section 23.01(a): This section should explain the concepts of affordability and minimum value, before listing the types of insurance that can constitute MEC. Affordability and minimum value are crucial concepts for determining whether an individual is considered “eligible for other MEC” under §12.02(b) and thus ineligible for APTC.*

Response: We have added a statement to the beginning of the section to refer to 23.02 and 23.03 for determinations of affordability and minimum value for employer-sponsored plans.

*Comment on Section 23.01(b)(2): This paragraph is confusing. The rule needs to clearly state its practical impact. It appears to provide individuals with a 3-month grace period in which they will not be treated as “eligible for government-sponsored MEC” following a qualifying event, unless they are actually enrolled in government coverage during those 3 months. If that is the case, the rule should clearly say that.*

Response: We agree that the language is somewhat vague, since it is making a general statement that is intended to apply to several different types of coverage. However, we believe that the examples given in 23.01(b)(6) are sufficient to clarify the meaning in 23.01(b)(2) for the various coverage types.

*Comment on Section 23.01(b)(6): In example 5, the draft rule may lead some readers to believe a beneficiary can't apply for Medicaid if they are on a QHP with subsidies and their income decreases. We understand the intent is that the beneficiary can choose to remain on the QHP with APTC rather than apply for MCA. We suggest adding a final sentence to the example to clarify this: “Therefore, G remains eligible for a QHP with APTC and CSR.”*

Response: The purpose of example 5 under 23.01(b)(6) is to explain how to apply the rule stated at 23.01(b)(5). We believe that the example, as written, does that, and will not be making any revision to this example.

*Comment on 23.01(c)(1): The definition of “related individual” should be moved to its own subsection, or to the definitions section. It is easy to miss a definition buried within a substantive rule.*

Response: We will consider adding a definition of “related individual” when we file the emergency and proposed rules this fall. We are expecting future federal guidance that may require modifications to this section.

*Comment on Section 23.02: Affordable coverage for employer-sponsored MEC  
(1) The relevant test of affordability for employees is whether the premium cost to the employee of their employer-sponsored insurance exceeds 9.5% of their household income. The affordability test is not the “required contribution percentage” as stated in the proposed rule.*

Response: The “required contribution percentage” is 9.5%, as defined in 23.02(c).

*Comment on 23.02(2): The rule needs to explain the affordability test for related individuals.*

Response: The federal government had marked this section as [Reserved] in prior rulemaking. The IRS has since provided the information necessary for this provision and the example under (d)(2), so we have added it to our rule (see final IRS regulation dated 2/1/13).

*Comment on 23.02(a)(4): What will the process be to update us on any federal rules affecting these rules?*

Response: This section on how wellness incentives and amounts made available under a health reimbursement arrangement are treated in determining the affordability of eligible employer-sponsored coverage will need to be addressed in future rulemaking.

*Comment on 23.02(d)(3): Example 3. This is another instance of the problem we noted in 23.01(b)(6), where by operation of the rules, a person is treated as if their situation were different than it actually is. We suggest additions (underlined) to the final sentence of this example. “Consequently, under paragraph (a)(3), X’s plan is considered not affordable for D and D is not considered eligible for MEC under X’s plan for 2014. Therefore, D remains eligible for a QHP with APTC and CSR for 2014.”*

Response: The purpose of Example 3 under 23.02(d)(3) is to explain how to apply the rule stated at 23.02(a)(3). We believe that the example, as written, does that, and will not be making any revision to this example.

*Comment on Section 23.02(d)(4): See comment to 23.02(d)(3).*

Response: The purpose of Example 4 under 23.02(d)(3) is to explain how to apply the rule stated at 23.02(a)(3). We believe that the example, as written, does that, and will not be making any revision to this example.

*Comment on Section 23.02(d)(8): See comment to 23.02(d)(3).*

Response: The purpose of Example 8 under 23.02(d)(3) is to explain how to apply the rule stated at 23.02(a)(1). We believe that the example, as written, does that, and will not be making any revision to this example.

## **Section 24.00 Patient share payment for MABD for long-term care**

*Comment: Section 24.01 includes an explicit reference to “hospice” services (in addition to “institutional” and “waiver” services). (2) Section 24.04(d) extends the “home-upkeep deduction” period from 3 to 6 months. We are in favor of both of these changes.*

Response: We appreciate the commenter's support for both of these changes. However, as part of our ongoing effort to streamline the language in the rule and promote clarity, the definitions of hospice services and long-term care services have been modified in Section 3.00. As a result of those modifications, the reference to "hospice" services in 24.01 was removed as being unnecessary since, by definition, hospice services are included in long-term care services.

*Comment on Section 24.01(a): The definition of "patient share" should contain a citation to the pertinent federal regulations of 42 C.F.R. §§435.725, 435.726 & 435.735.*

Response: We have added the citation.

*Comment on Section 24.01(b)(1): This section says that the patient share payable by the individual is the lesser of (i) The balance of the individual's income remaining after computing the patient share; and (ii) the cost of care remaining after third-party payments. Subsection (i) would be more clear if it said, "the balance of the individual's income remaining after subtracting allowable expenses."*

Response: We have considered the commenter's revised language, but have determined that the language in this section as it is currently written is clear. No change to this section will be made.

*Comment on Section 24.02(b)(4): This chart only calculates charges based on the day the resident was admitted, not on the day they were discharged. It appears that a person may not be charged if they are not residing in the facility at the end of the month. Clarify whether this is true.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4461.1). Questions with respect to existing policy are not within the scope of this rulemaking effort. We would, though, direct the commenter to Section 24.02(a) for information in response to the question. We would also be willing to confer with the commenter outside of this forum should that be insufficient in answering their question.

*Comment on Section 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: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4462). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would, though, be willing to confer with the commenter outside of this forum to address their concern and respond to their question.

*Comment on Section 24.05(b): Both (1) and (2) are unclear as to whether "the last day of the month..." modifies the date the payment is due or the date of the hospitalization.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4463.1). Comments with respect to existing policy are not within the scope of this rulemaking effort. We have, however, reviewed this section and feel that it is clear as it is worded. We would be willing to confer with the commenter outside of this forum to address their concern since we do not find these sections unclear.

### **Section 25.00 Income or Resource Transfers and MABD for Long-term Care Eligibility**

*Comment: Section 25.01(b) makes explicit that post-eligibility transfers by a community spouse are NOT considered (or penalized). We are in favor of this change.*

Response: We appreciate the commenter's support for this change. To provide further clarity with respect to this change, we have determined that additional language is needed to make it clear that such transfers by the community spouse are not considered for purposes of the institutionalized spouse's ongoing long-term care Medicaid eligibility. We are concerned that without such additional language there might be confusion, since any transfers by the community spouse would be considered for purposes of the community spouse's eligibility should the community spouse apply for MABD for long-term care services in the future. Further, we have reconsidered our insertion in this section of the word "new" preceding the reference to "resources of the CS," and have determined that the word should be removed from the rule, since the concept of "new" isn't appropriate in that the community spouse could have "existing" resources not counted at the time of the institutionalized spouse's initial eligibility determination (for example, as part of the community spouse's community spouse resource allocation (CSRA)).

*Comment: There is an ambiguity in the "annuity" rules set forth at 25.01 (h & i) which makes it unclear whether a community spouse may continue to shelter excess assets by using them to buy an annuity for his/her own benefit. While Rule 25.01(h)(1)(1) indicates a community spouse may continue to do so, Rule 25.01(h)(2) suggests otherwise, by only referring to payments to and/or the life expectancy of "the individual" while deleting any reference to "their spouse." We suggest this ambiguity be clarified. Federal law (the Deficit Reduction Act of 2005) and a 2d Circuit Court of Appeals decision, *Lopes v. Starkowski*, Docket No. 10-3741-cv., October 02, 2012, clearly state that a non-assignable income stream from an annuity to a community spouse are not a resource.*

Response: We do not agree that there is any ambiguity in the annuity sections 25.01(h)(1) and 25.01(h)(2), and agree with your general statement that a community spouse may continue to shelter excess assets by using them to buy an annuity for his/her own benefits. Section 25.01(h)(2) does not state that a community spouse can no longer do that. Rather, this section, in compliance with Section 6012(c) of the DRA of 2005 which amends Section 1917(c)(1) by adding a new subparagraph (G), addresses only annuities that are purchased by or on behalf of an annuitant who is applying for MABD for long-term care services. With respect to such an individual, the requirements under this section are in addition to the requirements under Section 25.01(h)(1); they apply only when the annuitant is the individual requesting MABD for long-term care services. As stated by CMS in its SMD letter #06-018, Section 6012(c) of the DRA of 2005 added new subparagraph (G) to Section 1917(c)(1) of the Social Security Act to provide that the purchase of an annuity by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services will be treated as a transfer of assets for less than fair market value unless the annuity meets certain criteria. We believe that, as worded in the proposed rule, Section 25.01(h)(2) accurately states the additional requirements of Section 6012(c) of the DRA of 2005.

*Comment on Section 25.02(a): The first sentence is a fragment. It is clearer to state, "For the purposes of this section, a transfer of income or resources is any action taken by an individual..."*

Response: The definition in this section was not intended to be a full sentence, but, for clarity, we will add the language suggested.

*Comment: Section 25.03(c)(1) omits any reference to pre- versus post- 02/08/2006 transfers. We assume that this omission is due to the passage of time since DRA; any pre-DRA transfers were more than 5 years ago.*

Response: This assumption is correct.

*Comment: Section 25.03(c)(2 & 3) appears to narrow the "cure" rule by deleting language found in the current version to the effect that a cure will result if a transferred asset is returned to the transferor "or another member of the financial responsibility group." It is unclear if the definition of "transferor" has been expanded to include "other members of the financial responsibility group." We are concerned about this change. If a transferred asset is returned to a member of the financial responsibility group other than the applicant, it should be considered a cure of the gift penalty, as in the present rule.*

Response: It was not our intent to narrow this exception, and we have added language to this provision to reflect the language in the current rule at 4473(B).

*Comment: Section 25.03(d)(1) appears to narrow the "trust" exceptions to the gift penalty rules by providing that a transfer to an irrevocable trust made more than 5 years before the date for which*

*Medicaid LTC is sought will be subject to a gift penalty if there are any circumstances under which the trust permits disbursements to or for the benefit of the individual "or a member of the individual's financial group."*

Response: It was not our intent to narrow this exception, and, while we do not necessarily agree that the added language did that, we have removed that language. We would, however, want to make sure it is understood that any trust created by an individual or a member of their financial responsibility group would be subject to the trust exclusion requirements under Section 29.08(e).

*Comment on Section 25.04(a)(2): The second sentence in this paragraph needs a bit more detail. It states, "An individual with a penalty is subject to the penalty period start date the date the spenddown is met." This should likely say, "An individual...is subject to the penalty period start date beginning on the date the spenddown is met."*

Response: We agree and have made the change.

*Comment on Section 25.03(a)(4)(iv): The "fair market value" penalty exemption for expenses associated with a "transferred property" such as taxes, mortgage, insurance and repairs should also include payment for the maintenance and upkeep of the property.*

Response: We presume the commenter intended to reference Section 25.03(a)(5)(iv). If so, this section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4472(E)(4)). Comments with respect to existing policy are not within the scope of this rulemaking effort. However, when it is possible, as it is here, we have done our best to be responsive to comments. We have reviewed the commenter's suggested revision to this section and have revised the section accordingly.

*Comment on Section 25.03(c): This general provision 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: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4473). Comments with respect to existing policy are not within the scope of this rulemaking effort. We do, however, want to clarify that this section is not intended to be a general statement on transfers for less than fair market value and, rather, is intended to identify transfers for less than fair market value that are not subject to the imposition of a penalty period. We would be willing to confer with the commenter outside of this forum to address their concern.

*Comment on Section 25.03(c)(4): To be consistent with federal law and Human Services Board precedent, this transfer penalty exemption should be reworded. It should say: The transferor*

*has made a satisfactory showing 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 satisfactory 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: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4473(D)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We appreciate the detailed summary by the commenter on this issue and will take their proposed revision to this section under consideration for future rulemaking.

*Comment on Section 25.03(c)(4)(ii): The parenthetical in this transfer penalty exemption should not be limited to a “traumatic accident” but should also include an unanticipated and significant change or worsening of an individual’s condition after the date of transfer.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4473(D)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We will take the commenter’s proposed revision to this section under consideration for future rulemaking.

*Comment on Section 25.03(c)(7)(ii): The proposed rule language concerning transfers of excluded income or resources is wrong. No penalty should be imposed for a transfer of an excluded resource. The only exception is for a transfer of a home under certain circumstances. Also, this provision is internally contradictory. It should read as follows:*

*A penalty period is not imposed for transfers for less than fair market value of any asset considered by the SSA’s SSI program to be excluded, with the exception of the home, unless the transfer of the home meets the conditions of 25.03(e).*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4473(G)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We respect the concern raised by the commenter and will take their proposed revision to this section under consideration for future rulemaking.

*Comment on Section 25.03(c)(8): 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: Existing policy does not include an exemption from transfer penalty for nominal gifts. The suggestion that new policy be made to include such an exemption is outside the scope of this rulemaking effort.

*Comment on Section 25.03(j)(1): The last sentence of this provision 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 section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4473.5(A)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We appreciate the commenter's earlier detailed summary on this issue and will take their proposed revision to this section under consideration for future rulemaking.

*Comment on Section 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.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4474.4(C)(4)). Comments with respect to existing policy are not within the scope of this rulemaking effort. However, when it is possible, as it is here, we have done our best to be responsive to comments. We reviewed the commenter's suggested revision to this section and have revised the section to include a portion of the proposed revision.

*Comment on Section 25.05(e)(1): This provision states, “When the transfer is to a person, AHS presumes the recipient of the transferred asset could make arrangements for the individual’s care and the care of dependent family members up to the value of the transfer unless...” This presumption of care provision should be changed from “person” to “relative” (e.g. son, daughter, grandchild or other relative).*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4474.4(C)(6)(a)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to address their concern with this section as it is worded.

*Comment on Section 25.05(e)(2): this rebuttal provision should include assignment. AHS should insert: An individual can rebut the presumption of care by assigning his or her rights to any claims for recovery or support from the recipient of the transferred asset.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4474.4(C)(6)(b)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to discuss their concern.

*Comment on Section 25.05(f)(4): This standard of proof requires demonstration of actual hardship. This is too stringent a burden in situations where the hardship has not yet occurred but is likely to occur. Requiring proof of either “likely” or “probable” undue hardship is more reasonable.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4474.4(B)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to discuss their concern.

## **Section 28.00 Financial Eligibility Standards**

*Comment on Section 28.02(a) Definitions for MAGI: Is there an age requirement for a “child”?*

Response: We have moved “child,” “parent,” and “sibling” out of definitions under 28.02 and added them as an introduction to section 28.03(d) since their purpose is to describe the degrees of relationship in terms of forming the MAGI household and not to define them.

*Comment on Section 28.02(f) definition of “tax dependent”: There is a conflict in the definition of “tax dependent” in the federal Medicaid and Exchange rules. The Medicaid rule includes the spouse as a tax dependent, whereas the Exchange rule, which is based on the IRS definition, does not. Vermont should not adopt two different definitions. We recommend that the HHS Exchange definition of tax dependent be used in these rules. The intent of HHS’s Medicaid rule can be preserved through minor changes in wording, e.g. ensuring that the relevant rules mention “tax dependent or spouse” in all sections rather than just “tax dependent.”*

Response: In order to ensure compliance with the federal Medicaid regulations, when applicable, and federal Exchange regulations, when applicable, we have created separate definitions for “tax dependent;” a definition that will apply for purposes of APTC and CSR eligibility, and a definition that will apply for purposes of MAGI-based Medicaid eligibility. We have also revised the definition of “tax dependent” in Section 3.00 in light of these changes.

*Comment on Section 28.02(b)(2): I like this counting rule for Medicaid, and advise that VHC also adopt this rule. It is crucial to getting prenatal care, and would increase the availability of APTC for the family. In addition, the first 30 days after the birth of a child (the window of the qualifying event in which to change your coverage) is hectic, and the parents are more often than not sleep-deprived. It is not a good time for them to be trying to change coverage, and they are likely to miss the 30-day window. If the counting was updated while the mother was pregnant, this would ease the family’s burden considerably.*

Response: We are not able to use the Medicaid rule, which allows a pregnant woman’s household size to include the number of babies she is expecting, for purposes of determining household size for APTC, since IRS regulations do not permit this.

*Comment on Section 28.03(b)(2) MAGI-Based Medicaid: Income of children and tax dependents: The current language used in both (i) and (ii), “required to file a tax return” is imprecise. We suggest, “required to file a federal income tax return.” As noted by footnotes 230 and 231, this rule only applies to people with a federal income tax filing requirement, as determined under IRC 6012(a)(1).*

Response: We agree and will clarify that it is the federal tax return filing requirements that are relevant to this section.

*Comment on Section 28.03(d) Household: This section should be substantially revised for greater clarity.*

Response: We understand that the household composition rules for MAGI-based Medicaid are complicated, but we have thus far not been able to describe them in a way that is simple and clear. We may develop examples at a later time for training purposes and could share those examples with stakeholders.

*Comment on Section 28.03(d)(1): “subject to paragraph (d)(5) of this subsection” should be replaced by “subject to paragraphs (d)(3), (d)(4), and (d)(5) of this subsection.”*

Response: We believe that the reference to (d)(5) is correct. Section (d)(1) is specific to the individual who is a tax filer; sections (d)(3) and (d) (4) are specific to individuals who are tax dependents or who are neither tax filers nor tax dependents.

*Comment on Section 28.03(d)(4): See comment to 28.02(f) above. Suggested revision: "...or whether one spouse expects their personal exemption to be claimed by the other spouse under IRC 151(b)." The rules also need to specify that "married couple" is defined by federal standards. Add the following sentence to the end of this section: "This rule only applies to couples considered married under federal law. See Sec. 58.02(b)(2)."*

Response: We have made revisions to the definition of "tax dependent" for purposes of MAGI-based Medicaid eligibility that we think addresses this comment. It is not clear based on recent Supreme Court decisions how same-sex married couples will be treated under the tax code and other federal laws. We may need to clarify this point in the emergency and proposed rules this fall after federal guidance has been issued.

