

# VERMONT LEGAL AID, INC.

264 NORTH WINOOSKI AVENUE, P.O. BOX 1367

BURLINGTON, VERMONT

802-863-5620 (VOICE AND TTY)

802-863-7152 FAX

By email to [michele.betit@state.vt.us](mailto:michele.betit@state.vt.us)

June 21, 2013

Michele Betit, Health Care Eligibility Director  
Economic Services Division, DCF  
103 South Main Street  
Waterbury, Vermont 05671-1201

Re: DCF Bulletin No. 13-12P  
Comments on Proposed Rules

Dear Ms. Betit:

We are writing to comment on the Agency of Human Services (AHS) proposed regulations for Health Benefits, Eligibility and Enrollment in Bulletin 13-12P. These regulations will implement Vermont's Health Benefits Exchange (HBE) and establish eligibility for Vermont's health care programs.

Vermont Legal Aid is submitting this single set of comments written by advocates from different VLA projects, including the Office of Health Care Ombudsman, the Poverty Law Project, the Disability Law Project and the Senior Citizens Law Project. The Senior Citizens Law Project represents the Community of Vermont Elders, and submits these comments on behalf of COVE as well.

## **General comments**

### **Format**

The new format is an improvement over the format of the current regulations in some ways, but there are significant problems with it.

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.

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.

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.

## **Omissions**

### **Purpose and scope of Medicaid and EPSDT**

AHS has removed current regulation language about the purpose and scope of the Medicaid program and the federal Early, Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. These overviews serve an important purpose in the current regulations by emphasizing the legal basis and breadth of Medicaid and EPSDT. At least some of this overview language should be restored. See our further comments about this in Section 2.00 below.

### **Medicare-eligible individuals**

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.

### **State subsidies**

There is no mention of the additional state subsidies which the legislature enacted this spring in the Fiscal Year 2014 Appropriations Act. The Vermont premium subsidies and cost sharing reductions should be included in these rules, if possible.

### **Interpretive memoranda**

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.

### **Exemption appeals**

The HBE, 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. Certain exemptions, including hardship, can only be claimed through an exchange. Two proposed federal rules provide some guidance:

Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage, 78 Fed. Reg. 7314 (proposed Feb. 1, 2013) (to be codified at 26 CFR Part 1); Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions, 78 Fed. Reg. 7348 (proposed Feb. 1, 2013) (to be codified at 45 CFR Parts 155 and 156). We understand that AHS may need to employ emergency rulemaking to adopt rules on this topic. We would like to be included in the rulemaking process as early as possible so that we have a chance to give meaningful input.

#### Reopening Final Determinations

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

#### 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.

#### Medicare Savings Program expansion

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.

#### **Other general concerns**

##### Multiple representatives

The definition section describes multiple types of representatives an applicant or beneficiary can have. It includes the following types of representatives: appeal, authorized, eligibility, and fair hearing. The eligibility and the authorized representatives are governed by proposed rule 5.02, which in turn is governed by several proposed federal regulations. It is confusing to have so many possible representatives. We propose having just one type of representative, an "authorized representative."

##### Written authorization requirement

All of these representatives require written authorization from the applicant or beneficiary.

A requirement for written authorization is potentially problematic for Vermont Legal Aid in general and the Office of Health Care Ombudsman (HCO) in particular, because we often try to resolve our clients' issues quickly and over the phone. The HCO operates a statewide telephone hotline and it would greatly reduce our efficiency if we have to get written authorization from our clients in every case. HCO advocates often do some of the authorized representative tasks listed in 5.02. 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.

We would like assurance that we will continue to be able to act quickly for our clients without having to get written authorizations, or formally be designated as "authorized representatives." We submit that acting without written authorization on behalf of our clients is allowable for the HCO and all of VLA because we are all part of a law firm. As such we are bound by the attorney Rules of Professional Conduct. We would prefer to have specific permission in these regulations to assist our clients and get information from AHS without the requirement of written authorization. In the alternative, we would like clear recognition that the Interpretive Memo mentioned above will continue to apply to health care cases.

