February 21, 2013

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention: **CMS-2334-P**
P.O. Box 8016
Baltimore, Maryland 21244-8016

Submitted via www.regulations.gov

Re: File Code CMS-2334-P

Dear Secretary Sebelius:

Consumers Union, the policy and advocacy division of Consumer Reports, submits these comments regarding the proposed rule implementing provisions of the Affordable Care Act (ACA), Medicaid, and the Children's Health Insurance Program Reauthorization Act of 2009.

We commend HHS and its agency partners in crafting draft provisions implementing the ACA that strive to maximize enrollment and minimize disruption in coverage. To that end, we see a number of laudable principles incorporated throughout the proposed regulations:

- Efforts to provide a uniform experience for consumers. For example, community-based application assisters have been a successful component of state efforts to connect eligible consumers with coverage in Medicaid and CHIP. We support the proposed rule to create a certified application counselor program (CAC) for Medicaid and CHIP, consistent with similar provisions in the Exchange.

- Protecting consumers by requiring the designation of an authorized representative to be in writing, and comply with federal and state conflict of interest and confidentiality laws.

- Close coordination among agencies to ensure a smoother process for consumers applying for all affordability programs. Coordinated information sharing between agencies reduces duplicative requests for consumer information. Having a common approach to notices, eligibility determinations, and appeals also streamlines the consumer experience.

- Helping families whose circumstances change during the year, such as allowing employees and their dependents to access special enrollment prior to the end of their employer coverage when existing employer sponsored coverage will no longer be affordable or provide minimum value.

In addition to the items that we welcome above, there also are a number of provisions that we would like to comment on in detail below.

Certified Application Counselor Certification Program

In addition to the standards set out in §435.908(c)(i)-(iii) (Medicaid), §457.340 (CHIP), and §155.225 (Exchange), we recommend additional minimum standards for the Certified Application Counselor (CAC) program.

CACs must act in the best interests of clients and should be prohibited from receiving compensation for enrollment from a Qualified Health Plan (QHP), insurance issuer or specific managed care organization (MCOs) that provides coverage under any insurance affordability program or in the Exchange. We urge HHS to strengthen the regulations to explicitly exclude insurance issuers, their subsidiaries and licensed insurance brokers and agents from being certified as CAC (for both Exchange and affordability programs) given their inherent financial conflict of interest associated with enrollment. While our preference is to exclude these entities from being CACs altogether, they can still provide assistance without being compensated. If the final rule does not exclude them entirely from being compensated under the CAC program, HHS should require Exchanges, Medicaid, and CHIP Agencies to rigorously oversee and monitor these types of CACs to ensure they act in the best interests of consumers.

The proposed rule only requires CAC individuals or entities to disclose existing relationships with QHPs or insurance affordability programs to the Exchange. The same disclosure should be required for other insurance affordability programs, including the Medicaid and CHIP programs. If the final rule allows CACs with conflicts of interest to receive compensation for enrollment in a QHP or MCO, the disclosure to the consumer must describe the relationship and potential conflict of interest explicitly, even if the CAC assists with enrollment in less than the full scope of QHPs and MCOs.

Recommendation:

Amend § 435.908(c) to add new conflict of interest subsection (5) as follows:

(5) **Issuers, their subsidiaries and licensed insurance agents and brokers, shall not be permitted to serve as application assisters.**

Amend §155.225 to add conflict of interest subsection (f) as follows:

(f) Issuers, their subsidiaries and licensed insurance agents and brokers shall not be permitted to serve as certified application counselors.

Reciprocity between Medicaid CACs and Exchanges

We support the requirement at §155.225(a) that the Exchange must have a CAC program and that the Exchange must accept CACs trained and authorized by Medicaid. However, the regulations should clarify that the Exchange must only certify those Medicaid CACs that are authorized to provide the full scope of activities required for the Exchange Navigator program or require the Medicaid CAC to receive additional training to be certified in the Exchange.

As written, the proposed rule at §155.225(b) requires the Exchange to certify any individual or organization that registers, gets trained, discloses to consumers and the Exchange any relationships, and signs an agreement requiring compliance with privacy and security standards, as well as applicable authentication and data security standards. We do not believe that "taking all comers" is in the best interest of consumers as required under

§155.225(b). Rather than rely on after-the-fact monitoring and decertification, the Exchange should be granted greater discretion in selection of CACs.

Notwithstanding the recommendation above, we agree that CACs must disclose (§155.225(b)(3)) to the Exchange and applicants any relationships the application counselor or sponsoring agency has with QHPs or insurance affordability programs, as well as any potential conflicts of interest. We recommend that HHS develop standards for the types of relationships and potential conflicts of interest that must be disclosed (e.g., health care providers that participate in a QHP network). Such information should be disclosed as part of the process through which the consumer will designate a CAC. This information will be important not only to consumers, but also to the Exchange in identifying patterns of enrollment that suggest steering to a plan.