*Comment on Section 28.03(f) Budget period: (2) gives AHS the option to use projected annual income instead of current monthly income. Beneficiaries should be able to choose the budget period that they believe works best in their situation.*

Response: We have revised the final proposed rule to reflect our decision to use projected annual income. We do not believe that the federal regulations allow individuals to choose the budget period that works better for them at the time. The options for states are (1) use current income, or (2) use projected income. To promote flexibility, administrative simplicity, and continuity of coverage, we have chosen the "projected" income so that fluctuations in an individual's income through the end of the year can be taken into consideration.

*Comment on Section 28.03(h): Eligibility groups for which MAGI-based methods do not apply. Since the MAGI methodology will not be used for determining eligibility for the pharmacy programs until some time in the future, they should be added to this list.*

Response: We believe that the reference to current rules in Section 10.01 is sufficient, given that the retention of current rules is temporary.

*Comment on Section 28.03(h)(2): It would be clearer to specify the situations where age is a condition of eligibility instead of saying "when age is a condition of eligibility."*

Response: We believe that, as a whole, Section 28.03(h) is clear.

*Comment on Section 28.03(h)(3): This explanation of eligibility for the blind and disabled is unclear.*

Response: We have not made a change to this section. The language we use in (h)(3) is taken verbatim from the federal regulation. The wording of (h)(3) is similar to the wording of (h)(2) and (h)(5). Section (h)(3) is not an explanation of eligibility for the blind/disabled, but rather a statement to make clear that if a person is being determined eligible for Medicaid on the basis of being blind or disabled, their eligibility will not be determined using MAGI-based methodologies.

*Comment on Section 28.04(b)(ii) Medically-needy MCA: financial responsibility of relatives and other individuals. To clarify the meaning of “parent” in this section, add “...unless the child is pregnant or a parent whose child is living in the household...”*

Response: We agree and have made this change.

*Comment on Section 28.05(b)(2)(ii): see comment to 28.03(b)(2). We suggest the following language: “Are required to file a federal income tax return under IRC 6012(a)(1).” The language regarding IRC §1(g)(7) has been removed from the federal regulations. Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909 (proposed May 3, 2013).*

Response: We agree and have made this change.

*Comment on Section 28.05(c): The last sentence in this paragraph states, “Pursuant to Sec. 58.02(b)(2), married couples must file joint tax returns.” This sentence should be deleted, as this is not a financial eligibility standard, and it is covered in 58.02(b)(2). Alternately, it should be revised to clarify its meaning and purpose. If the sentence is retained, we suggest, “To receive APTC or CSR, married couples must file joint tax returns. This requirement only applies to couples considered married under federal law. See Sec. 58.02(b)(2).”*

Response: We believe it is useful to keep the reference to 58.02(b)(2) in this section. Although filing a joint return is not a financial eligibility criterion, it is an eligibility criterion for APTC and CSR. We will add your suggested clarification without the reference to federal marriage law.

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

*Comment on Section 29.03(d)(3): This paragraph refers to “qualifying quarters,” but this concept is not defined.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4221.4(A)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would, however, note that a reference is made in this section, as it is in existing policy, to applicable federal law.

*Comment on Section 29.04(c)(2)(i): This section can apply to separated couples. Specify whether this requires physical separation in that the couple is no longer living in the same residence, or if the couple can be considered separated when the relationship has ended but the couple is still living in the same residence and maintaining separate households at that residence.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4474.4(C)(6)(b)). Comments with respect to existing policy are not within the scope of this rulemaking effort.

*Comment on Section 29.04(c)(2) (iii) and 29.02(d)(iii): Does this mean the couple is divided economically at point of assessment? The first section refers to the point of assessment. The Note in the second section refers to no longer living together. So where is the authority to request CS information at renewal when they have been divided economically at point of original assessment? This is not specified or addressed on page 170, 29.10 (e). What CS information, if any, needs to be addressed at point of renewal?*

Response: Section 29.04(c)(2)(iii) of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4222.2). Section 29.02(d)(1)(iii) is also not a substantive change from existing policy (see Medicaid SSI Rule 4222.3). Questions with respect to existing policy are not within the scope of this rulemaking effort. We would, though, be willing to confer with the commenter outside of this forum to address their concern and respond to their question.

*Comment: Section 29.07(b)(2)(iii)(A) defines annuities. (I) states: There are always two parties to an annuity: The writer of the annuity, usually an insurance carrier or charitable organization, and the purchaser who owns the annuity (sometimes referred to as the annuitant). Actually, there may be three parties: the writer, the owner of the annuity and the annuitant, the person on whose life the annuity payments are based.*

Response: We agree, and have added a provision in this section to state that the party to the annuity known as the “annuitant” may be an individual other than the owner of the annuity.

*Comment: Section 29.08(a)(1)(ii)(D) addresses the home exclusion.*

*(D) The home exclusion also applies if the owner is absent from the home due to institutionalization, provided they have not placed the home in a revocable trust, and any one of the following three conditions is satisfied:*

*(I) The owner intends to return to the home even if the likelihood of return is apparently nil.*

*(II) The owner has a spouse or dependent relative residing in the home. Dependent relative in this context applies to:*

*(i) Any kind of dependency (medical, financial, etc.); and*

*(ii) A relationship to the owner that is one of the following: child, stepchild, or grandchild; parent, stepparent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, stepbrother or stepsister, half brother or half sister; cousin; or in-law.*

*(III) The owner has a medical condition that prevented them from residing in the home before institutionalization.*

*A PPD, Number M 234, dated 12/30/1988, states that the ESD is supposed to accept the individual's or dependent relative's statement of dependency unless there is a reason to question it. If this PPD is still current, why is the substance of the PPD not included in the new rule?*

Response: Rule M234 was replaced by Rule 4260, which is the current rule on countable resources.

There is no PP&D (aka Interpretive Memorandum) in the current rule at Rule 4260. Accordingly, it would appear that the PP&D from 12/30/1988 referred to by the commenter is not current. Therefore, we have no response to this comment.

*Comment on Section 29.08(1)(D)(III) and (F): There is ambiguity between the first section as to a "medical condition" which is not defined, preventing residency, and the Section, (F) which uses 'hospitalization.' Neither is defined.*

Response: The proposed rule does not contain a section 29.08(1)(D)(III) or a section 29.08(1)(F). We presume that the commenter is referring to Sections 29.08(a)(1)(D)(III) and 29.08(a)(1)(F). If that presumption is correct, neither section is a substantive change from existing policy (see Medicaid SSI Rule 4241.1). Questions with respect to existing policy are not within the scope of this rulemaking effort. We would, however, be willing to confer with the commenter outside of this forum to address their concern and respond to their question.

*Comment on Section 29.08(a)(4)(iii): This section stating that any proceeds retained from a home equity conversion plan are countable as a resource conflicts with 29.09(c)(6)(iv), which states that lump sum proceeds from a home equity loan or reverse mortgage are not countable. 29.08(a)(4)(iii) should be revised to clarify that the proceeds from reverse mortgages and home equity loans are not countable as resources if they are retained after the month received.*

Response: We presume that the commenter intended to reference Section 29.09(d)(6)(iv) of the proposed rule. If that presumption is correct, we agree with the commenter that the language in these two (2) sections of the proposed rule is confusing, and have revised each section to resolve that confusion.

*Comment: Section 29.08(a)(5)(i) speaks about real estate owned by joint owners. Is that term meant to include both joint tenants and tenants in common? This comment also relates to section 29.09(d)(3) ("jointly owned real property").*

Response: The language contained in Section 29.08(a)(5)(i) is not a change from current policy. In the current rule, at 4251, assets co-owned in a "tenancy-in-common," a "joint tenancy" or a "tenancy-by-the-entirety" are all described as types of "joint ownerships."

*Comment on Section 29.08(5)(A): Is the intent here that a retained power of income only for any property, including commercial property, will exclude the life estate? I see that the next section (B) requires the retention of the power to sell or mortgage to exclude the "life estate owner's home."*

Response: The proposed rule does not contain a section 29.08(5)(A). In light of the content of the comment (the commenter's reference to "life estate"), we presume that the commenter is referring to Sections 29.08(a)(6)(i)(A) and (B). If that presumption is correct, we are not able to understand the question that is being asked and, therefore, are unable to respond to it. We would note that this section is not a substantive change from existing policy (see Medicaid SSI

Rule 4241.6(B)), and questions with respect to existing policy are not within the scope of this rulemaking effort. We would, however, be willing to confer with the commenter outside of this forum to address their concern and respond to their question.

*Comment: Section 29.08(a)(7) deals with income-producing real property. Subsection (i) deals with non-business real property and excludes the property as a resource if it produces significant income to the owner. Subsection (ii) deals with real property used in a trade or business and excludes the property if it is essential to the owner's self-support and used in a trade or business. This is confusing. These two may not be mutually exclusive. Renting property may be a trade or business. Are these subsections designed to distinguish between rental property and commercial property? Essential is not defined and the way it is used in the proposed rule is circular—the property is “essential” if it is “in current use in the type of activity that qualifies it as essential.” Because the term “current use” has a specific meaning relative to real estate, it might be preferable to use another term in this sentence.*

Response: The language added at Section 29.08(a)(7)(ii) was an effort to state the SSI resource exclusion under Section 1613(a)(3) of the Social Security Act. While current rule 4248.1 makes reference to the exclusion of nonliquid property essential to an individual's self-support, we felt that that language could be more clearly expressed. In response to the commenter's question, if real property rentals is an individual's trade or business, then the exclusion under 29.08(a)(7)(ii) may be applicable to that individual. For guidance on the “current use” criterion, the commenter may find the information provided by the Social Security Administration in its POMS SI 01130.504 helpful.

*Comment: Section 29.08(i)(1) and (2) contain a new sentence that household goods (1) or automobiles (2) that an owner “acquires or holds because of their value or investment are not excluded.” What is the derivation of this addition? It might be clearer to say “value as an investment.” What is the basis in federal law for this addition?*

Response: The explanation in 29.08 (i)(1)(ii) that the exclusion of household goods and personal effects does not apply to such items that are held for their value or as an investment is derived from federal regulation 20 CFR Section 416.1216. The explanation in 29.08(i)(2)(ii) that the exclusion of automobiles does not apply to any automobile that is held for its value or as an investment is derived from federal regulation 20 CFR Section 416.1218. We are aware that the federal exclusion regulation for an automobile is narrower than Vermont's rule as the Vermont allows for the exclusion of all automobiles of an individual. We maintain, however, that automobiles must still be owned by the individual for purposes of transportation of the individual or of a member of the individual's household, and not for their value or as an investment, and that such limitation accurately reflects the federal requirements. We agree that the wording of the explanations in these sections could be clearer and has revised them accordingly.

*Comment on Section 29.08(i)(1): The heading should say “household goods”, not “household good”.*

Response: We agree and have made that change.

*Comment on Section 29.08(i)(1)(ii): This provision on household goods states, "Items an owner acquires or holds because of their value or investment are not excluded." This is a major change in policy, given that the previous regulations excluded all household goods, personal effects and personal property, without looking to the reason the owner holds them. This section should be eliminated. In the alternative, the word "exclusively" should be added so that it says "Items an owner acquires or holds exclusively because of their value or investment are not excluded".*

Response: The addition of 29.08(i)(1)(ii) is not a shift in current policy. See response to earlier, similar comment.

*Comment on Section 29.08(i)(2): This provision on vehicles states, "Automobiles or other vehicles an owner acquires or holds because of their value or investment are not excluded." This is a major change in policy, given that the previous regulations excluded all automobiles, without looking to the reason the owner holds them. This section should be eliminated. In the alternative, the word "exclusively" should be added so that it says "Automobiles or other vehicles an owner acquires or holds exclusively because of their value or investment are not excluded."*

Response: The addition of 29.08(i)(2)(ii) is not a shift in current policy. See response to earlier, similar comment.

*Comment on Section 29.08(i)(5)(ii): Exclusion of retirement funds. This section states, "If the member is eligible for periodic payments or a lump sum, the member must choose the periodic payments." Add to the end of this sentence, "for the funds to be excluded" to clarify when this choice must be made.*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4248.5(B)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to discuss their concern about the clarity of this section.

*Comment on Section 29.08(5): Where is the federal authority to support the current ESD position to count the IRA of a working Community Spouse who is under retirement age? This is contrary to the intent of the federal legislation prohibiting the impoverishment of the Community Spouse. There needs to be an exclusion in the rule to meet federal law.*

Response: There is no Section 29.08(5) in the proposed rule. In light of the content of this comment, we presume the commenter is referring to Section 29.08(i)(5). Assuming this presumption is correct, this section was derived from existing Medicaid SSI Rule 4248.5. The only substantive change made to existing policy was to combine existing rule 4248.5(B)(2) with existing rule 4248.5(B)(3). This is reflected in 29.08(i)(5)(i)(B). We determined that the combining of these two (2) sections was necessary in order to give meaning to Section 29.08(i)(5)(ii) which contains no substantive change from existing policy. Since this comment is

not with respect to the substantive change that was made to this section and, rather, questions existing policy, it is not within the scope of this rulemaking effort. We would, however, be willing to confer with the commenter outside of this forum to address their concern and respond to their question.

*Comment on Section 29.08(i)(10)(iii): This section excludes state and federal earned income tax credits from resources for nine months after receipt. This is a substantive change from the current rules(Rule 4249.3) which exclude state and federal earned income tax credits without a time limit. The language “for nine months” should be taken out, and this section should be moved from 29.08(i)(10), which is the section of exclusions for limited periods.*

Response: The limited time period for the exclusion of earned income tax credits is derived from federal regulation 20 CFR Section 416.1235(a)(2). This limited time period is not a change from current rule. The current exclusion of tax credits can be found in Medicaid SSI Rule 4249.3. That exclusion is one of nine exclusions identified under Rule 4249 as being excluded for “specific periods” only. Current rule inadvertently omitted the specific period of exclusion for tax credits; the proposed rule is correcting that omission.

*Comment: There is a definition of JT on page 166 which suggests that it includes TIC. 29.09 9(C) (3), even though TIC is defined in 29.09 (2). On page 150, 29.08(5), is this intended to include TIC, or is it limited to JT? The same question applies to Page 167, 29.09(d) (3) which addresses “jointly owned real property.” Where is the authority to limit it to JT if that is the intent?*

Response: Section 29.09(c) of the proposed rule addresses the counting of jointly-owned resources. Section 29.09(c)(3) contains the definition of “joint tenancy.” We are unable to find any language under the definition of joint tenancy in this section to suggest that it includes “tenancy-in-common,” but, if there is any confusion in that regard, we do not intend to define “joint tenancy” to include “tenancy-in-common.” As to the second part of this comment, the proposed rule does not contain a section 29.08(5). In light of the content of the comment (the commenter’s reference to “jointly owned real property”), we presume that the commenter is referring to Section 29.08(a)(5)(i). If that presumption is correct, the language in this section is not a substantive change from existing policy (see Medicaid SSI Rule 4251).

*Comment on Section 29.09(b): This rule on valuing resources is unclear, and should be replaced with the current rule 4230 language. In (b)(2), what is the “original estimate” to be used? Does this mean the price paid for the item, even if it was many years ago and the item has deteriorated substantially since then? If the owner is required to submit evidence from disinterested, knowledgeable sources, then the rule should require that AHS pay for the services of the disinterested knowledgeable source if a fee is charged. The previous definition of “equity value” in Rule 4230 was: “Equity value means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances.” This language should be retained as 29.09(b).*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4250). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to discuss their concern about the clarity of this section.

*Comment: Section 29.09(c)(1) is taken from Rule M 4251. The current rule includes a third paragraph not included in the proposed rule: "Under Vermont law, a co-owner may demand partition, the dividing of lands held by more than one person. For this reason, the department counts the individuals proportionate share of the lands as an available resource, unless excluded as a home (rule 4241.1) or property up for sale (rule 4241.3)." Why was the third paragraph omitted?*

Response: This paragraph will be re-inserted into the rule at 29.09(c)(1)(iii).

*Comment: Section 29.09(c)(5)(ii) is very confusing. "For an account in a financial institution, AHS assumes that all of the funds in the account belong to the member of the financial responsibility group, in equal shares if there is more than one member of the financial responsibility group on the account." The two parts of the sentence seem opposed to each other.*

Response: This section was drafted in an effort to bring clarity to the language contained in current rule 4251.1(B) and to more closely align with the language in 20 CFR Section 416.1208(c). In response to this comment that this section is still confusing, we have further revised it .

*Comment: Section 29.09(d)(1)—annuities states:*

*"Unless an annuity is excluded as a resource under § 29.08(d)(1) or, for purposes of MABD for long term care, treated as a transfer under § 25.03(h), the fair market value of an annuity is counted. The fair market value is equal to the amount of money used to establish the annuity and any additional payments used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees. If evidence is furnished from a reliable source showing that the annuity is worth a lesser amount, AHS will consider a lower value. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other source AHS considers, in its discretion, to be reliable."*

*Does this rule mean that annuities that were subject to a penalty period and/or were purchased before the lookback period are not countable resources?*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4252.1). Questions with respect to existing policy are not within the scope of this rulemaking effort. We would, though, be willing to confer with the commenter outside of this forum to address their concern and respond to their question.