#### Appeals process

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.

#### Accessibility

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.

## Reliance on language of federal rules

Our final general concern relates to 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.

### **Specific comments by section**

Our suggested language is underlined. In some instances we have used strikethroughs to show proposed deletions. In instances where it would be too distracting we did not use strikethroughs.

## **Part One: General Provisions and Definitions**

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

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.

Medicaid Rule 4100 also 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. The EPSDT program is extremely important for Vermont's children because it requires coverage for kids that is more extensive than coverage for adults. It should not be given short shrift or diminished by these rules. Beneficiaries and caseworkers need to know about the program.

Aside from Rule 4100, there was also good language in an early draft of these rules about the purpose and scope of the Medicaid program and EPSDT, including a descriptive footnote about EPSDT which was on page 15 of that early draft.

2.01(a): CHIP is listed as one of the types of benefits offered by Vermont. Although the acronym is repeated from the rule above, it should be spelled out again, Children's Health Insurance Program, for clarity. Also, it would be helpful to explain that CHIP falls within Dr. Dynasaur in

Vermont, or refer to the subsequent rule, 2.03, which explains the relationship of CHIP to Dr. Dynasaur.

2.02(b): This section that 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.

2.04(a): The bronze plan is followed by parentheses stating, “Represents minimum creditable coverage.” We suggest the silver plan to be followed by parentheses stating something like, “only coverage for which beneficiaries can get CSRs.”

2.04(b): Mention the state subsidies in addition to the federal subsidies.

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.”

## **2.05 Administration of eligibility for health benefits**

2.05(b): Modify the text to read: “The eligibility determination process is administered such that...”

2.05(b)(12): This provision is too narrow. It should read, “~~Upon request,~~ Individuals are helped to obtain needed information upon request and when incapacitated...”

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.

## **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.”

**“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.”

**“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.”

**“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.”

**“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.”

**“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.

**“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.

**“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).

**“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.

**“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.

**“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.

**“Tax dependent”** 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.

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

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

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.

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.

4.06(a): The source of the quoted language should be identified.

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.

We propose the following language: “The state has the right to recover payment for benefits to which an individual was not entitled at the time the benefit was received. The state may recover

such benefits only if the beneficiary was responsible and there was fraudulent intent. An alleged overpayment is an appealable issue which triggers all due process rights, including the right to proper notice and the right to contest the alleged overpayment at a fair hearing.”

In the alternative we suggest adding the opportunity for a waiver of recovery, similar to what is allowed for SSI overpayments. See 20 CFR §§ 416.550, 404.508.

## **5.00 Eligibility and enrollment assistance**

5.01: Assistance Offered Through AHS. 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.

A good deal of the language in this section is written in the passive voice: “Eligibility and enrollment assistance . . . is provided”; “A toll-free call center is provided”; “A web site is maintained.” The Rule should specify who is responsible for providing and maintaining these services.

5.01(c)(2): It would be helpful to include examples of auxiliary aids and services, such as video-relay and in-person ASL interpreter services.

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).

We approve of the statement that any ADA or 504 complaint may be brought to the Human Services Board. However, this is not the only legal avenue for filing an ADA or 504 action. The rule should go on to say “or the Vermont Human Rights Commissioner or to any other investigative agency or court of competent jurisdiction.”

5.02(b): Scope of authority. Add “request a fair hearing or a grievance” as one of the enumerated powers of a representative.

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.

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.

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. Individuals cannot always get to a Legal Aid office quickly. Sometimes individuals have very limited phone access, or limited funds to put minutes on their phone. Advocates from Vermont Legal Aid and Legal Services Law Line should be able to get information in urgent situations even if a written release cannot be immediately obtained.

### **5.03 Navigator Program**

5.03(a): General Requirements. 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.

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.

### **5.04 Brokers**

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.”

### **5.05 Certified application counselor**

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.

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.

5.05(b): Certification. 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.

## **Part Two: Eligibility Standards**

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

#### **7.03 Categorical and financial criteria**

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.