*Comment: Section 29.09(d)(2) contains a mechanism for calculating the value of a life estate if the value of the life estate is not excluded under section 29.08(a)(6). Section 29.08(a)(6) excludes the value of a life estate if created before July 1, 2002 or on or after July 1, 2002. Under what circumstances would a life estate have value? The reference to the table in the Medicaid Procedures Manual is incorrect, as the values in that table actually relate to the value of the remainder interest, not the value of the life estate.*

Response: Life estates created before July 1, 2002 are treated differently than those created on or after July 1, 2002. The difference in treatment under Section 29.08(a)(6) is not a substantive change from existing policy (see Medicaid SSI Rule 4241.6). Questions with respect to existing policy are not within the scope of this rulemaking effort. However, in the event that our addition of cross-references to Section 29.09(d)(2) in Section 29.08(a)(6) has caused confusion, we have removed those cross-references. As to the commenter's question with respect to the valuation of a life estate, the valuation of life estates under Section 29.09(d)(2) is also not a substantive from existing policy (see Medicaid SSI Rule 4252.2) nor is the reference in it to the Medicaid Procedures Manual. While questions with respect to life estate valuation are not within the scope of this rulemaking effort, we reviewed our Medicaid Procedures Manual and confirmed that the table in the Manual is not the best source for valuing a life estate, and revised this section to reference the source that should be used for this purpose.

*Comment: Section 29.09(d)(3) states, with respect to jointly owned property, "AHS presumes that a member of the financial responsibility group that owns real property jointly with another person (or persons) owns the entire equity value of the real property if the joint ownership was created less than 60 months prior to the date of the MABD application." However, section 29.09(c)(5)(i) states as follows, in part: "With the exception noted in (ii) below, AHS assumes, absent evidence to the contrary, that each owner of shared property owns only their fractional interest in the property. The total value of the property is divided among all of the owners in direct proportion to the ownership share held by each. . . ." These two provisions seem inconsistent.*

Response: We agree with the commenter that the presumption stated in Section 29.09(d)(3) seems inconsistent with the assumption made in Section 29.09(c)(5)(i). Accordingly, we have revised Section 29.09(c)(5)(i) to make it clear that the assumption regarding ownership under that section is subject to the presumption of ownership under Section 29.09(d)(3).

*Comment: Section 29.09(d)(5) applies to promissory notes and contracts. The same question arises as pointed out earlier for annuities in section 29.09(d)(1).*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4252.5). Questions with respect to existing policy are not within the scope of this rulemaking effort. We would, though, be willing to confer with the commenter outside of this forum to address their concern and respond to their question.

*Comment on Section 29.09(d)(5)(ii): The phrase “in the discretion of AHS” should be deleted throughout the rules. 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: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4252.5). Comments with respect to existing policy are not within the scope of this rulemaking effort.

*Comment: Section 29.10(e) discusses transfers by an institutional spouse to a community spouse during the one-year period before the first annual certification review. The language is confusing. Can the IS transfer more than the CSRA to the CS if the CS turns the excess assets into something that is not countable?*

Response: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4264). Questions with respect to existing policy are not within the scope of this rulemaking effort. We would, however, be willing to confer with the commenter outside of this forum to address their concern and respond to their question.

*Comment: Section 29.12(d)(3)(vi) states that unearned income includes, inter alia,*

*(3) Unearned income also includes, but is not limited to, the following:*

*\* \* \**

*(vi) Interest earned on life insurance dividends;*

*Whole life insurance sometimes earns dividends, which often take the form of paid up additions to the face value of the policy. Such dividends do not earn interest.*

Response: This section is derived from existing Medicaid SSI Rule 4280.2 which lists the items excluded as unearned income, and includes in that list, at paragraph AH, “[d]ividends paid on life insurance policies, excluding interest.” Accordingly, it is our understanding that a life insurance policy may pay interest on dividend accumulations and, if it does, that interest is considered unearned income for purposes of MABD eligibility. We also found guidance for including interest earned on insurance dividends as unearned income from the Social Security Administration’s POMS SI 00830.500.

*Comment on Section 29.13(b)(1): 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: This section of the proposed rule is not a substantive change from existing policy (see Medicaid SSI Rule 4280.2(A)). Comments with respect to existing policy are not within the scope of this rulemaking effort.

*Comment: Section 29.15(b)(ii) deals with unearned income deductions:*

*“The following are deducted from unearned income:*

*(1) \$20, unless the source of the income gives all assistance based on financial need; and*

*(2) Amounts used to comply with the terms of court-ordered support or Title IV-D support payments.”*

*The way the Department calculates eligibility may exclude, for example, child support payments ordered by a court. However, the Department does not reduce the individual’s patient share for court-ordered child support, which seems inconsistent. If the individual has to pay the child support, but does not receive a deduction from patient share, how will the individual pay his or her patient share?*

Response: The question raised by the commenter is beyond the scope of this rulemaking effort. We would, however, be willing to confer with the commenter outside of this forum to address their concern and respond to their question. We want to remind the commenter that all of the provisions under Section 29.00 of the proposed rule address only an individual’s MABD eligibility. The amount of an individual’s “patient share” for purposes of MABD for long-term care services is a post-eligibility matter and the rules for eligibility purposes under Section 29.00 are not the same as the rules for post-eligibility purposes. We direct the commenter to Section 24.00 of the proposed rule for information an individual’s patient share.

### **Section 30.00 Spenddowns**

*Comment: To be consistent with federal law, all references to “medical expenses” in this section should be changed to “medical or remedial expenses.” 42 U.S.C. § 1396a(a)(17); 42 C.F.R. §435.735(4), § 435.831(e)(2) - (3).*

Response: The reference to “medical expenses” throughout the subsections under Section 30.00 of the proposed rule is not a substantive change from existing policy. Comments with respect to existing policy are not within the scope of this rulemaking effort. We will, however, take the commenter’s proposed revision under consideration.

*Comment on Section 30.05: Is spend down one word, or two? Please be consistent.*

Response: We generally use “spenddown” when referring to the noun, and “spend down” when we are using the term as a verb. For example: “Person A must spend down \$500 of her income to meet her spenddown.”

*Comment on Section 30.05(d)(2)(i) & (ii): These sections should be combined and changed to: Eligibility becomes effective on the first day of the month when a spenddown requirement is met using health insurance expenses, noncovered medical or remedial expenses, or covered medical expenses that are not paid for by Medicaid.*

Response: These sections of the proposed rule are not substantive changes from existing policy (see Medicaid SSI Rules 4441(A) and (B)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to discuss their suggested revision.

*Comment on Section 30.05(f)(3): Change to: "Covered medical expenses (see § 30.06(d)) that exceed limitations on amount, duration, or scope of services covered and are not paid for by Medicaid (see DVHA Rules 7201-7606)."*

Response: These sections of the proposed rule are not substantive changes from existing policy (see Medicaid SSI Rules 4442(C)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to discuss their suggested revision.

*Comment on Section 30.05(f)(4): Change to: "Covered medical expenses (see § 30.06(d)) that do not exceed limitations on amount, duration, or scope of services covered and are not paid for by Medicaid.*

Response: These sections of the proposed rule are not substantive changes from existing policy (see Medicaid SSI Rules 4442(D)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to discuss their suggested revision.

*Comment: Proposed Rules 30.06(c)(3)(v) and 30.06(c)(4)(iv) omit the reference found in current Rules M 4452.3 and 4452. "All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act." What is the authority for this omission?*

Response: It was our determination that such statements in the rule were unnecessary since all changes to the rule must be made via the APA process. However, upon further review of the context within which these references to the APA process are made, we agree that they should be re-inserted and have done so.

*Comment on Section 30.06(c)(5): This should be changed to say: "Dental services in excess of the allowable annual maximum or that Medicaid does not pay for may be deducted."*

Response: These sections of the proposed rule are not substantive changes from existing policy (see Medicaid SSI Rules 4452(E)). Comments with respect to existing policy are not within the scope of this rulemaking effort. We would be willing to confer with the commenter outside of this forum to discuss their suggested revision.

*Comment: Section 30.06(c)(6) allows a deduction from patient share for “private-duty nursing services inpatient or in a nursing facility setting for an individual, age 21 and older.” The current rule, 4452 F, does not limit private-duty nursing to those performed in an inpatient or nursing facility setting. Why was this change made?*

Response: We have removed the language in question, which was inadvertently added.

## **PART SIX**

*Comment on small employer rules: A default definition of dependent should be adopted for this part. If a default definition is not adopted, the part is quite confusing. Some sections appear to assume the HIPAA definition of dependent (e.g. §31.00 definition of AEOEP), while others refer to “spouse or dependents,” e.g. §31.00 definition of Employee). We propose that the federal HIPAA regulations’ definition of dependent be adopted for this part. This definition will encompass everyone to whom an employer may choose to offer coverage. Our proposed definition is set out in our comment to 31.00 below.*

*If our proposed default definition of dependent for Part Six is not adopted, the references to “employees and their dependents” throughout Part Six should be expanded to include spouses.*

*Although applicable large employers are not required to offer coverage to employees’ spouses in order to avoid a federal shared responsibility payment, nothing prohibits employers from offering such coverage.*

*Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.*

Response: We accept the comment and are adding the definition of dependent as provided in 45 CFR § 144.103, which is defined in the same terms as used under the HIPAA.

## **Section 31.00 Definitions**

*Comment on Section 31.00: There are no bullets for the definitions in the first column.*

Response: We adopted the table format, have alphabetized the terms, and believe bullets are not anymore helpful.

*Comment on Section 31.00, annual employee open enrollment period: It is our understanding that after a transition year, all small employer plans in Vermont will be required to become calendar year plans (i.e. renewing on January 1). As such, we suggest that this definition be modified to specify exactly when open enrollment periods would be for all small employers starting on January 1.*

Response: All plans on Vermont Health Connect in the merged market comprising small employer and individual coverage are required to have calendar year terms beginning on January 1, 2015, for the 2015 plan year. Small employers, in addition to an annual enrollment

period will have the opportunity to begin plans on a rolling basis throughout the year. Specific dates are provided for under sections 38.00 and 39.00.

*Comment on Section 31.00, applicable large employer: The number 50 should be changed to 51. Under Vermont law a small employer is one who has 50 or fewer employees. Large group starts at 51.*

Response: While federal law permits states to define employer size for purposes marketplace eligibility during a two-year transition period, the definition of an applicable large employer for purposes of the employer responsibility penalty is set by the federal government. We do not adopt the comment. Recent guidance has delayed the effective date of the employer responsibility penalties. We will update the affected rules during emergency rulemaking.

*Comment on Section 31.00, employee: In the definition of employee, clarify whether “partners” refers to a relationship in business or personal life. We believe the intent was “business partners.”*

Response: We have clarified that employee does not include business partners nor a sole proprietor's dependents.

*Comment on Section 31.00, full-time employee: We understand that this is a moving target and what constitutes a “full time employee” has become an extremely complex analysis. However, we strongly recommend that this definition be aligned with federal definitions pertaining to mandated offers of coverage to avoid the “pay or play” penalty, at least by 2016.*

Response: The proposed rule already reflects the alignment that the commenter recommends. The definition is the same as that in 26 U.S.C. 4980H(c)(4), as referenced in 45 CFR § 155.20.

*Comment on Section 31.00, qualified employer: Qualified Employer: (b), (c), and (d). The language regarding plan years is incomplete. It should read, “For plan years beginning on or after January 1,…”*

Response: We have adopted the comment and added clarifying language.

*Comment on Section 31.00, qualified employer: We recommend that the language contained in this section of the rule pertaining to the number of employees be aligned with federal law (effective for states January 1, 2016) and with other parts of the rule.*

Response: The number of employees is set in accordance with Vermont and federal law. The proposed rule reflects amendments made by Act 79 of 2013.

*Comment on Section 31.00, qualified employer: Qualified employer uses the term “working days”, but Business Day is defined as days state offices are open to serve the public. In Part 6, Section 31.00, Applicable large employer is defined as 50 full time employees on “business days” during the preceding calendar year. Most businesses have “business days” on days the state offices are not open.*

Response: While federal law permits states to define employer size for purposes marketplace eligibility during a two-year transition period, the definition of an applicable large employer for purposes of the employer responsibility penalty is set by the federal government. We have corrected the language in (b) to reflect business days as provided for in federal law.

*Comment on Section 31.00, seasonal employee: Several comments were received. One commenter understood the definition was changed to match the federal definition. Other commenters noted the differences with a federal definition for seasonal employee.*

*This definition of seasonal employee is different from the federal definition of seasonal employee. To some extent the federal definition of seasonal employee is being incorporated into Vermont law (see, e.g., the July 1, 2013 amendments to 33 V.S.A. § 1804). We would recommend aligning the definitions where appropriate and specifying in what context the differing definitions apply.*

Response: To determine if an employer is a small employer for purposes of eligibility to participate on Vermont Health Connect seasonal employee are defined like the term seasonal worker found in the federal regulation that relates to the applicability of the employer responsibility penalty, 26 USC § 4980H(c)(2)(B). We have corrected the definition of seasonal employee.

*Comment on Section 31.00, small employer: Several comments were received.*

*First, the end of this section refers to cross references to 4.00, 4.01 and 4.02, but these appear to no longer be the correct cross reference.*

*Second, there seems to be a disconnect between the definition of small employer on page 32 and section 34(a) re: the inclusion of seasonal employees or not. The legislature passed H107 which specifically excludes seasonal employees for the counting of employees for purposes of determining group size during 2014-2016.*

*Last, (a) Take one “on working days” in the first sentence. This is a loophole that could be construed as: ‘if you have 50 or fewer employees that work Monday through Friday.’ This leaves the weekends wide open; some facilities are much busier (and have more employees) on the weekend. This is a loophole that should be closed.*

Response: First: We have corrected the references. Second: We have removed the definition of small employer from section 3.00. Last: Working days encompasses all the days that the employer is in operation. It is distinguished from the term “business days” which refers to the Monday to Friday work week.

*Comment on Section 31.00, proposed addition: The newly proposed federal rules include a definition for a “SHOP application filer” which explicitly contemplates that an employer can file on behalf of an employee for benefits. See proposed 45 C.F.R. § 155.700. In turn, accepting applications from SHOP application filers is proposed to be a mandatory function of the SHOP. 45 C.F.R. § 45 C.F.R. § 155.730. We support this approach. As you know, currently many employers provide a great deal of support to their employees in acquiring health benefits. The*

*transition to VHC will likely be a more positive and less disruptive experience if employers can continue providing this valuable support if they so choose.*

Response: We are considering the new definition and may propose to adopt it under emergency rulemaking.

### **Section 32.00 Employer Eligibility**

*Comment on Section 32.00(a)(1): This sentence might be drafted to read: "Before permitting an employer's offer of coverage through VHC to its employees, VHC shall determine the employer is eligible in accordance with the requirements of §§ 31.00 and 32.00(b)." We are not sure it is accurate to say "the purchase of coverage in a QHP."*

Response: "Purchase of coverage in a QHP" is language taken directly from federal regulations.

*Comment on Section 32.00 (d)(4): The way this is phrased, it appears that accommodations are only available to people who apply in person. "In person" should stand on its own in (4) because in-person assistance is available for everyone regardless of disability. The ADA language should be set out on its own as (d)(5). The language should refer to Section 504 as well as the ADA.*

Response: This provision establishes specifically that applications may be filed in person and establishes that the facilities where someone files an application in person comply with the Americans with Disabilities Act. The cited language is taken directly from federal regulations. 77 FR 18310, 18386. Accessibility standards for assistance with eligibility and enrollment offered through AHS is addressed in Section 5.01.

### **Section 33.00 Employee eligibility**

*Comment on Section 33.00(b): Is the "additional payment with his or her federal income tax return" the individual penalty for non-coverage? If so, (or if not) please clarify.*

Response: Federal regulations regarding minimum essential coverage have recently been finalized. We agree that the section is not clear and will update in emergency rulemaking. The additional payment does refer to the tax penalty on individuals for not maintaining minimum essential coverage and not being otherwise exempt.

*Comment on Section 33.00(e)(4): This section references 33.00(e)5, which does not exist. The correct reference appears to be 33.00(g).*

Response: We have corrected the reference.

*Comment on Section 33.00(g): Specify how much time VHC has to provide this notification. There should be a time frame within which VHC must make a decision on an employee's application.*

Response: We have updated the provision specifying that VHC will notify an applicant within 1-2 weeks of the application date.

### **Section 34.00 Method for counting employees for purposes of determining employer eligibility**

*Comment on Section 34.00(a): This section defines how employees will be counted for VHC eligibility purposes in 2014 and 2015. This definition purports to include as “full time” any employee that works 30 hours per week for a given month. We object to this definition. This definition is inconsistent with 33 V.S.A. § 1804 (effective July 1, 2013). However, it would also be incredibly complex for employers to calculate full time status on a month by month basis. We strongly encourage rules which support long term coverage and avoid unnecessary churn between health benefit programs (both public and private). And although the federal law is not without its flaws, we strongly encourage the adoption of rules which clearly define a transition from state specific laws to federal rules where those federal definitions will apply to employers in other contexts (such as the pay or play tax penalty).*

Response: 33 V.S.A. § 1804 defines a qualified employer in terms of an entity that employed an average of not more than 50 employees on working days during the preceding calendar year. 33 V.S.A. § 1804 also establishes that the calculation of the number of employees of a qualified employer shall not include a part-time employee who works fewer than 30 hours per week, or a seasonal worker. We proposed the counting method in section 34.00 in response to concerns raised in public forums that 33 V.S.A. §1804, and early drafts of the proposed rule, left it unclear how employees should be averaged over a year in light of the exclusion of part time employees whose service is measured per week.

We proposed to measure the period over which a full-time employee’s service is counted that is consistent with federal regulations regarding applicable large employers, 26 CFR § 4980H(c)(4), and 45 CFR § 155.20. We did this in part to be consistent with the period over which full-time employee stats will have to be measured beginning in 2016, after the two year transition period is over. Under the federal definition full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours of service per week.

Vermont Health Connect has issued a worksheet on performing the calculation, “For Employers: How to Count to 50”, accessible at:

[http://healthconnect.vermont.gov/sites/hcexchange/files/Counting\\_to\\_50\\_Worksheet\\_Final.pdf](http://healthconnect.vermont.gov/sites/hcexchange/files/Counting_to_50_Worksheet_Final.pdf).

Finally, once Vermont Health Connect determines that an employer is a qualified employer, the qualified employer enjoys continuing eligibility. This provision was adopted to minimize churn. See Section 32.00(b).

*Comment on Section 34.00(a)(1): Define “variable hour employees” (some employees have significant ranges in hours, while others vary once in a while by a few hours here or there. This wording makes it sound like if the employee’s hours vary at all, they are not counted as a full time employee.).*

Response: Variable hour employees refers to a new employee if based on the facts and circumstances at the start date, it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week. The method of counting employees as described in the Vermont Health Connect worksheet, “For Employers: How to Count to 50”, accessible at:

[http://healthconnect.vermont.gov/sites/hcexchange/files/Counting\\_to\\_50\\_Worksheet\\_Final.pdf](http://healthconnect.vermont.gov/sites/hcexchange/files/Counting_to_50_Worksheet_Final.pdf) may assist employers in determining whether an employee is full-time for a given month.

*Comment on Section 34.00(b)(2): This paragraph would be more clear if it stated, “An employer shall in addition...include for such month a number of full-time equivalent employees determined by...”*

Response: We accept the clarification and have revised the language in (2) to specify full time equivalent employee.

*Comment on Section 34.00(b)(2): What does the “120” number represent? Was it supposed to be 12?*

Response: The language is drawn from the federal regulations. In the calculation 120 is the denominator. We understand that this is a product of 30 hours per week times 4 weeks per month, meant to be the standard number of hours a full time employee works during a month.

*Comment on Section 34.00(c): We appreciate and support the use of examples in these rules. We note that this example seems out of context in this rule as it draws heavily from concepts that are incorporated into federal tax rules. We suggest that this be redrafted or that these concepts be expressly defined and incorporated into the Vermont rule.*

Response: We have removed the example as it did not clearly illustrate that a seasonal employee would not be counted as a full time employee according to VT law and rule during the 2014 and 2015 plan years.

### **Section 35.00 Employer choice**

*Comment on Section 35.00: What about the option for small employers to drop coverage for their employees?*

Response: The section establishes that qualified employers may either make available to their employees and dependents all of the qualified health plans offered on Vermont Health Connector or limit the choice to only the QHPs offered by one carrier of its choice. A small employer who does not sponsor coverage is not a qualified employer. Small employers may make the business decision to not offer health coverage to their employees.

### **Section 36.00 Employee enrollment waiting periods**

*Comment on Section 36.00: This section of the rule relates to employee waiting periods (which cannot exceed 90 days pursuant to federal law). Will VHC be responsible for enforcing this? How will that happen? Will the Department of Labor or the Department of Financial Regulation*

*be involved? We respectfully request clarity on state agency roles as it relates to enforcement of these provisions.*

Response: The US Department of Labor is the enforcement agency.

### **Section 37.00 Short plan years**

*Comment on Section 37.00(a)(2): This section provides that small group “sponsors” must be qualified employers. Is the introduction of the ERISA concept of “sponsor” intentional in this sentence? And if so, what is the intent of introducing this concept in this context? Absent a compelling reason, we suggest using the term “employer” instead of sponsor.*

Response: We have revised the language in section 37.00 to consistently refer to employers.

*Comment on Section 37.00(c): We recommend inserting “2014” prior to the term “short plan year” for clarity.*

Response: We accepted the change.

*Comment on Section 37.00(c): This sections states, “carriers may carry over accumulated claims from the short plan year against the deductible and out-of-pocket amounts to the 2015 plan year.” It is not clear why a carrier would do this. Add more specificity to how this would work such as a policy that the carrier may increase the deductible at a prorated amount in proportion to the amount of time represented in the short plan year. Any other instructions that could be provided on how a short year plan would work would also be helpful.*

Response: Carriers are not required to carry over accumulated claims from a short plan year to the next year’s policy. A carrier might do this for enrollees whose renewal dates fall for example on December first or November first. We defer to carriers to make this workable, in accordance with any Department of Financial Regulation rules and guidance.

*Comment on Section 37.00(c): This is not an actuarially sound method of accumulating a deductible for a short plan year.*

Response: We understand that if the deductible and out-of-pocket (OOP) accumulated during the short year were carried over to 2015 the carrier would, on average, be expected to pay more claims in 2015 than if the deductible did not carry over, and the premium rates would have to be correspondingly higher. However, as long as rates are developed such that they include the cost of the anticipated additional benefit we believe that the rates could be actuarially sound and defer to the Vermont Department of Financial Regulation. Similarly, 2014 rates have been built ~~without~~ assuming short plan years, for which the carrier on average would be expected to pay less claims in 2014.

### **Section 38.00 Employer election period**

*Comment on Section 38.00(a): This section states that in 2014 small employers “shall have at least 75 days to purchase coverage for their employees.” From the rule, we are not certain*

*what this time period refers to exactly. For example, does this period include the time that employees are choosing their plans as well?*

Response: We have revised language in (a) to make it clear that the employer must apply and receive an eligibility determination before the employee may create an account on the system to select an employer plan. The number of days an employer has to apply in order to get coverage for their employees effective January 1, 2014 is not without limit, during this initial enrollment period is flexible. Employers should estimate back from November 30, 2013 how much time their employees will need to compare and select plans. November 30, 2013 is the date by which employees must select plans in order to ensure that they are entered into the insurer's systems and receive insurance cards by January 1, 2014. Plan selections after that date will result in not being added to insurer's systems until after January 1, 2014. We have also revised language in (c) and (d), and added a new (g) to further clarify the employer election period process.

*Comment Section 38.00(a)(2): The payment cannot happen until VHC submits a summary of employee elections and a corresponding premium notice to the employer.*

Response: Vermont Health Connect will generate premium invoices beginning December 1, 2013 for all employers who completed employee enrollment by November 30, 2013. Any adjustments to the employee roster between December 1, 2013, and December 31, 2013 will be reflected in the employer's invoice generated January 1, 2014. We urge employees to make their plan selections by November 30, 2013 and urge employers to pay their invoices by December 21, 2013 in order to ensure that carriers will activate enrollee information into their systems for coverage that will begin on 1/1/14.

*Comment Section 38.00(b)(2): The rule states that during the election period, the employer can decide whether to offer a health plan to its employees, but isn't it likely that employers can do that outside of the election period? We suggest more clearly specifying what will happen during each specific time period (and what can happen at any time), with specific attention to those activities that will be subject to specific and meaningful deadlines..*

Response: The rule states that employers will be able to go onto the website and use the available tools for assistance in making their decision. While the employer doesn't need to use the tools to make the decision, the employer will not have access to the tools prior to the election period which will coincide with the launch of the website.

At the request of employers the initial election and enrollment period is designed to be flexible to the greatest extent possible given operational constraints. We urge employees to make their plan selections by November 30, 2013 and urge employers to pay their invoices by December 21, 2013 in order to ensure that carriers will activate enrollee information into their systems for coverage that will begin on 1/1/14. The flexibility built in to the enrollment process allows for late enrollment if employers do not pay their invoices by the dates we are urging. However, that flexibility for late enrollment for 1/1/14 coverage will result in delays in effectuating coverage.

*Comment on Section 38.00(b)(4)(iii)(A): These should be deleted and replaced with a footnote. Proposed section 38.00(b)(4)(iii)(A) states: "Qualified employers who are also applicable large employers will be required by federal employer shared responsibility rules to offer coverage to their employees' dependents." This is not accurate. ALEs are not required to offer coverage; they can pay the SRP instead. Shared Responsibility for Employers Regarding Health Coverage, 78 Fed. Reg. 218 (proposed January 2, 2013).*

Response: We have removed (A) as this is specifically a federal tax penalty provision whose regulations have not been finalized. We note that the definition of dependent that we adopted in this rule is broader than that in the proposed federal rules relating to the employer shared responsibility payment. The definition we adopted accounts for children as well as spouses. We note also that the state definition is narrower than the definition of dependent used in determining APTC eligibility for individuals.

*Comment on Section 38.00(b)(4)(iii)(B): We received two comments on (B): First, these should be deleted and replaced with a footnote. 38.00(b)(4)(iii)(B) states: "Dependents are defined to not include spouses." This is accurate under the proposed federal regulation. However, employers are not prohibited from offering coverage to spouses. The current language suggests otherwise. Also, the Employer SRP definition of dependent does not only exclude spouses, it excludes a lot of other people who could be considered dependents under other sections, and it includes older children who may not be tax dependents. Id. at 241. The footnote to (iii) should read: "Applicable large employers may owe a federal shared responsibility payment if they do not offer coverage to employees' children under the age of 26. Shared Responsibility for Employers Regarding Health Coverage, 78 Fed. Reg. 218, 241 (proposed January 2, 2013) (to be codified at 26 CFR § 54.4980H-1(a)(11))."*

*Second: This section provides that dependent does not include spouse. Although we understand the genesis of this language, we believe it may be confusing in this context. For the purpose of this rule, it may be more appropriate to simply clarify that employers may elect to exclude spouses from coverage. We would also suggest language that clarifies how this federal mandate will coordinate with the State decision to require all income eligible children be covered by Dr. Dynasaur.*

Response: In response to both comments, we have removed (B) as this is specifically a federal tax matter whose regulations have not been finalized. We note that the definition of dependent that we adopted in this rule is broader than that in the proposed federal rules relating to the employer shared responsibility payment. The definition we adopted accounts for children as well as spouses. We note also that the state definition is narrower than the definition of dependent used in determining APTC eligibility for individuals.

*Comment on Section 38.00(e): This section defines, with dates, the employer annual election periods for plan years beginning January 1, 2015 and begins the election period on September 15, 2014. We appreciate this process is to begin earlier and to the extent this happens, we believe it will support employers and employees. However, we would recommend including language that allows for an alternate election period in the event of unforeseen circumstances (such as no approved rates). We would also strongly recommend that this section include a*

*special election period for those groups that are newly formed and, as such, should not be subject to the standard open enrollment period (although they would be subject to a short plan year).*

Response: We expect 2015 rates to be approved prior to September 15, 2014. New groups forming for 1/1/15 coverage will have the same election period as groups who had coverage for the 2014 plan year. All groups will have rolling enrollment. We have added language in 38.00(d) to clarify that VHC must permit a qualified employer to purchase coverage for its small group at any point during the year.

### **Section 39.00 Employee enrollment periods**

*Comment on Section 39.00 and 41.00(a): Vermont Health Connect is planning on getting enrollment tapes to insurers as late as December 31st for an enrollment date of January 1. This is not enough time for insurers to process the enrollment and mail ID cards, so it will appear that members have no coverage for possibly up to 2 weeks. This will cause serious member dissatisfaction and potential denial of treatment (i.e., prescription refills). Final enrollment files should be sent to insurers no later than December 15th for a January 1 effective date.*

Response: We understand that at the time comments were submitted discussions between carriers and Vermont Health Connect regarding enrollment and premium billing timelines for plans sold on Vermont Health Connect had not concluded. The timelines are documented in the State of Vermont, Department of Vermont Health Access, Vermont Health Connect's "Individual and Small Business Enrollment and Billing timelines, Final, Version 2.0, June 2013." We urge employees to make their plan selections by November 30, 2013 and urge employers to pay their invoices by December 21, 2013 in order to ensure that carriers will activate enrollee information into their systems for coverage that will begin on 1/1/14. The flexibility in the enrollment process allows for late enrollment and even retro-active enrollment if employers do pay their invoices by the dates we are urging. However, that flexibility for late enrollment for 1/1/14 coverage comes with potential delays in coverage.

*Comment on Section 39.00(b): Initial Open Enrollment, employer's eligibility is 1st of the month following date of hire, person is hired on the 30th of June, coverage is effective 1st of July, individual enrolls on 30th, will coverage be effective on July 1? VHC needs to notify employer of employee election, employer needs to send payment to VHC, VHC needs to process through to insurer. Currently, new enrollees are hired and appear on a subsequent bill for all months from enrollment through current bill.)*

Response: We have not finalized the coverage effective dates, and enrollment timeframes for plans beginning on February 1, 2014 or any month after that in 2014..

*Comment on Section 39.00(b)(2): This section notes that enrollment will be effectuated once the issuer has received full payment from the employer. We request clarification in the rule as to what will happen when payment (full or otherwise) is not timely (or ever) received by the issuer.*

Response: We expect to provide further specifics regarding effectuation of enrollment during emergency rulemaking. Potential carriers were engaged in discussions regarding enrollment and premium billing timelines for plans sold on Vermont Health Connect. The timelines are documented in the State of Vermont, Department of Vermont Health Access, Vermont Health Connect's, "Individual and Small Business Enrollment and Billing timelines, Final, Version 2.0, June 2013." We intend to publish a summary of the document in a consumer friendly format and post it to Vermont Health Connect. Termination by issuers for non-payment is addressed in section 47.00.

*Comment on Section 39.00(e): We note that this imposes one open enrollment period on all employers. We are concerned about negative impacts that may arise from imposing an open enrollment period on employer groups. However, as noted above, we would at least suggest that there be an exception for those employers that did not exist during the open enrollment period.*

Response: Federal regulations require that all plans purchased by small employers in a merged market, such as Vermont, be on a calendar year beginning January 1, 2015. See section 37.00. We have added a new subsection 38.00(g) to clarify that a qualified employer may purchase coverage for its small group at any point during the year.

#### **Section 40.00 Special Employee Enrollment Periods**

*Comment on Sections 40.00 and 71.03: 40.00(a)(iii) and 71.03(d)(4) both state that a special enrollment period may be triggered if enrollment in a QHP is "unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee or agent of AHS or HHS or its instrumentalities as evaluated and determined by AHS." Please explain the agents or instrumentalities of AHS that this section is referring to and whether it includes Navigators and Certified Application Counselors.*

Response: We are waiting for further guidance from HHS on their meaning of "instrumentalities." In the meantime, we do believe that if an individual can show they relied on advice from a Navigator or a CAC, and the advice was wrong, we would allow that to be an exceptional circumstance, and trigger a special enrollment period..

*Comment on Section 40.00: See comment to Part 6 and 31.00 above regarding the need for a definition of dependent. If HIPAA regulations' definition of dependent is not adopted for all of Part 6, it should at least be adopted for the SEP rules in 40.00. The federal SEP regulations express an intent to align the SHOP SEP provisions with HIPAA. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 33,233 (June 4, 2013) (to be codified at 45 CFR Parts 155 and 156). These regulations assume that the HIPAA definition of dependent applies. Id. at 33,236 n. 7 (citing 26 CFR 54.9801-6, 29 CFR 2590.701-6, and 45 CFR 146.117). In all three HIPAA regulations cited in footnote 7 to the federal rule, "Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant." 26 CFR 54.9801-2; 29 CFR 2590.701-2; 45 CFR 144.103. We*

agree with the way this issue was treated in proposed rule 71.03(a)(2), where there is a citation to the relevant federal rule.

*Alternatively, the references to “employees and their dependents” throughout this section should be expanded to include spouses. We suggest replacing “a qualified employee or dependent” with “a qualified employee, spouse, or dependent”. Although employers are not required to offer coverage to employees’ spouses, they may choose to offer such coverage.*

Response: As noted in the response to comments at 31.00, we have included the definition of dependent as provided in 45 CFR § 144.103.

*Comment on Section 40.00(a)(1): A new subsection (xi) should be created. An employee who declines employer-sponsored insurance (ESI) as unaffordable or insufficient and applies for APTC in good faith, but receives a denial on their APTC application after the ESI open enrollment period has closed, should be entitled to an SEP for ESI. An employee should not have to wage a high-stakes gamble if they believe their employer’s insurance is unaffordable. For another example, if an employer successfully appeals an employee’s award of APTC, the employee should receive an SEP for ESI. Appeals in the current benefits system can take months, so an SEP may be necessary. Alternately, these beneficiaries should be eligible for a hardship exemption from the requirement to maintain MEC. As noted in our general comments above, the Vermont rules governing hardship exemption certificates have not yet been proposed.*

Response: We agree and have included this circumstance as an exceptional circumstance under (vii). We propose to adopt several other circumstances as triggers for exceptional circumstances.

*Comment on Section 40.00(a)(1)(iii): Errors made by navigators should be included here, and result in an SEP. Also, this rule is written to apply only to the qualified employee, but should also apply to the employee’s spouse and dependents.*

Response: We interpret the provision to include navigators and certified application counselors for the purpose of assistance with enrollment. We have added this circumstance as an exceptional circumstance under (vii).

*Comment on Section 40.00(a)(1)(x): This section allows for a special enrollment period when a “qualified employer terminates a contract with the carrier they chose under the carrier-choice model.” It is unclear to us that employers will have a contract with issuers; in fact, we do not currently know how issuers will even know if an employer has elected a carrier-choice model. Allegedly the state has declined to provide this information.*

Response: We have removed this provision as it is an example of loss of minimum essential coverage under (a)(1)(i).

*Comment on Section 40.00(a)(2): Employers are not prohibited from offering coverage to spouses. If the HIPAA definition of dependent is not adopted for the SEP rules (see comment to 40.00), this section should read, “A dependent of a qualified employee is not eligible for a*

*special enrollment period if the employer does not extend the offer of coverage to dependents. A spouse of a qualified employee is not eligible for a special enrollment period if the employer does not extend the offer of coverage to spouses.”*

Response: We propose to adopt the definition of dependent defined in the same terms as the HIPAA definition referred to in the comment.

*Comment on Section 40.00(b): This section pertains to special enrollment periods. We suggest that the rules require employers to notify VHC and add an employee promptly after a qualifying event so that the employee can sign up for coverage within the specified special enrollment period.*

Response: We are extending the duration of special enrollment periods in (b)(1) from 30 days to 60 days to give employees more time in which to notify their employer and enroll.

*Comment on Section 40.00(d): This section is not clear. We believe this section means that an employee can receive an SEP under 40.00(a)(1)(i) if they elect and exhaust COBRA coverage. The rule should plainly say that. Also, more explanation regarding COBRA is needed. This may be a logical place to include it. The rules need to clarify whether an individual who elects COBRA can voluntarily terminate that coverage and receive an SEP to join a QHP. We understand the intent is to allow this, but that is not obviously stated anywhere.*

Response: We have revised (d) to clarify that an employee or dependent may enroll in COBRA, cancel coverage and qualify for a special enrollment period.