7.03(a)(6): Families with Medicaid eligibility extended because of increased earnings or hours of employment.

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.

Tracking the proposed federal regulation word for word (42 C.F.R. 435.112 (NPRM, 78 FR 4593), §7.03(a)(6)(i)(B) states that “If Transitional Medical Assistance under §1925 of the Act *is not available* or applicable, extended eligibility must be provide in accordance with this subclause, if applicable.” (emphasis added) Vermont currently offers Transitional Medicaid, so we are assuming that it *is available*. Since the sub clause mentioned in the proposed federal and state rules provides for only four months of Transitional Medicaid, rather than Vermont’s current 36 months of Transitional Medicaid, we ask that the State continue this more generous program rather than defaulting to the stingier federal option.

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.

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.

7.03(a)(7): Families with Medicaid eligibility extended because of increased collection of spousal support. This section appears to extend Medicaid for pregnant women, parents of dependent children, and caretaker relatives of dependent children for four months if their income rises above the income limit for MCA due to increased spousal support.

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.

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.

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

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.

## **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.

## **9.00 Special Medicaid groups**

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.

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.

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).

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

A section or subsection should be added describing the Vermont premium subsidies passed by the legislature in the Fiscal Year 2014 Appropriations Act.

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).

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

This section should be amended to reflect the cost-sharing reductions passed by the Vermont legislature in the Fiscal Year 2014 Appropriations Act.

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).

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.

### **14.00 Eligibility for enrollment in a QHP that is a catastrophic plan**

Include a minimum age of 19, so that catastrophic coverage is available only to adults under age 30.

## **Part Three: Nonfinancial eligibility requirements**

### **16.00 Social Security number**

16.01(a)(2)(i) and (ii): replace “it” and “its” with AHS.

### **17.00 Citizenship and immigration status**

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.”?

### **18.00 Assignment of rights and cooperation requirements**

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.

## **21.00 Residency**

21.02 (c): From the last draft to this one, "mental retardation" was changed to "intellectual disabilities." This is a good change.

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?

21.08(a): This rule states, "For an individual who is capable of indicating intent and who is emancipated from his or her parents or who is married, the state of residence is determined..." It is not clear whether a married person must also be capable of indicating intent. If a married person must also be capable of indicating intent, then it should state, "capable of indicating intent and who is either emancipated..." If a married person does not have to show capacity, then the phrase should state, "or an individual who is married..."

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

21.13(c): In reference to residency, this rule states that 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?

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.

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.

## **22.00 Pursuit of potential unearned income for Medicaid eligibility**

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."

### **23.00 Minimum essential coverage**

This 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).”

In certain sections mention of “eligibility” for MEC is confusing. AHS should clarify the meaning and impact of this phrase wherever possible. “Treated as not eligible for Medicaid” does not necessarily mean that a person is not eligible for Medicaid; in some contexts it means that the person is not disqualified from receiving a QHP with APTC or CSR.

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. Explaining the interaction up front will make the rule less confusing. This could be done in the introduction under 23.00, or in 23.01(a). Currently, affordability and minimum value are not mentioned until the employer-sponsored MEC section in 23.01(c). However, grandfathered plans are listed in 23.01(a) as MEC. 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. The rule should give a general explanation in 23.01(a) or 23.33, and then state that the tests for affordability and minimum value for employer-sponsored plans are set out in 23.01(c).

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.

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.”

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.

23.02(a)(2): The definition of affordability for a related individual should be added. A final federal regulation on this topic has been issued: Health Insurance Premium Tax Credit, 78 Fed. Reg. 7264 (Feb. 1, 2013) (to be codified at 26 C.F.R. § 1.36B–2).

23.02(d)(2): This example should be added consistent with the federal regulation on related individuals.

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.”

23.02(d)(4): see comment to 23.02(d)(3).

23.02(d)(8): see comment to 23.02(d)(3).

#### **Part Four: Special Rules for MABD for Long-Term Care**

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

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.

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.”

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.

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 a 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.

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.

## **25.00 Income or resource transfers and MABD for long-term care eligibility**

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...”

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.”

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.

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).

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.

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.

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).

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).

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.

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.

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).

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.

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.

## **Part Five: Financial Methodologies**

**28.02(f): Definitions;Tax dependent.** This definition is ambiguous; it does not make sense.

The current proposed definition is, "*Tax dependent* has the same meaning as the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year."

The problem is that the category of people for whom an exemption may be claimed under IRC §151 is broader than the category of people who can be claimed as dependents under IRC §152. Exemptions for the taxpayer and spouse are claimed under §151(b). Dependents are defined in IRC §152 and their exemptions are claimed under §151(c). Section 152 dependents never include the taxpayer's spouse. It's just the way the Internal Revenue Code was written. People who can be claimed as dependents under §152 are a subset of the people whose exemptions can be claimed under §151.

We understand that this definition was taken from an HHS Medicaid rule. Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17143, 17204 (March 23, 2012) (to be codified at 42 CFR §435.4). However, the definition is truly nonsensical.

There is another HHS rule defining "tax dependent" for the Exchange. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18309, (March 27, 2012) (to be codified at 45 CFR §155.300).The HHS Exchange rule defines the term in a more sensible way, and that definition should be adopted in these rules. It reads, "*Tax dependent* has the same meaning as the term

dependent under section 152 of the Code.” The effect of this is that a taxpayer’s spouse is not included in the definition. All other people who can be claimed on the taxpayer’s return are included.

The problem with the proposed language is that although the definition of “tax dependent” in the HHS Medicaid rule is ambiguous, it is clearly intended that “tax dependent” include a spouse. This conflicts with HHS’s Exchange rule, and with the general tax principle that one spouse is never the other spouse’s “dependent”. IRS Publication 501 explains, “Your spouse is never considered your dependent.” [www.irs.gov/publications/p501/](http://www.irs.gov/publications/p501/) (Click on “exemptions” and scroll down.)

The definition in the HHS Exchange rule should be adopted instead of the definition in the HHS Medicaid rule, because the definition makes more sense and is consistent with general tax principles, on which MAGI methodologies are based. The rule should also note, perhaps in a footnote to 28.02(f), that “a taxpayer’s spouse is not included in the definition of *tax dependent*. All other people who can be claimed on the taxpayer’s return are included.”

Vermont should not adopt two different definitions of “tax dependent” for 28.03 and 28.05. Given the complexity of the ACA, the eligibility rules must be as understandable and accessible as possible. Having different definitions of “tax dependent” for different sections of the rules will confuse everyone. As it is, there is a completely different definition of “dependent” in the Special Enrollment Period rules, because they are derived from HIPAA regulations. See proposed 71.03(a)(2) and comment to 40.00. This is confusing enough without also having different definitions of “tax dependent” for Medicaid and the Exchange programs.

Thus, 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.” The sections that need minor changes to preserve HHS’s intent under our proposed definition of “tax dependent” are 28.03(d)(1) and 28.03(d)(4). We have suggested modified language for these sections below.

**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). We are glad to see the citation in the footnotes and do not propose removing them. However, the rule’s language should be tightened slightly. Most people reading this rule will not understand what the footnotes mean. “Federal income tax return” is more accurate than “tax return.”

Federal regulations explain that household income does not include the MAGI of a family member who is required to file a tax return under another section of the IRC. For example, an individual could have a filing requirement to report self-employment income that is under the

general income tax filing threshold. Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377, 30378, 30386 (May 23, 2012) (to be codified at 26 CFR § 1.36B–1). An individual in this situation thus has to file a tax return (reporting self-employment income), but does not have to file a federal income tax return under IRC 6012(a)(1) (because they are under the filing threshold). That individual’s MAGI does not have to be included in the household’s income for Medicaid or APTC purposes.

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

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.”

28.03(d)(2) and (3): The proposed language is extremely confusing and hard to follow. The rule can be simplified and made more understandable while retaining the same meaning. We propose the following text to replace existing (d)(2) and (d)(3).