*Comment on Section 40.00(e): Loss of COBRA Continuation Coverage. The rule states that a person who elects COBRA and then loses coverage due to nonpayment of premiums is not entitled to a special enrollment period. This is an example of a situation in which a beneficiary should be able to request a hardship exemption from VHC. As mentioned above, VHC needs rules on how IRC 5000A exemptions will be applied for, considered, and how adverse decisions will be appealed.*

Response: We intend to provide rules for exemptions in emergency rulemaking.

## **Section 41.00 Coverage Effective Dates**

*Comment on Section 41.00(a): This section provides that coverage will be effective January 1, if payment is postmarked December 10, 2013. If paid electronically, funds need to be received by December 16. Please note that these dates are inconsistent with dates included in the VHC publication “Individual and Small Business Enrollment and Billing Timelines” published in its final form on May 23, 2013. A copy of this publication is attached for your reference. As has been stated in numerous forums and other communications, BCBSVT strongly objects to the Enrollment and Billing Timelines publication. These timelines do not only appear to be in violation of existing state and federal laws, but they are inconsistent with this proposed rule. More importantly, the publication defines billing and enrollment processes that will hurt Vermonters and small businesses.*

*We believe billing and enrollment timelines must be included in the VHC rule. These timelines impact the legal rights and remedies available to Vermonters who purchase their health insurance through VHC. As such, these enrollment and billing timelines should be subject to a public participation process as contemplated in formal rulemaking. We are concerned with the numerous inconsistencies between this document and other parts of the proposed rule and strongly suggest that the rule and any operational guidance formally issued by VHC be aligned and coordinated.*

Response: We understand that at the time comments were submitted discussions between carriers and Vermont Health Connect regarding enrollment and premium billing timelines for plans sold on Vermont Health Connect had not concluded. The discussions addressed all of the carriers' concerns and the timelines agreed to by the carriers are documented in the, State of Vermont, Department of Vermont Health Access, Vermont Health Connect's "Individual and Small Business Enrollment and Billing timelines, Final, Version 2.0, June 2013." We intend to publish a summary of the document in a consumer friendly format and post it to Vermont Health Connect. We have aligned the timelines in the document and the proposed rule.

*Comment on Section 41.00(b): This section provides that VHC will ensure that coverage will be effective if a QHP selection is received by VHC on or before December 7 for plan years beginning January 1, 2015 and for subsequent years. Please note that this could conflict with Section 41.00(a) to the extent a QHP is selected, but no payment is received. We recommend clarifying the relationship of these two requirements.*

Response: We agree and have clarified the requirement.

*Comment on Section 41.00(c)(4): It appears the cross references in this section may no longer be accurate and should be updated. We would also recommend ensuring that these special enrollment periods are appropriate for the group market specifically.*

Response: We have updated (c) to correct the references and provide dates in accord with federal regulations at 45 CFR §155.420(b).

## **Section 42.00 Employee Cost-sharing Limits**

*Comment on Section 42.00: This section includes general rules relating to employee cost sharing. It is our understanding that the Department of Financial Regulation will be responsible for enforcing these federal standards by providing the initial product review process prior to DVHA/VHC/AHS choosing which products are available for sale. As such, we think this portion of the rule could be deleted. We also note that the reference to "merged" market is unclear without some additional context. Finally, we are confused by the specific reference to 8 V.S.A. § 4089i(d) pertaining to prescription drug coverage for plans offered with an HDHP, as it is one very specific set of rules that applies for in a limited set of circumstances, but similar rules with broader application are not mentioned. Again, we believe that regulations pertaining to the product specific attributes might be more appropriately promulgated and enforced by the Department of Financial Regulation.*

Response: We have removed this section. The Vermont Department of Financial Regulation will be responsible for enforcing these federal standards. Information regarding plans and cost sharing is available on Vermont Health Connect. Moreover, during the enrollment process employees will be able to compare plans' cost sharing as they shop.

*Comment on Section 42.00(a)(2): Specify where the subparagraphs referred to in this section, "(A)(i), (4), (A)(ii), (A)(i), and (i)" come from. As is, this section does not make any sense. The referenced sections do not seem to come from the section of the CFR that is cited with this rule or the section of the ACA that is cited in the CFR rule.*

Response: We have removed this section. The Vermont Department of Financial Regulation will be responsible for enforcing these federal standards.

### **Section 43.00 Employer Contributions to Cost-sharing through HSAs or HRAs**

*Comment on Section 43.00: We understand additional federal regulations are pending on HSAs and HRAs. To avoid the need for any revisions, the Vermont rules should more simply defer to IRS regulations. We suggest deleting (a) and (b) and stating, "HRAs and HSAs may be used in conjunction with a QHP as permitted by IRS regulations."*

Response: We agree with the comment and propose to adopt it.

### **Section 44.00 Renewal**

*Comment on Section 44.00: This section states that an employee will remain in the same plan upon renewal if certain circumstances are met. We respectfully request a little more clarity around what constitutes the same plan from year to year. As you know, plans are often changed a little bit from one plan year to the next, usually because of mandated regulatory changes. We understand the purpose of this portion of the rule is to eliminate churn and gaps in coverage if people elect to do nothing and we support this goal. For that reason, we believe it will be less confusing for issuers and VHC if this rule contains basic parameters relating to what constitutes "the QHP selected the previous year" for the purposes of this section.*

Response: We share the concern about people experiencing lapses in coverage due to failing to enroll annually during the open enrollment periods. VHC is and will be making every effort through outreach and mailed notifications to stress the importance of making a plan selection. Regarding automatic renewals, at this time we have not adopted a definition of what constitutes the same plan. We intend to clarify through emergency rulemaking.

### **Section 45.00 Termination of Coverage by Employee**

*Comment on Section 45.00(a): This allows an employee to terminate coverage at any time with notice to the issuer or VHC. This is inconsistent with our understanding of current guidance received from the State. We have been told that the employee would need to go to VHC and that issuers may only initiate a termination for non-payment and fraud. Please clarify. We also suggest that notice be provided to the employer as well. Please also note that in the current group market, we typically provide coverage to the end of the month. Please specify if the*

*expectation is that mid-term terminations will be required and what the expectations will be related to premiums. Please note that the proposed federal rules indicate the FF-SHOP will be terminating coverage at the end of the coverage month. 45 C.F.R. § 155.735*

Response: We intend to update the termination effective dates in emergency rulemaking. We are directing employees to VHC to notify of cancellations. However, federal regulations for employee initiated termination refer to the standards cited that provide for appropriate notice by an enrollee to VHC “or the QHP”. We interpret QHP to mean the QHP issuer. In that case the QHP issuer should direct the employee to VHC.

*Comment on Section 45.00(a)(2): for termination of coverage you define reasonable notice as 14 days from the requested date of termination. It would be beneficial if the termination effective date were always the end of a month due to the manner in which MVP bills, which is using the "wash" method.*

Response: We intend to update the termination effective dates in emergency rulemaking and are considering always terminating at the end of the month.

*Comment on Section 45.00(a)(3): you again reference the termination can be done in less than 14 days if the QHP can effectuate in fewer days. In our meetings you briefly touched on this topic and wanted a consensus from all QHP's to set this for fewer days. MVP can accommodate terminations with less than 14 days notice, but we would want a minimum of 10 calendar days from the date the member/group enters the termination notice to the requested termination date. This would provide us with adequate time to update our systems and provide eligibility changes to our vendors. Has this been resolved by the state?.*

Response: We understand that Vermont Health Connect and carriers did not reach an agreement for terminating coverage in fewer than 14 days. We intend to update the termination effective dates in emergency rulemaking and are considering always terminating at the end of the month.

*Comment on Section 45.00(b): This section allows for voluntary employee termination of group coverage at any time. How will this work with payroll withhold? We do not believe this section is as robust as it needs to be in order for employees, employers and issuers to understand how voluntary employee termination will work.*

Response: How termination, or enrollment for that matter, works with payroll withholding is beyond the scope of this rule.

## **Section 46.00 Employer Withdrawal from VHC**

*Comment on Section 46.00: This section provides that when an employer terminates coverage, VHC will send notice. However, based on previously received State guidance, it is our understanding that the issuers will effectuate terminations and that issuers will have to send notices of cancellation under current Vermont law. We request that this section be coordinated with operational decisions and the issuer's current legal obligations.*

*Also, we note that this section of the rule fails to address the scenario where an employer is terminating an employee's coverage, typically due to the separation of employment. As this is a typical scenario, this should be addressed in the rule.*

Response: This section provides that VHC ensures that the carriers issue such notices. We intend to provide further specifics either through emergency rulemaking or these terms will be memorialized in agreements between the carriers and VHC. We have revised language in the section to make this clearer.

*Comment on Section 46.00(b): Could you give more specific dates around time limits for these notifications?*

Response: We intend to provide further specifics either through emergency rulemaking, in carrier agreements, or posted on the electronic application. .

### **Section 47.00 Termination of Coverage by Issuer**

*Comment on Section 47.00(a): We recognize that this language comes from the federal law, however, we recommend that it be customized for Vermont – both legally and operationally. Additionally, we note that there is no 40.00(f)(6).*

Response: We have corrected the reference.

*Comment on Section 47.00(b): This section provides that QHP issuers must apply a standard policy to all small groups for the termination of coverage of enrollees due to non-payment of premium and further provides that “Non-payment of premium occurs when full payment has not been received by the last business day of the month.” We request that the “business month” referred to in this sentence be clarified as to which business month (The month before coverage begins? The month the premium was due?) We also strongly encourage that this section be fully aligned with the Individual and Small Business Enrollment and Billing Timelines publication produced by VHC, attached hereto for reference. As noted, we object to numerous provisions in this publication. Nonetheless, the rule and any such State issued guidance must be aligned. Finally, we direct your attention to the newly proposed federal provisions relating to SHOP terminations. 45 C.F.R. § 155.735. Although the new proposed rules only require that the SHOP (VHC) have policies relating to termination, the proposed rules do include such policies for the FF-SHOP. These federal processes appear generally more consumer oriented and consistent with the needs of small businesses than the current Vermont proposals. For example, the FF-SHOP will allow reinstatements with timely payment of past-due premiums. We know from our own experiences, that small businesses sometimes need these opportunities. We strongly encourage you revise current proposals so that small businesses aren't unnecessarily harmed by the transition to VHC.*

Response: At the request of carriers we have changed the billing due date from the end of the month to the 21<sup>st</sup> of the month prior to the month of coverage. In light of new federal guidance we intend to further revise this section in emergency rulemaking and align it with the billing timelines documented in the State of Vermont, Department of Vermont Health Access, Vermont

Health Connect's "Individual and Small Business Enrollment and Billing timelines, Final, Version 2.0, June 2013."

*Comment on Section 47.00(b): Allows Exchange enrollees to submit payment through the last day of the month. Coupled with the fact that VHC will not remit payments to insurers until full payment is received means that insurers could potentially be on the hook for claims incurred during that month.*

Response: At the request of carriers we have changed the billing due date from the end of the month to the 21st of the month prior to the month of coverage.

*Comment on Section 47.00(c): requires insurers to give enrollees 30 days notice of termination (albeit "where possible") means that insurers may have to cover claims for a total of two months without payment of any premium, and presumably without VHC not remitting even partial payment to the insurers. This puts insurers at an obvious disadvantage and will end up increasing costs for all enrollees in the Exchange. We request that enrollees need to submit full payment by an earlier date in the month, either the 21st or 15th. We also request that the state send us partial payments and not wait until full payments are made (again because that might mean we will not receive even partial payments where full payments are never made). Will the state keep those partial payments? Why will they not be remitted to insurers? Please also see the letter to Commissioner Larson, attached, for further explanation on these issues..*

Response: At the request of carriers we have changed the billing due date from the end of the month to the 21st of the month prior to the month of coverage. Handling of employer premium payments is beyond the scope of these rules. Vermont Health Connect and carriers will enter into agreements in which these matters will be settled.

*Comment on Section 47.00(c)(1): This section provides "If an enrollee's coverage in a QHP is terminated by the issuer for any reason, the QHP issuer must provide the enrollee with notice of termination of coverage that includes the reason for termination at least 30 days, where possible, prior to the last day of coverage, and consistent with the effective date established by VHC." Again, we do not believe this language is consistent with the VHC's May 23, 2013 publication titled "Individual and Small Business Enrollment and Billing Timelines." We strongly recommend these discrepancies be addressed and the rule include clear, consumer and small business friendly, rules pertaining to termination processes.*

Response: We have revised this section to require the QHP issuer to provide the notice of termination of coverage at least 30 days prior to the last day of coverage. We understand that at the time comments were submitted discussions between carriers and Vermont Health Connect regarding enrollment and premium billing timelines for plans sold on Vermont Health Connect had not concluded. The timelines are documented in the State of Vermont, Department of Vermont Health Access, Vermont Health Connect's "Individual and Small Business Enrollment and Billing timelines, Final, Version 2.0, June 2013." We intend to publish a summary of the document in a consumer friendly format and post it to Vermont Health Connect.

*Comment on Section 47.00(c)(3): This section refers QHP issuers seeking recertification. It is not clear if the entire Section 47.00 is intended to apply only in those cases where an issuer is withdrawing from the Exchange. If that is the intent, we would suggest that the withdrawal process be more clearly defined and that this section be redrafted to clearly apply only in that limited circumstance. If that is not the case, this subsection may need some revision to clarify how certification is intended in the context of these requirements.*

Response: We have revised language to make it clearer.

*Comment on Section 47.00(d): This section reads: "In the case of termination where the enrollee is no longer eligible, the last day of coverage is the last day of the month following the month in which notice of termination is sent, unless the individual requests an earlier termination date." It is unclear in which context these provisions apply. Does this apply when someone is no longer eligible because they have been terminated from employment? If so, we believe this to be extremely problematic as the employer will no longer be collecting premiums from the employee. Furthermore, it is not clear how this relates to COBRA coverage. We suggest expanding on these provisions and provided additional detail relating to specific scenarios.*

Response: We intend to revise this section in emergency rulemaking in light of newly issued federal regulations.

*Comment on Section 47.00(e): We respectfully request that this portion of the rule include language indicating that the employer must notify VHC of the withdrawal and that VHC will initiate the termination process by notifying the issuer, consistent with how the State has indicated this process will work in operational discussions.*

Response: We have updated this section to reflect the comments.

## **Section 48.00 Termination of Coverage by VHC**

*Comment on Section 48.00(a): This section provides "VHC must terminate participation of qualified employers that do not pay premiums as billed in accordance with the provisions of § 50.00(a)." However, in discussions with VHC representatives, the issuers have been repeatedly informed that it will be up to the issuers to terminate coverage for nonpayment. See, Individual and Small Business Enrollment and Billing Timelines, attached hereto for reference. This rule must coordinate with other State issued guidance, although we strongly suggest that issues such as termination, consequences for nonpayment and termination notices are most appropriately included in rules subject to the formal rulemaking process..*

Response: We have updated this section to make it clearer that VHC will not permit qualified employers to purchase coverage with another carrier if they have unpaid premiums and have been terminated for non-payment of premiums by another QHP issuer.

## **Section 49.00 Employer Appeals**

*Comment on Section 49.00: We received comments requesting specification of the entity that will hear employer appeals. First, the rules should identify the state agencies with which*

*employers can file a VHC appeal. They should also identify the entity that will adjudicate employer appeals and the relevant time periods for deciding appeals. The proposed rules seem to indicate that staff within VHC will hear employer appeals. VHC should ensure an independent review of employer appeals. Last, this section does not state who the appeals entity is. 49.01(c) implies that VHC is the appeals entity, but 49.01(d) suggests that the appeals entity is separate from VHC.*

Response: We intend to provide further details about and clarify employer appeals rules in emergency rulemaking in light of recent federal guidance and outstanding federal regulations.

*Comment on Section 49.01(c): This section provides that employers can request appeals by phone. Although we support making it easier for employers to navigate the Exchange, to the extent a communication is intended to initiate a formal appeals process, we suggest that there be additional guidance about the difference between a verbal appeal and a verbal complaint that does not trigger the appeals process.*

Response: We intend to provide further details about and clarify employer appeals rules in emergency rulemaking in light of recent federal guidance and outstanding federal regulations.

*Comment on Section 49.01(d): Who is the appeal entity? Additionally, what happens in the meantime while the employer appeals? How will this affect the effective date of coverage?*

Response: We intend to provide further details about and clarify employer appeals rules in emergency rulemaking in light of recent federal guidance and outstanding federal regulations.

*Comment on Section 49.01(g): Refer to employee appeals. Under what circumstances would an employee be appealing under this section?*

Response: We intend to provide further details about and clarify employer appeals rules in emergency rulemaking in light of recent federal guidance and outstanding federal regulations.

*Comment on Section 49.01(h): Refer to employee appeals. Under what circumstances would an employee be appealing under this section?*

Response: We intend to provide further details about and clarify employer appeals rules in emergency rulemaking in light of recent federal guidance and outstanding federal regulations. Employees could appeal a decision that they are not qualified employees and may also file appeals based on a lack of promptness in VHC's decision on eligibility.

*Comment on Section 49.01(j): This provision states that "an appeals entity must issue written notice of the appeals decision to...the employee if an employee's eligibility is implicated." When would an employer appeal their eligibility and an employee's eligibility not also be implicated? This appears to require notification to all employees to whom the employer had proposed to offer coverage. This is probably not the intent.*

Response: We intend to provide further details about and clarify employer appeals rules in emergency rulemaking in light of recent federal guidance and outstanding federal regulations.

*Comment on Section 49.02: Employer Appeals of Employee Eligibility for APTC/CSR. It is difficult to understand how on one hand an employee's eligibility record is part of the record on appeal and must be made available to the employer (49.02(d)), yet on the other hand, confidential tax information cannot be disclosed to the employer (49.02(g)). These provisions seem contradictory.*

*Does the employee receive APTC/CSR while the appeal is pending? We believe the employee should receive APTC during the employer's appeal.*

Response: We intend to provide further details about and clarify employer appeals rules in emergency rulemaking in light of recent federal guidance and outstanding federal regulations.

*Comment on Section 49.02: This subsection requires VHC to transmit the employee's eligibility record to the appeals entity, which means the employer will also have access to it. An employee's eligibility record will contain confidential information such as their household composition and income. The Agency needs to ensure that it is protecting confidential information and not transmitting it without an employee's explicit written consent.*

Response: We intend to provide further details about and clarify employer appeals rules in emergency rulemaking in light of recent federal guidance and outstanding federal regulations.

## **Section 50.00 Premium Processing**

*Comment on Section 50.00: This section pertains to premium processing. We believe it is necessary to specify who owns funds collected by the State, but due to the issuers. We also would like specification in the rule as to how the funds will actually be managed. For example, will the State collect the funds in separate accounts for each issuer? Will issuers receive the interest earned on the funds collected by the State on their behalf? Does the State act as the issuer's fiduciary relating to the collection of these funds? Who will be liable in the event the State's collection process results in a loss of funds? Although it may not be feasible to address these issues in this rule, we believe such issues are appropriate for a rule and respectfully request that the state begin such process.*

*We also respectfully request that this section of the rule address the various scenarios that may face an employer plan submitting premiums to the State. For example, late payments, overpayments, refunds, partial payments and related situations. Employers should have a clear understanding of their rights and obligations regarding funds transferred to the State on their behalf.*

Response: Handling of employer premium payments is beyond the scope of these rules. Vermont Health Connect and carriers will enter into agreements in which these matters will be settled. We intend to provide enrollee rights and responsibilities along with the applications and would post these on Vermont Health Connect when finalized. We intend to provide further specifics through emergency rulemaking.

*Comment on Section 50.00(b): This section provides that QHP issuers must accept payment from VHC on behalf of a qualified employer. Please clarify if this includes partial payments or payments made in error.*

Response: Partial payments will not be forwarded to carriers.

## **Section 52.00 Application**

*Comment: It appears Part Seven applies to individuals enrolling directly through the exchange, not employer-sponsored plans? Unclear.*

Response: Although the bulk of Part Seven applies to individuals requesting Medicaid or APTC, all individuals enrolling in a QHP through the Exchange must complete an application process. An individual enrolling in an employer-sponsored QHP will not have to comply with many of the steps required of an individual who is seeking APTC. For example, an individual enrolling in an employer-sponsored QHP will not have to provide information on income.

*Comment on Section 52.01: This section provides that an individual shall be afforded the opportunity to enroll for health benefits at any time, without delay. We believe this is intended to only apply to publicly funded programs not subject to open enrollment periods. We respectfully request this be clarified.*

Response: Section 52.01 states that an individual will be afforded the opportunity to apply, not necessarily enroll, at any time without delay. This is a requirement specified in 45 CFR 155.310(c), which states “the Exchange must accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.”

*Comment on Section 52.02(a): This is no longer accurate, as they now have several applications (unless you are applying online). Also, is Dr. Dynasaur counted as Medicaid for this definition?*

Response: Federal law and regulations, which are effective beginning with the coverage month of January 2014, require states to use a single application for all health care programs, including Medicaid, Dr. Dynasaur, and APTC.

*Comment on Section 52.02(b): Single Streamlined Application. The way this is phrased, it appears that accommodations are only available to people who apply in person. The ADA language should be set out on its own as (b)(2)(vi). “In person” should stand on its own because in-person assistance is available for everyone regardless of disability. The language should also refer to Section 504 as well as the ADA.*

Response: We are removing the reference to the ADA, since it is not in the section of the federal regulations on which this section of the rule is based, and with the understanding that

AHS must and will adhere to all federal laws, including the ADA, in all facets of the application and eligibility determination process.

*Comment on Section 52.02(e): How does the process around missing information or incomplete applications affect the effective date of QHP coverage, especially for coverage starting January 1, 2014?*

Response: When we receive an incomplete application, we require the individual to complete it before we determine eligibility. Once eligibility has been determined, the individual would enroll in a QHP with an effective date as defined in Sections 71.02 and 71.03. Since coverage in a QHP does not occur retroactively (as does some Medicaid coverage), the effective date of QHP coverage would be the first of a month following the eligibility determination date.

*Comment on Section 52.02(e): As part of streamlining application processing (a policy change we strongly support), AHS should simplify and reduce its documentation requirements to the fullest extent possible. This appears to be the intent of 53.00(h), which we support. If an application is complete when submitted, it should be granted quickly without verification. If verification is needed, AHS should send one verification request to the applicant, listing all aspects that need to be verified.*

Response: A key tenet of the Affordable Care Act is a simplified application process, a goal which we fully support. The ACA requires the acceptance of self-attestation whenever possible, except in instances where information reported by the applicant is inconsistent with information available from other sources, in which case a verification request will be necessary. AHS's new automated eligibility system, once in place, will support the identification of missing and inconsistent information, which should reduce, but not entirely eliminate, the incidence of multiple verification requests.

*Comment on Section 52.02(e)(2): Can this be changed to either 12 business days, or 15 business days? This would account for holidays and other delays caused by the mail delivery system. Also, 12 days in general is usually not enough time for busy families to gather information, compile it, and return it to the appropriate place.*

Response: Under 45 CFR 155.310 of the proposed federal regulations issued 6/19/13, a new subsection (k) on incomplete applications was added. It states that an applicant must be provided with at least 15 days from the date a notice is sent to provide the information needed. We have revised Section 52.02(e) to allow for 15 days instead of 12 to align with this proposed federal regulation. In addition, everything in this section of the rule about "inconsistent" information has been removed since it belongs in Sections 53.00-57.00.

*Comment on Section 52.02(e)(4): This says that if answers to all unanswered questions are not received by the due date, the individual will be notified that AHS is unable to determine their eligibility for health benefits. State what the individual can do next. Are they allowed to start the application process over? This section should also include language that any notice about*

*missing information will be sent to both the individual and to any person acting as a representative for the individual, since some applicants will not have the capacity to respond to requests for more information on their own.*

Response: Applicants who are denied coverage for any reason may reapply at any time. All denial notices will contain an explanation of the denial and the toll-free customer service number. We don't feel it is necessary to add language to this section to the effect that notices will also be sent to authorized representatives, since §5.02(b) defines the scope of authority for authorized representatives, including the authority to receive copies of the individual's notices and other communications.

*Comment on Section 52.02(g): "Information regarding citizenship, status as a national, or immigration status will not be requested for an individual who is not seeking health benefits for themselves on any application or supplemental form." It is not clear whether "on any application or supplemental form" modifies "will not be requested" or seeking health benefits." If it modifies "will not be requested," can this information be requested by AHS in person or verbally?*

Response: We have modified this provision to improve clarity.

### **Section 53.00 Attestation and Verification**

*Comment on Section 53.00(d): Need to include the ability for individuals to change the information that pre-populates the application (for example, if their income was drastically different than it was on their previous tax return).*

Response: Section 53.00(d) merely states that AHS will use electronic data sources to verify an individual's attestation. Individuals will be given ample opportunity to respond if information from the federal data sources is inconsistent with the individual's attestation. See §57.00 for rules governing inconsistencies.

### **54.00 Attestation and Verification of Citizenship and Immigration Status**

*Comment on Section 54.00: This section includes lengthy rules pertaining to proving identity and citizenship. As the only state with no off-Exchange market, we are concerned that certain classes of people who are not "eligible" for coverage on the Exchange are entirely denied the opportunity to purchase any type of health insurance (even with no government subsidy) in Vermont. However, we understand that the Legislature has made this decision and the rules must reflect this. We strongly encourage that the rules, wherever possible, allow maximum access for Vermonters to purchase insurance. We want to ensure that rules intended to protect federal or state funds do not inadvertently deny people access to any health insurance coverage whatsoever (because of no off-Exchange market). As such, we strongly request that where possible, rules (and operational protocol) facilitate access to private insurance where public insurance is not available. We also strongly encourage caution in applying complex citizenship*

*and identify validation processes to those people who are receiving no federal subsidy (such as in the group market) to the extent legally permissible to do so.*

Response: While we understand your concern, we are bound by state and federal law. We will not, however, impose any verification requirements above and beyond those required. Although it is not a substitute for comprehensive coverage, the regulations contained in section 17.02(c) do entitle ineligible non-citizens to emergency medical assistance.

*Comment on Section 54.02: "Except as provided in Sec. 54.06, an individual seeking health benefits must sign a declaration that they are..." If a person is a minor or incapacitated, do they still provide their own declaration? Should this state, "an individual seeking health benefits or the individual's representative"?*

Response: We feel that, in its entirety, the proposed rule adequately addresses representation of minors and incapacitated adults.

## **56.00 Attestation and Verification of Income and Family Size**

*Comment on Sections 56.02 and 60.02: These sections refer to both "family" size and "household" income, which makes the eligibility and verification process confusing. If eligibility is determined based on the tax-filing household, referring to family size may be irrelevant.*

Response: The term "family size" is relevant for purposes of determining the FPL level that applies to an individual. Defined in Section 28.02, "family size" means "the number of persons counted as members of the individual's household." This definition is derived from both the federal Medicaid regulations and the federal tax code.

*Comment on Section 56.02(b): The rule should state that AHS will accept the individual's attestation of income if there is no electronic data available. In other words, if there is no income data received under 56.01, AHS should accept the individual's attestation.*

Response: In order to be in compliance with 42 CFR 435.952(c), if income data are not available, the individual will be required to provide additional information or documentation, and we will proceed in accordance with the provisions of Section 57.00 (inconsistencies) to obtain that additional information or documentation. Section 56.02(b) will be revised to include this requirement.

*Comment on Section 56.02(b): Some applicants for Medicaid, particularly those seeking long term care Medicaid, may be incapable of obtaining documents related to their application, or may be unable to submit verification, or may be unable to even assist in their application or provide attestation. In those circumstances, AHS should provide a rule that allows verification of income and resources for MABD eligibility, including long term care, to be made by the information reasonably available to the applicant or AHS, or based on attestation by the applicant or the person acting on their behalf.*

Response: We are informed by our field staff that it is very rare for an individual, even with assistance, to be unable to provide requested verification. We do not, therefore, believe that it is necessary to address this situation in the rule.

*Comment on Section 56.03(d): Verification for APTC/CSR, generally.- what is the purpose of including both (2) and (3)? What is the conceptual difference? Can these subsections be combined? Why not use the same 25% standard for both?*

Response: Section 56.03(d)(2) defines a situation in which the applicant's attestation may have been compatible with tax data, but other electronic sources report income that is higher than the attestation. Section 56.03(d)(3) defines a situation in which the applicant's attestation may have been compatible with tax data, but other information provided by the applicant is inconsistent with the attestation. For section 56.03(d)(3), the preamble in 78 FR 4593 gives the example of an applicant who attests to an annual income amount, but whose attestation of current income is significantly higher. For consistency, we have revised section 56.03(d)(3) so that it has a 25% standard.

*Comment: Titles of 56.04, 56.05, 56.06, 56.07, 56.08: delete the word "alternate." The descriptions in each section stand on their own and the term alternate is confusing. If the use of the term "alternate" was intended to signify that the procedures in 56.04 through 56.08 only apply to APTC and CSR applicants, and not to Medicaid applicants, then that should be stated. For example, the title of 56.05 could be simply, "APTC and CSR procedure for small decrease in projected household income."*

Response: The use of the term "alternative verification procedures" is to distinguish these verification procedures from the "basis" verification process under 56.03(c). Accordingly, we will not delete that term.

*Comment on Section 56.07: This subsection is unclear. How does this interact with 56.03(d)? We believe the process in 56.07 is actually a continuation of the process laid out in 56.06 and should be incorporated into that subsection as 56.06(c) and (d).*

Response: We agree that it is not sufficiently clear that section 56.07 applies only in situations in which federal tax data are not available. We have made that clarification in the final proposed rule.

*Comment on Section 56.08(a): This states that if an individual does not respond to a request for information within the 90-day period and tax data or non-tax data indicate that a household member is eligible for Medicaid, the application for government sponsored health benefits will be denied. If no one in the household appears to be eligible for Medicaid, is the application approved in this situation? AHS should only deny those household members for those for whom AHS requires more information. Also, the way this section is written, it is not clear whether it only applies to APTC and CSR applicants.*

Response: Sections 56.03 through 56.08 apply only to verification for APTC and CSR purposes. As the result of additional research following the initial submission of the proposed rule, we have determined that Section 56.08 applies only in situations described under 56.06 (see 45 CFR 155.320(c)(3)(vi)(E), 78 NPRM 4714). Under Section 56.08(a), if it appears that an individual's income is below the Medicaid limit, and requested verification has not been provided within the 90-day limit, eligibility for Medicaid will not be provided. However, under 56.08(b), if the individual's income is above the Medicaid limit and requested verification has not been provided, AHS will approve APTC based on the tax-based income. Anytime an individual has provided all information and verification necessary for AHS to determine eligibility for Medicaid, the individual will be approved for Medicaid. Section 56.08(a) does not assume that all Medicaid eligibility criteria have been met; rather, it assumes only that electronic data seem to indicate that the individual's income is below the Medicaid limit. Electronic data are never used to establish Medicaid eligibility unless the individual has attested to their accuracy. The APTC verification process requires AHS to continue with the eligibility determination process using only tax data without the individual's attestation of their accuracy.

*Comment on Section 56.09(c): Verification for catastrophic plans. This section says, "To the extent that the information required to determine eligibility for enrollment in a QHP that is a catastrophic plan as described in paragraphs (a) and (b) of this subsection is not able to be verified, the procedures specified in § 57.00, except for § 57.00(c)(4), will be followed." We believe the reference to 57.00(c)(4) means that applicants for catastrophic plans will not be allowed to enroll in a plan while verification is pending. This should be plainly stated here. What is the justification for this difference?*

Response: The reference to Section 57.00(c)(4) means that individuals enrolling in a catastrophic plan will not be processed for APTC or CSR, since they are not eligible for those benefits. We have added clarification to this effect in Section 56.09(c).

*Comment on Section 56.10: The rule should define the education and assistance that will be provided.*

Response: Any request for verification will explain the information and documents needed. In addition, verification request notices will contain the member services toll-free number, the VHC website, and information about the availability of navigators to help if needed. We are waiting for future guidance from HHS on this subject.

## **58.00 Determination of eligibility**

*Comment on Section 58.01(a): Reading provisions (1) and (2) in conjunction, we believe that individuals who are potentially eligible for non-MAGI-based Medicaid will be provided MCA (if eligible) while a determination is being made as to eligibility under another basis. For example, a person under the MCA income limit should receive MCA pending a disability determination. This should be made explicit at the end of 58.01(a)(2).*

Response: Yes, that is correct. The steps in Section 58.01(a) are intended to be sequential; therefore if an individual is eligible using MAGI-based methodologies, he or she will be approved for Medicaid. If the individual wishes to be considered under a non-MAGI- based program, Medicaid under MAGI will continue while other eligibility factors, such as disability, are being established. We have clarified that #3 means that an individual who is found ineligible for Medicaid will be reviewed for eligibility for premium assistance and cost-sharing reductions.

*Comment on Section 58.01(g): This section is confusing; its practical intent and effect are unclear. What population is this intending to address?*

Response: This was a special provision added at the federal level due to public comment based on the concern that there might be individuals who are citizens and whose income using Medicaid MAGI-based methodology is above 133% FPL but whose income using APTC MAGI methodology is below 100%. These individuals would be eligible neither for Medicaid nor for APTC (APTC requires income in the 100-400% range). To avoid such a gap, HHS added this “special rule” to allow states to revert to the APTC MAGI methodology to determine the individual’s eligibility for Medicaid. We do not expect this to happen very often, if at all.

## **Section 60.00 Computing the Premium-assistance Credit Amount**

*Comment on Section 60.00: This section provides details relating to computing the federal premium credit. Although we understand that this generally tracks the federal framework, we feel that in this rule it appears somewhat out of context. We recommend including more language regarding how these concepts are going to be applied within the context of a Vermonter applying for a premium tax credit determination through VHC.*

Response: Although the final determination of the amount of the premium tax credit is the responsibility of the IRS, we included in the rule detailed information for the computation from the tax code because we think it is important for Vermonters to understand how that computation is done in the context of determining an individual’s eligibility for APTC.

*Comment on Section 60.00: The rule should consistently refer to assistance available to help with the cost of premiums as the Advance Payment of the Premium Tax Credit (ATPC). It is confusing to also refer to it as the “premium-assistance credit amount.”*

Response: We cannot use only the term “APTC” because the tax credit is not always paid in advance. It can occur for the first time - or will be subject to adjustment - at the end of the tax year. There is no requirement that an individual take the credit in the form of an “advance” payment. A person can choose as much – or as little – of an advance on the credit as they want. We believe the distinction between the two terms is necessary in light of the difference in their meaning and application.

*Comment: It would be better to separate individual enrollees who are paying full premium to a section independent of the subsidized plan sections.*

Response: Although we acknowledge that the integrated approach to this rule has its disadvantages, we believe that the advantages outweigh the disadvantages.

*Comment: Throughout, it seems income is the basis for calculating subsidies, etc. Does the state (or the Feds) not consider assets? If one lives in a trust-owned multi-million dollar home on the lake, receives a stipend from the trust for living expenses, has no worldly needs, taxpayers pay the health insurance premium?*

Response: Yes, it is correct that federal law bases eligibility for MAGI-based Medicaid and APTC and CSR on income. Assets are not taken into account; however, income generated by assets, such as interest and dividends and capital gains, does affect eligibility to the extent that it is taxable income under IRS regulations. This may also include distributions that a trust beneficiary receives from the trust.

*Comment on Section 60.00: In general, the language around MEC needs to be more precise. QHPs are a type of MEC. Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage, 78 Fed. Reg. 7314, 7325 (proposed Feb. 1, 2013) (to be codified at 26 CFR §1.5000A-2). The language proposed here suggests otherwise. The requirement for APTC is that the individual not be eligible for MEC other than through VHC. See Proposed Rule 12.02(b).*

Response: We believe that Minimum Essential Coverage is sufficiently explained in Section 23.00.