(d) Household...	
(2) Basic rule for individuals claimed as a tax dependent	In the case of an individual who expects to be claimed as a tax dependent by another tax filer for the benefit year in which an initial determination or renewal of eligibility is being made, the household is the household of the tax filer claiming such individual as a tax dependent, subject to the exceptions in (d)(3).
(3) Rule for individuals who neither file a tax return nor are claimed as a tax dependent and exceptions to (d)(2).	<p>(i) An individual’s household is determined in accordance with paragraph (d)(3)(ii) when the individual fits one of the following scenarios:</p> <ul style="list-style-type: none"> <li>a. Individuals who do not expect to file a federal tax return and do not expect to be claimed as a tax dependent for the benefit year in which an initial determination or renewal of eligibility is being made;</li> <li>b. Individuals other than a spouse or child who expect to be claimed as a tax dependent by another tax filer;</li> <li>c. Individuals who are under age 19 or, in the case of a full-time student, age 21, who <ul style="list-style-type: none"> <li>i. expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; or</li> <li>ii. expect to be claimed as a tax dependent by a non-custodial</li> </ul> </li> </ul>

	<p>parent. For purposes of this paragraph:</p> <ol style="list-style-type: none"> <li>1. The custodial parent is the parent so named in a court order or binding separation, divorce, or custody agreement establishing physical custody; or</li> <li>2. If there is no such order or agreement, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.</li> </ol> <p>(ii) In the cases listed above in paragraph (d)(3)(i), the household consists of the individual and, if living with the individual:</p> <ol style="list-style-type: none"> <li>a. The individual's spouse;</li> <li>b. The individual's children who are under age 19 or, in the case of a full-time student, age 21; and</li> <li>c. In the case of an individual under age 19 or, in the case of a full-time student, age 21: <ol style="list-style-type: none"> <li>i. the individual's parents; and</li> <li>ii. the individual's siblings under age 19, or, in the case of a full-time student, age 21.</li> </ol> </li> </ol>
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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)."

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.

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.

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."

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..."

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).

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)."

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

29.03(d)(3): This paragraph refers to "qualifying quarters," but this concept is not defined.

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.

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.

29.08(i)(1): The heading should say "household goods", not "household good".

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".

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."

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.

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.

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).

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.

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.”

### **30.00 Spenddowns**

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).

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.

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).”

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.”

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.”

## **Part Six: 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.

### **31.00 Definitions**

Dependent: As explained above in our general comment to Part Six, a definition of *dependent* is needed. The HIPAA definition is the most logical for this section. It should read, “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.” A footnote should be added citing to 26 CFR § 54.9801-2, 29 CFR § 2590.701-2, and 45 CFR § 144.103.

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.”

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,…”

### **32.00 Employer eligibility**

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.

### **33.00 Employee eligibility**

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

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.

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

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..."

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

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.

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

38.00(b)(4)(iii)(A) and (B): 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). Proposed section 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))."

#### **40.00 Special employee enrollment periods**

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.

40.00(a)(1)(i): The end of this phrase needs a closing parenthesis to match the opening parenthesis before “see”.

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.

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.

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.”

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.

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.

#### **42.00 Employee cost-sharing limits**

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.

#### **43.00 Employer contributions to cost-sharing through HSAs or HRAs**

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.”

#### **49.00 Employer appeals**

49.01: 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.

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.

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.

## **Part Seven: Eligibility and Enrollment**

### **52.00 Application**

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.

52.02(e): AHS has a longstanding and chronic problem processing Medicaid applications in a timely manner as required by Federal law and regulation. A major source of this processing problem for AHS is excessive and unnecessary documentation requests. These problems are particularly pronounced for long term care Medicaid. 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. Also contributing substantially to the delay in processing applications is repeated and sequential documentation requests. 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. Additional verification requests should generally not be utilized, and only when the response to the initial request was incomplete.

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.

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?

### **54.00 Attestation and verification of citizenship and immigration status**

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"?

## 56.00 Attestation and verification of income and family size

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

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.

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?

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."