*Comment: AHS should use the term “tax dependent” rather than just “dependent” throughout this section. Alternately, a footnote to 60.06(g) and other sections could be added to alert the reader that “tax dependent” is meant by “dependent” throughout the examples.*

Response: We have added the word “tax” before all of the uses of the term “dependent.”

*Comment on Section 60.02(c): This section should be created to define the term family for the rules under 60.00, since it is non-intuitive and not defined elsewhere in the rules. The need for this definition becomes evident when the reader reaches 60.08. The federal APTC regulations define family as “the individuals for whom a taxpayer property claims a deduction for a personal exemption under section 151 for the taxable year.” Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377, 30386 (May 23, 2012) (codified at 26 CFR § 1.36B-1(d)). That definition should be incorporated here, with a footnote citation to the federal rule.*

Response: We were concerned with the potential for confusion in the proposed rule with respect to the use of the term “family” in the tax code (for purposes of APTC), and the use of the term “household” in the federal Medicaid regulations (for purposes of MAGI-based Medicaid). Accordingly, we opted in the initial proposed rule to use the term “household” for both situations (see definition of “household” for APTC and CSR under Section 28.05(c)). We inadvertently failed to make that change in Section 60.08, and have done so in the final proposed rule.

*Comment on Section 60.04(b) Premium Assistance Amount: This subsection is very confusing and unclear as written.*

Response: Although we agree that the written explanation of what is actually a mathematical formula is difficult to follow, we have not substantially changed the language in this section since it is taken directly from the federal regulation. We believe the examples provided under ABP (60.06) help to explain this rule. We have, however, removed references to “adjusted” monthly premium, since that is referring to age-adjusted premiums, which we do not have in Vermont.

*Comment on Section 60.05: This section pertains to the adjusted monthly premium as used in the tax credit calculation. We suggest removing the language pertaining to age rating since there is no permissible age rating in Vermont.*

Response: We have removed the reference to age rating.

*Comment on Section 60.06(g)(3): Will K qualify for a premium tax credit if O’s employer subsidizes the plan? Or does this all only apply to non-employer sponsored insurance?*

Response: If O’s plan is an employer-sponsored plan that includes K, neither K nor O would be eligible for APTC.

*Comment on Section 60.07(b): The labels on this table are confusing. “Initial” and “Final” sound like amounts to be applied over a time period, not percentages to be determined based on where a person’s income falls within the spectrum. Something like “bottom percentage” and “top percentage” would make more sense.*

Response: We think the meanings of these terms in the table, when read in conjunction with the examples in 60.07(c) illustrating this rule, are clear.

*Comment on Section 60.08: The term family needs to be defined in 60.02, since it is non-intuitive and not defined elsewhere in the rules. See comment to 60.02(c) above.*

Response: See response to comment on 60.02(c) above.

## **Section 63.00 Individual choice**

*Comment on Section 63.00(a): An individual will need information about the different types of eligibility in order to make a reasonable choice between programs. The rules should state, “AHS will provide the individual with information about eligibility categories to assist in making this choice.”*

Response: This section is not a change from current policy at section 4134. We do provide information to an individual who may qualify for assistance under more than one category.

## **Section 64.00 Premiums**

*Comment on Section 64.01(g)(3): Individuals who opt for (g)(3)(i), combined payment to AHS, should get a single, combined, bill from AHS for the private and public coverages.*

Response: Bills will be generated by the state's premium processor and will include premiums due for both public and private programs individuals are enrolled in through VHC.

*Comment on Section 64.01(g)(3): The rule should clearly state how individuals will be required to pay their premiums. If the Agency intends that all premiums, for both public programs and QHPs will be paid to the Exchange, then the rule should not be written as if there is a choice.*

Response: The majority of premium payments will be handled by the premium processor and collected/processed through the "lockbox" accounts that are held by the State of Vermont; however, if an individual chooses to send a payment directly to the issuer, the issuer will accept the payment.

*Comment on Section 64.01(g)(3)(ii): This language states that an individual must pay the QHP issuer directly. It is true that by law, individuals must have the right to pay QHP issuers directly, but it is our understanding that the State has mandated that it will collect all premiums. This portion of the rule should be redrafted to reflect the current plan for billing and premium collection.*

Response: The joint lockbox will allow payment to issuers or the state, but essentially all funds are being sent to the premium processor, who is managing all premium payments paid on behalf of individuals and small businesses; however, if an individual makes a payment directly to an issuer, the issuer will accept the payment.

*Comment on Section 64.03: This section is called "Initial billing" and simply refers to Section 64.01. We recommend either deleting this section or enhancing its content.*

Response: We have removed this section from the final proposed rule.

*Comment on Section 64.04: A crucial term is missing from this section. AHS should provide at least the amount of notice that Medicaid and Catamount beneficiaries currently receive.*

Response: Individuals enrolled in QHPs will have a 90-day grace period prior to disenrollment and will receive notices at various stages of the grace period if payment is not received.

*Comment on Section 64.04(a): The number of days is missing.*

Response: After enrollment, a monthly bill for ongoing premiums will be sent by the fifth day of the month and will be due on the last day of that month. Section 64.04 has been revised to reflect this. There is a document, "Individual and Small Business Enrollment and Billing

Timelines,” posted on the VHC website that explains billing and enrollment timelines in more detail.

*Comment on Section 64.05(b)(1): As written, the state will pay itself first where there is a multiple premium household. Premiums will be credited to past due Medicaid premium balances, then Dr. Dynasaur, VPharm, and finally a qualified health plan. Insurers will be the last to be paid. We request that premiums be prorated amongst all the programs so insurers are not disadvantaged.*

Response: There is a hierarchy that has been built into the payment terms with the payment processor, and it is intended to ensure that the most disadvantaged individuals do not experience a gap in coverage.

*Comment on Section 64.06 Late Payment:*

- 1. The rule should set time frames by which QHPs have to issue notices for nonpayment of premiums.*
- 2. Notices should clearly state the consequences of losing coverage at the end of the grace period for nonpayment of premiums, including that the individual will not be able to re-enroll in a QHP until the next open enrollment period unless there is a triggering event for a special enrollment period.*
- 3. The notice should provide the next open enrollment dates and events that are considered triggering events for special enrollment, and should explain that open and special enrollments are not relevant for those eligible for Medicaid or Dr. Dynasaur.*
- 4. The rule should also explain the process for reinstating APTCs when late payments are made during the grace period.*

Response: We intend to provide further specifics either through emergency rulemaking or these terms will be memorialized in agreements between the carriers and VHC. In addition, notices issued by AHS will also contain information on the consequences of failing to pay premiums and how to reinstate coverage.

*Comment on Section 64.06(a)(1)(i)(B): Children enrolled in Dr. Dynasaur should also receive a three month grace period. Having different grace periods for different programs is confusing and more difficult to administer.*

Response: Although we agree that it would be less confusing to have one grace period for all individuals enrolled in coverage, whether that coverage is Medicaid or a QHP, federal regulations have established two different grace periods. Dr. Dynasaur beneficiaries do have the advantage of reapplying for coverage at any time, whereas individuals enrolled in QHPs must wait until the next open enrollment period unless they qualify for a special enrollment period. Dr. Dynasaur applicants may also receive three-month retroactive coverage, which is not an option for applicants for QHP coverage.

*Comment on Section 64.06(a)(2): For Dr. Dynasaur enrollees, subsection (ii) provides several concrete timeframes. E.g., “at least 11 days before the end of the grace period, the individual will be sent a closure notice advising that enrollment will terminate at the end of the grace month.” Subsection (i) regarding APTC beneficiaries has no comparable timeframes. There is no provision governing the amount of notice that must be provided prior to termination for an APTC enrollee. There is no requirement to send multiple notices to APTC beneficiaries. The provisions of (ii) should be made applicable to APTC beneficiaries as well. The disenrollment protection program should be expanded to APTC beneficiaries. Alternately, in place of Dr. Dynasaur disenrollment protection, the APTC notice should advise beneficiaries of their ability to report changes in income or household composition and request a redetermination of their premium amount.*

Response: The timing and content of notices sent by QHP issuers will be defined in the contracts between VHC and the issuers. Individuals enrolled in QHPs will receive timely notices that adequately explain what steps enrollees must take to avoid losing coverage.

*Comment on Section 64.06(a)(2)(i)(B)(II): This rule appears to require insurance companies to notify all of a beneficiary’s potential providers if the individual is in their nonpayment grace period. This is unrealistic and too broad. An issuer does not know who all of a beneficiary’s potential providers are. Notifying all potential providers would only serve to publicly humiliate beneficiaries.*

Response: Although the meaning of this federal regulation is not completely clear at this time, we believe the intent is for issuers to notify only those providers from which an individual is currently receiving services, rather than all providers in the issuer’s network. Providers currently serving an individual could be identified through the issuer’s claims history.

*Comment on Section 64.06(a)(2)(i)(B)(II): This requires insurers to notify providers of the possibility of denied claims when a person is in the second and third months of a grace period. This should be a business decision by the insurer, and a matter between the insurer and its contracted providers. We ask that you either remove this requirement or change the word “requires” to “insurers may notify providers.”*

Response: The requirement to notify providers when an individual is in the second and third months of a grace period is a federal requirement (45 CFR 156.270(d)). As stated above, we believe the intent is for issuers to notify only those providers from which an individual is currently receiving services.

*Comment on Section 64.06(b): This section should read, “the issuer shall ...” to make clear that the provisions are mandatory.*

Response: We believe the use of the word “will,” as opposed to “may,” makes sufficiently clear that issuance of the notice is required.

*Comment on Section 64.06(a)(2): This section pertains to the grace period applicable to a QHP without APTC. We note that Vermont law currently provides for different grace periods based on whether coverage is in the small group market or nongroup market (see 8 V.S.A. §§ 4089h and 4091c). We request that the proposed rule align with these current statutes.*

Response: VHC is currently working with issuers to align the grace periods if possible.

*Comment on Section 64.07: The disenrollment protection program should be expanded to APTC beneficiaries.*

Response: The disenrollment protection provision is contained in Medicaid federal regulations. We do not have the authority to expand it to include individuals enrolled in QHPs.

*Comment on Section 64.08(a): This provision allows that Medicaid may require past due premiums for outstanding balances when an individual applies for benefits. We respectfully request that this financial protection be expressly extended to issuers.*

Response: This provision applies only to Medicaid. Issuers may develop their own system for the collection of unpaid premiums.

*Comment on Section 64.08(a): 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 are not responsible for the debts of the other household member.*

Response: Section 64.07 does allow Dr. Dynasaur premiums to be waived or reduced if the individual has responded to the notice and has shown a change in circumstances. In addition, there is a hardship exemption for nonpayment of VPharm premiums (see Section 64.09), which allows an individual terminated for nonpayment of premiums to have coverage reinstated back to the date of termination.

*Comment on Section 64.09: This rule provides that individuals who failed to pay VPharm premiums due to medical incapacity, and whose VPharm was terminated for nonpayment, can pay all premiums due and receive retroactive coverage. This exception for "medical incapacity" should apply to all medical programs, not just VPharm.*

Response: The VPharm medical incapacity provision is not needed in Dr. Dynasaur, since anyone applying for Dr. Dynasaur may also apply for up to three months of retroactive coverage.

*Comment on Section 64.10: The household should be notified if they have a payment balance that will carry over to the next month.*

Response: Premium bills will contain credit balances, if any.

*Comment on Section 64.10: This section provides that payment balances that result from partial payments or overpayments will remain on the household premium account. It is not clear to us if this includes the QHP issuer account or VHC's account? This should be specified. Also, is this provision intended to apply to a group coverage scenario? This should be clarified.*

Response: Premium credit and debit balances will be maintained by the state's premium processor.

### **Section 66.00 Presumptive Medicaid Eligibility Determined by Hospitals**

*Comment on Section 66.03(a): "...the individual has gross income (or at state option, a reasonable estimate of household income) determined using simplified methods prescribed by the state..." This paragraph should be updated with Vermont specific information. Does Vermont plan to estimate household income? What "simplified methods" does Vermont plan to use to determine gross income?*

Response: In order to keep this process simple for the hospitals, we have decided to use the individual's gross income. The rule will be revised to reflect that decision.

*Comment on Section 66.03(c): When hospitals give out Medicaid applications, they should be required to provide information about where individuals can obtain assistance completing the application, including Navigators, the Call Center, and Certified Application Counselors.*

Response: According to federal regulations, hospitals must be prepared to assist individuals in completing applications. Hospital staff will contact navigators if assistance in certain situations is beyond their internal ability.

*Comment on Section 66.03(c): Subsections (v) and (vi) should not be subsets of (3). They could become new sections (6) and (7).*

Response: The purpose of all of the subsections under 66.03(c) is to identify what the hospital must do if it finds an individual presumptively eligible for Medicaid. This includes advising the individual about the filing of the Medicaid application (subsections (i) and (vi) of 66.03). However, as written, these subsections do not clearly state that intended purposes. The final proposed rule has been revised to correct this inadvertent error in drafting.

*Comment on Section 66.03(c)(4)(iii): People in this situation should not have to fill out a second Medicaid application. If the individual has already completed a Medicaid application as part of the presumptive eligibility determination, the hospital should forward that application to AHS for redetermination, at the individual's request.*

Response: The information being gathered by a hospital is to determine an individual's presumptive eligibility is only "preliminary information" – information sufficient to allow the hospital to determine if the individual is presumptively eligible. That information is not the "full" Medicaid application. The hospital must, however, take all reasonable steps to help the individual complete an application for Medicaid or make contact with AHS (see 66.03(c)(3)(vi)).

## **Section 67.00 General Notice Standards**

*Comment on Section 67.00(a): AHS notices must include the date the notice is sent to the individual (not the date it is printed).*

Response: To the best of our ability, notices will be sent on the day following their generation, which occurs at night, as they are now. Since notice generation and placement into envelopes are automated processes, we will not have the ability to date stamp each notice with a mail date.

*Comment on Section 67.00(c): The rule should address how appeal deadlines will be calculated when notices are being sent by regular mail and/or posted electronically. For example, does the appeal period start running from the day the notice is posted to an individual's electronic account or from the day the Agency notifies an individual that a notice has been posted?*

Response: Since there is no section 67.00(c), we presume you are referring to sections 67.01(a)(3) and (4). If so, the "posting" of a notice to an individual's account and the sending of an email to the individual that a notice has been posted will occur simultaneously. However, if for some reason they do not occur simultaneously, whichever occurs later is the date that will control.

## **68.00 Notice of Decision and Appeal Rights**

*Comment on Section 68.03(b)(6): Notice may be sent as late as the date of action if: "A change in the level of medical care is prescribed by the enrollee's physician." This should be narrower. For example, insert the phrase, "which affects the individual's eligibility," or modify this to say, "A significant change."*

Response: We have removed this condition from the final proposed rule since it is not a condition affecting eligibility for Medicaid.

*Comment on Section 68.03(c) Advance Notice of Decision: The rule is vague about the circumstances that would allow the agency to shorten the advance notice requirement to 5 days. Shortening the advance notice requirement should occur only in extraordinary circumstances, and the standard that the Agency must meet must be more stringent than "facts indicating ...probable fraud" and "verification through secondary sources, if possible."*

Response: The language in section 68.03 is from 42 CFR 431.214, and we do not believe it is vague. The use of the term "facts" means that we could not shorten the notice period on mere suspicion of fraud.

## **Section 70.00 Medicaid Enrollment**

*Comment on Section 70.02(c): This section provides that “If the initial coverage month is the month in which the individual applied for health benefits, the initial bill include premium charges for the application month, the approval month (if different than the application month), and the month following the approval month.” Please note that for a QHP enrollment, it is our understanding that application will not occur the month in which the coverage is becomes effective. As such, this should be clarified to include only Medicaid or other appropriate coverages. We make the same request relating to Section 70.02(d) and 70.03, since we do not believe these concepts apply to QHPs.*

Response: Section 70.00 in its entirety applies only to Medicaid, as stated in the title of the section.

## **Section 71.00 Eligibility of Qualified Individuals in QHPs**

*Comment on Section 71.00(b): We received two comments regarding the timeframe. First, this notes that AHS will send QHP selections to the implicated issuer “without undue delay.” Although we appreciate that HHS allowed flexibility for Exchanges in this turn-around time, at the State level it is more appropriate to provide a specified timeline for this data exchange as Vermonters will be harmed if the State delays in these processes. Additionally, health plans and consumers will be better served if they have realistic expectations regarding the expected turn-around time for this information transfer. Second, the rules require AHS to send eligibility and enrollment information to QHP issuers and HHS “promptly and without undue delay”. The rules should be more specific about how quickly AHS is required to transmit this information.*

Response: The timelines are documented in the State of Vermont, Department of Vermont Health Access, Vermont Health Connect’s “Individual and Small Business Enrollment and Billing timelines, Final, Version 2.0, June 2013.” We intend to publish a summary of the document in a consumer friendly format and post it to Vermont Health Connect.

*Comment on Section 71.00(b)(1): We received two comments regarding the timeframe. First, this notes that AHS will send QHP selections to the implicated issuer “without undue delay.” Although we appreciate that HHS allowed flexibility for Exchanges in this turn-around time, at the State level it is more appropriate to provide a specified timeline for this data exchange as Vermonters will be harmed if the State delays in these processes. Additionally, health plans and consumers will be better served if they have realistic expectations regarding the expected turn-around time for this information transfer.*

*Second, the rules require AHS to send eligibility and enrollment information to QHP issuers and HHS “promptly and without undue delay”. The rules should be more specific about how quickly AHS is required to transmit this information.*

Response: The timelines are documented in the State of Vermont Department of Vermont Health Access Vermont Health Connect, Individual and Small Business Enrollment and Billing

timelines, Final, Version 2.0, June 2013. We intend to publish a summary of the document in a consumer friendly format and post it to Vermont Health Connect.

*Comment on Section 71.00(d): This section notes that “AHS” will reconcile enrollment. Again, we strongly recommend that the state entity actually responsible for performing the function be identified in the rule. It is our understanding at this time that VHC will conduct these reconciliations.*

Response: You are correct that in this instance it will be DVHA/VHC that will perform the reconciliation function. However, we are reluctant to be specific in all areas of the rule about the department or division that performs a function, since the assignment of responsibility and the names of the departments and divisions can change over time. We would prefer not to go through the rulemaking process to change department and division names.