56.04: Delete the word "alternate" in the first paragraph of the right-hand column: "AHS will determine a tax filer's annual household income for APTC and CSR based on the ~~alternate~~ verification procedures described in §§ 56.05 through 56.07 if..."

56.05: the text of this section could be simplified to read, "If ~~an~~ tax filer ~~qualifies for an alternate verification process and~~ the individual's attestation to projected annual household income is no more than ten percent below the tax-based income calculation..." The individuals to which this procedure applies is already set forth in rules above.

56.06(a): delete "~~the tax filer qualifies for an alternate verification process and~~". This language is not necessary. The individuals to which this procedure applies is already set forth in rules above.

56.06(b): This should read, "the ~~alternate~~ verification process for this subsection is as follows"

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).

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. Does an indication that another household member is eligible for Medicaid change the outcome here? If no one in the household appears to be eligible for Medicaid, is the application approved in this situation? In addition, if the application covers more than one individual in a household, and AHS has sufficient information to approve some household members, those household members should be approved. 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. We believe that is the intent, based on the word “alternate.” As explained above, the title of the section should be revised for clarity.

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?

## **57.00 Inconsistencies**

57.00(c)(2)(ii): We agree that administrative simplification and consistency are important goals, and we applaud AHS for adopting the Exchange rule’s 90-day period as the “reasonable period” required in the Medicaid rule.

## **58.00 Determination of eligibility**

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).

58.01(g)(1)(i): This section contains a typo: “ADPC” should probably be “APTC.”

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

## **60.00 Computing the premium-assistance credit amount**

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).

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. The federal regulations from which these rules are derived use *dependent* to mean a person who can be claimed under IRC 152. Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377, 30387 (May 23, 2012) (codified at 26 CFR § 1.36B-1(f)). This is our proposed definition of “tax dependent” for the Vermont health benefits rules. See comment to 28.02(f) above. Using the term *tax dependent*, rather than *dependent*, reminds readers of the specialized meaning of the term in the context of the APTC. It also differentiates this section from the SEP sections of the rules, in which the term *dependent* means “anyone who can enroll in a health insurance plan because of a relationship to a beneficiary” (paraphrased). See proposed 71.03(a)(2). This definition comes from federal HIPAA rules and is completely different from the income tax definition. See also our comment to 40.00 above.

60.02(b): Modify the language to say that *coverage family* means, “Members of the tax filer's household who enroll in a QHP and are not eligible for other MEC.”

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.

60.03(c)(1)(ii): Modify the second sentence to say that “June through December 2014 are not coverage months because M is eligible for other MEC for those months.”

60.03(c)(2)(i): Modify the second and third sentences to read: “N is not eligible for MEC other than through VHC. N enrolls in a QHP for 2014 and AHS approves APTCs. On August 1, 2014, S loses eligibility for government-sponsored MEC.”

60.06(g) and (g)(1) - (15): Replace “dependent” with “tax dependent,” or add a footnote reminding readers of the definition of “dependent” for purposes of APTC. The former option would be simpler and more user-friendly.

60.06(g)(8): Title should be “Example 8. Other MEC for some coverage months.”

60.06(g)(9): Title should be “Example 9. Family member eligible for other MEC...”

60.07(b): The percentages should be adjusted to reflect the additional Vermont premium subsidies approved by the legislature in the Fiscal Year 2014 Appropriations Act.

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.

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.

60.08(b): Replace “dependent” with “tax dependent,” or add a footnote reminding readers of the definition of “dependent” for purposes of APTC. The former option would be simpler and more user-friendly.

60.11(c): Replace “dependent” with “tax dependent,” or add a footnote reminding readers of the definition of “dependent” for purposes of APTC. The former option would be simpler and more user-friendly.

60.12(a): If the term *family* is defined in 60.02, this section can be shortened. It should read, “If one or more members of a family individuals for whom a tax filer is allowed a deduction under § 151 of the Code are not lawfully present...”

### **63.00 Individual choice**

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.”

### **64.00 Premiums**

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.

64.03: This section has no content. It should be deleted.

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.

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.

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.

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.

64.06(b): This section should read, “the issuer shall will...” to make clear that the provisions are mandatory.

64.07: The disenrollment protection program should be expanded to APTC beneficiaries.

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.

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.

64.10: The household should be notified if they have a payment balance that will carry over to the next month.

## **66.00 Presumptive Medicaid eligibility determined by hospitals**

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?

66.03(c): Subsections (v) and (vi) should not be subsets of (3). They could become new sections (6) and (7).

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.

## **68.00 Notice of decision and appeal rights**

68.03(b)(2): change this sentence to active voice to indicate who receives the statement in this context.

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."

## **71.00 Enrollment of qualified individuals in QHPs**

71.03(d): Special Enrollment Periods. 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.

71.03(d)(4): Errors made by navigators should be included here, and result in a SEP for the beneficiary.

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.

The situations above should also qualify a beneficiary for a hardship exemption from the requirement to maintain MEC. The hardship exemption section of the Vermont rules have yet to be written.

## **75.00 Eligibility renewal**

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.

75.02(f)(iii): “If applicable, notify the individual’s employer.” Specify when this is applicable.

75.03(b): The title of this section is narrower than its contents.

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.

## **77.00 Administration of APTC and CSR**

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...”

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...”

## **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.

We have some suggestions for improvements if AHS retains this section.

Because this section is derived from IRS regulations, the definition of *dependent* is the same as in the APTC rule. AHS should use the term *tax dependent* instead of *dependent* throughout this section. If users of these rules become familiar with the term *tax dependent*, they will not need to guess which definition of *dependent* applies in each section. Alternately, a footnote could be added noting the definition. See also our comment to 60.00 above.

79.01(a): Section (a) only states, “Coordination of premium tax credit with APTC; it has no actual content. This section should be deleted, and the text moved to the title. Thus the title of 79.01 would be, “Reconciliation; coordination of premium tax credit with APTC.” Some sections, such as 79.02(b)(1) refer to 79.01(a), and this reference does not make sense when section (a) provides so little information.

79.01(b): Change language to, “...on the tax filer’s federal income tax return...”

79.01(b)(1): Insert a reference to the definition of *family*, which we have proposed for 60.02(c).

79.01(d)(2): “Limitation amount for tax filers whose tax is determined under IRC Sec. 1(c).” Specify the code corresponding to §1(c). Add a footnote explaining that §1(c) is commonly known as the “single” filing status.

## **Part Eight: Fair hearings**

### **80.00 Fair hearings**

After looking at the federal proposed regulations on appeals, it is clear that more work needs to be done related to this section. We expect AHS to expand and clarify this section in the future. See our comments in the General Comments section on appeals above. As mentioned in those comments, it is difficult to decide how to comment on these proposed fair hearing rules, knowing that they are likely to be significantly revised in a future bulletin. Nevertheless, we offer the following suggestions.

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.

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 delegatee.”

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...”

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.”

80.03(a)(1) 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.

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?

80.04(a): Method for requesting hearing. There's a typo here: "of fair hearing representative" should be "or fair hearing representative."

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)."

## **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.

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."

## **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.

## **Conclusion**

Thank you for your consideration of these comments. Please send us your responsive comments and the Final Proposed Regulations as soon as they are available.

Please contact Trinka Kerr ([tkerr@vtlegalaid.org](mailto:tkerr@vtlegalaid.org), 802-383-2226) and Christine Speidel ([cspeidel@vtlegalaid.org](mailto:cspeidel@vtlegalaid.org), 802-885-5181) with any questions.

Sincerely,

Sam Abel-Palmer, Disability Law Project  
Michael Benvenuto, Senior Citizens Law Project  
Bill Dysart, Senior Citizens Law Project  
Carolyn Jarrett, Senior Citizens Law Project  
Trinka Kerr, Office of Health Care Ombudsman  
Kaili Kuiper, Office of Health Care Ombudsman  
Barbara Prine, Disability Law Project  
Christine Speidel, Poverty Law Project