*Comment on Section 71.00(g): What circumstances would an Automatic enrollment come into play? This needs to be better defined and clarified.*

Response: At this time we do not anticipate automatic enrollment. We have removed this provision.

*Comment on Section 71.01: We note that this states that “AHS” will take certain actions. We strongly recommend that the actual state entity operationally responsible for these actions be identified. We believe failing to make these decisions and be clear about roles and responsibility may increase the chances of confusion and create the opportunity for a less streamlined process going forward.*

Response: As addressed in a response to an earlier, similar comment, we do not wish to name specific departments and divisions in the rule, since department and division names and functions change over time.

*Comment: Typo in section 71.01(b)(3): eligibility and enrollment data should be sent to QHP, not AHS by AHS.*

Response: This section says that AHS will provide eligibility and enrollment data to HHS, as required by federal regulations.

*Comment on Section 71.01(c): Record maintained by whom? Will health care providers be able to retrieve eligibility and enrollment verification?*

Response: This section refers to QHP enrollment records that will be maintained by AHS. Health care providers will be able to verify enrollment in Medicaid and private health insurance plans as they currently do.

*Comment on Sections 71.02(d) and 75.02: Who is responsible for providing this notice? Change to active voice in both sections.*

Response: We will clarify that AHS will send the notice.

*Comment on Section 71.03: This section spells out special enrollment periods. Based on instruction from the State, issuers are not monitoring these events in any way. We respectfully request language in the rule that makes it clear that VHC (or other appropriate State entity) is responsible for administering these enrollment periods.*

Response: We have clarified this in the final proposed rule.

*Comment on Section 71.03(b)(4): This is a section for APTC and CSR effective dates, and here you note that these items will adhere to the effective dates specified in 74.04. Unfortunately 74.04 is blank - can you provide the details for this item? Our preference is that eligibility changes for these items mirror the defined timeframes for enrollment eligibility. This would allow for consistency in determining eligibility.*

Response: Given that HHS has just recently released proposed rules on effective dates, we will be inserting those dates into the emergency rule and proposed rule to be filed this fall.

*Comment on Section 71.03(d): The SEP rules should be made more explicit regarding COBRA coverage, to avoid confusion. The rules should specifically state that a beneficiary may decline COBRA coverage and receive a SEP based on loss of ESI. Also, the rules should state that a beneficiary may receive a SEP if their COBRA terminates for any reason other than nonpayment of premiums, including voluntary termination by the beneficiary. This appears to be allowed by the proposed rules but is not explicitly stated.*

Response: We have revised (e) to clarify that an employee or dependent may enroll in COBRA, cancel coverage, and qualify as an individual for a special enrollment period.

*Comment: Section 71.03 (d) (4), individual is singular, their is plural. Enrollee is singular, their is plural, this pattern continues throughout this section. It may have been present throughout the document. The language is so cumbersome throughout.*

Response: Although we agree that traditionally style guides have instructed writers to use the singular pronoun when referring to a singular subject, the use of the plural and genderless pronoun “their” has become acceptable as an alternative to the more cumbersome “his/her” or “his or her.”

*Comment on Section 71.03(d)(4): Errors made by navigators should be included here, and result in a SEP for the beneficiary.*

Response: We agree and have revised the provision.

*Comment on Section 71.03(d)(4): State that a special enrollment period may be triggered if enrollment in a QHP is “unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee or agent of AHS or HHS or its instrumentalities as evaluated and determined by AHS.” Please explain the agents or*

*instrumentalities of AHS that this section is referring to and whether it includes Navigators and Certified Application Counselors.*

Response: We interpret the provision to include navigators and certified application counselors for the purpose of assistance with enrollment.

*Comment on Section 71.03(d)(9): Exceptional circumstances justifying a special enrollment period are not defined at all. Some guidance needs to appear in the rules. Vermont rules should not just refer to federal regulations that may not be immediately forthcoming. The rules should give examples of exceptional situations, while providing a flexible catchall provision. For example, people who are unable to pay their COBRA premiums for a good reason, such as an unforeseen financial crisis, should be able to apply for a SEP.*

Response: We intend to provide rules for exceptional circumstances in emergency rulemaking.

*Comment: With regard to APTC, we have an outstanding question not covered in this draft rule (or anywhere else we know of), and that is if an already enrolled member wants to modify the amount of APTC that they are receiving to offset premiums, what is the date the change is effective? There is speculation that it follows the enrollment effective date rules, but this is not clearly defined. Our preference is for notice to be given to QHP's by the 15th day of the month for the change to be effective the first of the following month. This will reduce the need for re-billing customers and alleviate reconciliation and collections issues that may occur with later changes allowed.*

Response: We will address this issue via emergency rule when we add substance to the current Section 74.04 effective dates “placeholder.” HHS has issued proposed rules that include effective dates for changes that result from redeterminations during the benefit year.

## **Section 75.00 Eligibility Renewal**

*Comment on Section 75.02(a), (b): These sections relate to notice upon QHP renewal. We understand that VHC will be sending these notices and request that be clarified in the rule.*

Response: We have clarified this provision to state that VHC will issue the notices.

*Comment on Section 75.02(b): What timing rules apply to renewals for coverage effective January 1, 2016? Probably the wording of (1) needs to be changed to include this year.*

Response: We do not believe that the suggested change is necessary. The rule under (1) states that for “renewals” for coverage effective 1/1/15, one notice can be sent, and under (2) for “renewals” for coverage effective on or after 1/1/17, two notices can be sent. Since 2016 cannot fit under (2), it must come under (1).

*Comment on Section 75.02(f)(iii): “If applicable, notify the individual’s employer.” Specify when this is applicable.*

Response: We have added language to clarify that an employer must be notified if an individual has been found eligible to enroll in a QHP and receive APTC because the employer does not offer affordable MEC. We have also added a reference to section 49.02.

*Comment on Section 75.03(b): The title of this section is narrower than its contents.*

Response: We have revised the title of this section to more accurately reflect the content.

*Comment on Section 75.03(b)(5): This subsection should be added to incorporate AHS's duty to assist beneficiaries in obtaining verification, when needed. Seniors and disabled people are particularly vulnerable to having their benefits terminated for failure to fill out recertification paperwork or obtain verification. See our general comment on accessibility above.*

Response: We have added a statement to the effect that review notices will contain the toll-free customer service number and a request that individuals call if they need assistance. In fact, all notices will contain the toll-free number, the VHC website, and the availability of translation services and assistance for individuals with sensory impairments. Notices will also contain language about the availability of navigators, with an invitation to call the toll-free number if they would like to be connected to a local navigator.

## **Section 76.00 Termination of QHP Coverage**

*Comment on Section 76.00(a): This section notes that AHS will "determine the form and manner in which coverage in a QHP may be terminated." We believe that such determination would be appropriately included in this rule and to the extent that additional guidance is intended, we respectfully request that it be included in this rule. We also note that it is our current understanding that the state is requiring issuers to terminate for non-payment. This expectation and the details thereto should be included in this rule so that both issuers and consumers have clear expectations.*

*We also note that portions of this rule seem to appear in other sections. It is unclear to us how the language is intended to be different. If the language is not intended to be different, we recommend including these provisions in only one place in the rule. If it is intended to be different, we seek clarification on which provisions apply in what circumstances.*

Response: The form and manner are described in Sections 76.00(b), (c), and (d). Termination for non-payment is specifically provided for in Section 76.00(2). The termination provisions in Part Six apply to Part Six. The termination provisions in Part Seven apply to Part Seven.

*Comment on Section 76.00(b): This section indicates that an individual can initiate a termination by notifying the issuer. This is not consistent with previous guidance we have received from the State. It is our understanding that the individual must contact VHC (or appropriate State entity) to initiate termination and issuers may only initiate termination for nonpayment of premium or fraud. Please clarify.*

Response: We are directing individuals to VHC to notify of cancellations. However, federal regulations for individual initiated terminations provide for appropriate notice by an enrollee to VHC “or the QHP”. We interpret QHP to mean the QHP issuer. In that case the QHP issuer should direct the employee to VHC, per state guidance to the carriers.

*Comment on Section 76.00(b): We are very concerned about the potential for individuals who may fall off of insurance and are not notified properly of termination of benefits. Will providers and health centers be notified of impending cancellation of benefits so they can assist patients?*

Response: We share the concern and are exploring means for reducing lapses in coverage.

*Comment on Section 76.00(c)(3): We received two comments requesting clarification. This section provides that AHS will require “QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the ADA) before terminating coverage for such individuals.” We respectfully request more detail on the State’s expectations in this area. Under current Vermont law, the only reason that an individual would be terminated from coverage is for nonpayment of premium (or product withdrawal). What sort of ADA accommodations would be expected relating to the payment of premiums (which are collected by the State)?*

Response: We are awaiting federal guidance on this provision.

*Comment on Section 76.00(d)(1)(ii): This section refers to 74.04 for reference on when APTC/CSR changes are effective. However, Section 74.04 is reserved. We believe this should be more clearly defined.*

Response: Given that federal regulations were released only recently on this section, we will be incorporating effective dates into the emergency and proposed rules to be issued this fall.

*Comment on Section 76.00(d)(5): Echoing our comments made in relation to the other termination section of this rule, we appreciate the generic reference to state grace periods included in this section. However, we respectfully request that applicable grace periods be specifically incorporated into the rule so that expectations are clear for all interested stakeholders.*

Response: We are currently in discussion on this issue with issuers, our contractors, and VHC staff who have consulted with the Department of Financial Regulation.

## **Section 77.00 Administration of APTC and CSR**

*Comment on Section 77.00(a): The initial sentence is confusing. It should read, “In the event that a tax filer is determined eligible for APTC or CSR, an individual is eligible for CSR, or in the event AHS determines that such eligibility for such programs has changed, AHS will...”*

Response: The rule reflects language used in federal regulations that attempts to clarify who is eligible for APTC vs. CSR. Only the tax filer is eligible to receive APTC, whereas all individuals

covered under the QHP receive CSR. If the tax filer is covered under the plan, he or she is also an “individual” who receives the benefit of CSR. We have made no change to this section.

*Comment on Section 77.00(a)(2): This section refers to what AHS will do in the event of a change in APTC or CSR eligibility. We respectfully request that this portion of the rule also require the “effective date of the change” be included in the information transmitted to the issuer.*

Response: We believe your request is reasonable and will explore whether it can be accommodated and, if so, when.

*Comment on Section 77.00(b)(1): Sections (ii) and (iii) state the opposite of the correct rule, because the language in these sections does not agree with paragraph (1). We believe this provision was intended to read, “(1) ...that an individual’s employer: (i) does not provide MEC; (ii) provides MEC that is unaffordable...”*

Response: We agree with the commenter that this section is not worded correctly, and have revised this section accordingly.

*Comment on Section 79.00 Reconciling the premium tax credit with APTC: Does Vermont need to include these provisions in its rules? These are entirely taken from federal regulations and appear to have no state involvement. The reconciliation is done on federal tax returns only. The rules and calculations set out here will be part of IRS publications, schedules, and forms.*

Response: We have removed this section from the final proposed rule but will make the information available to individuals who may wish to understand the reconciliation process as performed by the IRS.

## **Section 80.00 Fair hearings**

*Comment: An overview of the types of appeals would be very helpful at the start of this section. It is not completely clear to whom these proposed fair hearing rules apply, and for what issues. Are they solely for applicants, enrollees, or employees contesting eligibility determinations as mentioned in 80.01? If that is the case, it is not emphasized enough. If these rules do not deal solely with eligibility determinations but are also meant to cover appeals of other types of issues, like coverage, then explicit references to those other issues need to be made in additional sections. Appeals related to coverage denials are briefly mentioned in 83.00, which implies that these proposed fair hearing rules do apply to coverage determinations. It is difficult to identify all the places changes are needed without better understanding AHS’s intent.*

Response: This rule is limited to eligibility-related issues. Reference to coverage appeals under 83.00 is a carry-over from current rule. The rule for appeals on coverage issues is set forth in DVHA’s rule 7110.

*Comment on Section 80.00: This section and sections following pertain to fair hearings. We understand that these provisions largely draw from the robust Medicaid appeals process. However, we strongly encourage the state to consider how this appeals process shall apply to both the nongroup private insurance market and the small group private insurance market. For example, currently the Department of Financial Regulation receives complaints relating to health insurance. These complaints are processed through an existing and well understood process. If these complaints pertain to coverage terms of a policy, there is a robust and federally defined process for resolution. If the complaints pertain to other matters, DFR's complaint resolution process can result in an investigation or enforcement action against an issuer that is not operating within the confines of Vermont law. The DFR process is mature and efficient, in part due to the fact that DFR is responsible for other regulatory matters relating to issuers. We would encourage that these processes be maintained and that the current proposed rules clearly specify what would be an appropriate appeal to VHC/DVHA/AHS/DCF and what would more appropriately be handled through existing DFR processes. It would be our assumption that AHS would more appropriately consider eligibility issues pertaining to the APTC/CSR and the DFR would still be responsible for claims and services issues. However, this should be clearly defined in the rule.*

Response: The fair hearing process described in Section 80.00 is intended to apply to eligibility decisions rendered by AHS. We fully expect that DFR will use its existing complaint process for individuals with questions or complaints about claims and services under a QHP.

*Comment on Sections 80.01 and 80.02: The rule should more clearly describe all the actions of AHS that can be appealed, including coverage decisions, reductions in coverage, and premium determinations. The rule as proposed is too narrow in its description of actions that can be appealed.*

Response: We have not attempted to include all types of appealable decisions, since this list is not intended to be exhaustive. We have modified the section to make that clear.

*Comment on Section 80.02(b): "Contacting AHS" is not specific enough. We suggest: "Applicants and enrollees may request fair hearings either orally or in writing by contacting the Human Services Board, VHC Member Services, or any AHS Department, office, contractor or delegate."*

Response: We believe that the requested language is too narrow. Current rule does not state to whom requests for fair hearings can be made (see Rule 4151), and we are concerned about limiting the scope.

*Comment on Section 80.02(d): Notice of fair hearing rights should be provided on every notice that the Agency sends applicants and enrollees. The proposed rules as written is far too narrow about when the Agency is required to provide notice of appeal rights.*

Response: We provide hearing rights on all notices that involve an action affecting eligibility or level of benefits. There are some notices that are more informational in nature and do not require the inclusion of appeal rights.

*Comment on Section 80.03(a)(1): This section should also specifically contain the right to appeal income and penalty determinations, including spenddown, patient share and transfer of asset determinations. We suggest adding the following: (viii) A determination of the amount of paid or incurred medical or remedial expenses which may be used to establish a spenddown or patient share under §30.05 or §24.00 (ix) A determination of whether transfers of income or resources made by an individual requesting MABD for long-term care, or by any member of their financial responsibility group are allowable transfers or subject to penalty under §25.00.*

Response: We have modified Section 80.00 to clarify that fair hearings may be requested based on any AHS decision that affects eligibility or level of benefits. We do not wish to attempt to list all such decisions in the rule.

*Comment on Section 80.03(a)(1): This describes when a hearing is required. If this section is also meant to include appeals for coverage denials, it should be changed to: "Any individual who requests it because AHS denies them assistance, coverage, services, eligibility, level of eligibility, or..."*

Response: This section is not meant to include appeals for coverage denials, so no change is needed.

*Comment on Section 80.03(a)(1)(iii): This provision is extremely confusing and appears to imply that only employer sponsored plans that are determined affordable and offer minimum value will trigger the option for an appeal. It would be more accurate to state, "A determination for any month that an individual is ineligible for APTC because the individual is considered eligible for other MEC under §12.02(b) and §23.00. This includes but is not limited to determinations of affordability and minimum value for employer-sponsored plans."*

Response: We will incorporate the suggested language.

*Comment on Section 80.03(b) Exception for SSI enrollees: Why would someone who was found not disabled prior to 1990 be appealing now? Can this section be deleted?*

Response: Yes, we have deleted this section since it is obsolete.

*Comment on Section 80.04(b) Timely request: This section should read, "To receive a fair hearing, the individual must request a fair hearing within 90 days from the date that notice of action is mailed or sent electronically (§ 68.00)."*

Response: We have changed the word “mailed” to “sent.” The word “sent” is appropriate for both paper and electronic notices.

*Comment on Section 82.00 Eligibility pending fair hearing: Continuing “eligibility” in this context is confusing. We prefer the current term “continuing benefits” rather than “continuing eligibility.” Actual eligibility for benefits will be determined through the appeal. In plain English, what the beneficiary receives pending appeal are “benefits.” This term is far easier to understand. “Eligibility” should be replaced with “benefits” throughout this section.*

Response: We agree and will replace the term “eligibility” with “benefits” with respect to Medicaid, but will leave the term “eligibility” with respect to QHP under 82.01(g).

*Comment on Section 82.01(a): The proposed rule states in part: “If the last day before the adverse action date is on a weekend or holiday, the individual has until the end of the first subsequent working day to request the fair hearing.” The individual has 90 days from the date of notice to request a fair hearing. The end of the sentence should read, “...to request the fair hearing and receive continuing benefits pending the outcome of the appeal.”*

Response: Section 82.00 is addressing the individual’s right to continuing benefits, not the right to request a fair hearing, which is covered under Section 80.00. As such, section 82.01(a) is expressing the requirement for an individual to request a fair hearing prior to the effective date of the action in order to maintain continuing benefits.

*Comment on Section 83.00 Managed care organization appeal, fair hearing, and grievance: This section is too brief. “Managed care organization” could apply to QHPs, not just to Medicaid. The current appeal process for Medicaid coverage denials (through the Human Services Board) is very different from commercial plan appeals (internal appeals through the plans themselves and external appeals through the Department of Financial Regulation). This section should be fleshed out in a subsequent bulletin dealing with appeals.*

Response: This section pertains to Medicaid coverage appeals and grievances. The referenced DVHA Rules do not apply to QHPs.