Oversight and Enforcement

Exchanges, Medicaid and CHIP agencies should have a mechanism in place to evaluate the performance and effectiveness of the CAC program, as well as individual CACs. In particular, it will be important to examine enrollment patterns that suggest steering to specific plans, which may not be in the best interest of consumers. These agencies must implement an oversight mechanism to ensure that CACs provide quality services, comply with minimum CAC standards and serve the best interest of consumers. Performance metrics should include examining enrollment patterns to detect patterns of steering of consumers to a specific plan. We support that the Exchanges Medicaid, and CHIP agencies withdraw certification from those who fail to meet the minimum standards.

Training

Training is critical to the quality and effectiveness of the CAC program, however, the regulations allowing CACs to provide less than the full range of assistance activities is not consistent with the training requirement at §435.908(c)(1)(ii). We support certifying CACs to provide a full scope of services through QHP enrollment, as well as deploying CACs to assist with one, some or all of the associated activities. To that end, CAC training should be modular and correspond to a CAC's scope of activities. It will be important to provide training modules that include mandatory baseline competencies such as how to use the IT infrastructure for all programs, addressing privacy and security requirements, as well as training that encompasses the specific assistance activities for CACs that do not provide the full scope of services.

The training related to enrollment in a QHP should specifically include information about advance premium tax credits (APTC), cost-sharing subsidies, and the tax reconciliation process. Furthermore, CACs should go through both an initial and ongoing training to ensure that they remain current on policies and procedures.

We support strengthening §155.205(d) of the consumer assistance requirements of the Exchange to ensure that any individual providing consumer assistance must be trained regarding QHP options, insurance affordability programs, eligibility and benefit rules and regulations regarding all such programs. We suggest strengthening the rule by adding, "including advanced premium tax credits (APTCs), cost-sharing subsidies and the tax reconciliation process."

We strongly urge HHS to provide Exchanges, Medicaid and CHIP agencies specific guidance and examples of how they can effectively meet the needs of limited English proficiency (LEP) individuals and individuals with disabilities in the CAC program. The rule should

mandate that the CAC certification process include specific training components that provide information on how to provide culturally and linguistically appropriate services. These components should address how to knowledgeably and sensitively assist LEP individuals and immigrant families, including those of mixed immigration status.

Scope of Activities

We support the types of assistance listed in §435.908(c)(2) that CACs may provide and the ability of the state Medicaid agency to determine whether CACs will assist with one, some or all of the permitted activities. We note that the Preamble indicates CACs would not "receive notices" as authorized representatives may. While CACs should not receive notices on behalf of or in lieu of applicants, we believe it is helpful to allow applicants and enrollees to opt for their designated CAC to receive copies of Exchange, Medicaid, and plan notices or to authorize their designated CAC to access electronic notices in the client account.

Web Portal

We support the requirement in 435.908(c)(3)(i) that states have a designated web portal for use by CACs that has a secure mechanism for granting rights for only those activities the CAC is certified, and authorized by the consumer, to perform. Such a portal will increase the proportion of applications that are submitted electronically, thereby providing more applicants with access to electronic verification and real-time eligibility while increasing the state's administrative efficiency.

We recommend a clarification that states may use the same portal for Navigators and in-person assisters (if the state has an in-person assister program) with proper assignment of rights and functionality.

Public Directory of CAC Information

We agree that applicants and beneficiaries should be informed of the functions and responsibilities of certified application counselors (§435.908(c)(3)(ii)(A); §155.225)(d)(1)), but it will also be important for consumers to know who is certified and whether there are any limitations on the services each CAC is certified to provided. Exchanges, Medicaid and CHIP agencies should be required to maintain a current list of CAC's on their websites, which includes any limitations on services CACs are certified to provide.

We strongly support the confidentiality protections against disclosure of applicant or beneficiary information by the certified application counselor without authorization, §435.908(3)(ii)(B) and (C); §155.225(d)(2).

Prohibition on Charges to Consumers

We strongly support §435.908(c)(4) protecting consumers by prohibiting application assisters from imposing any charges on applicants or beneficiaries. However, we believe that CACs provide a valuable service to Medicaid and CHIP agencies and states should not be restricted from providing these organizations with resources to extend consumer assistance. It would be extremely helpful for HHS to provide states with sub-regulatory guidance on the availability of federal funding to help support grants or payments to CACs. In particular, information about how Medicaid administrative claiming can be used to match community-based investments in application assistance.

For Exchange provisions, we strongly support protecting consumers by disallowing application assisters from imposing any charges on applications or beneficiaries (§155.225(e)). However, we are concerned about the language in the Preamble, which states that CACs are not funded through the Exchange, through grants or directly. We believe that CACs provide a valuable service to Exchanges and states should not be restricted from providing these organizations with resources to extend consumer assistance. It would be helpful for HHS to clarify that Exchanges are not prohibited from providing financial resources to CACs.

Duty to Act in the Best Interest of the Consumer

We also appreciate that HHS notes that CACs must act "in the best interest of the applicants assisted." However, we believe that the standard for application counselors should be the same as for Navigators, who are required to be fair and impartial. Given that applicants likely will not understand the differences between CACs, assisters and Navigators, we believe it is important to hold all of them to the same high standard.

Recommendation:

Amend § 435.908(c) to add new (v) as follows:

(v) Held accountable to act **in a fair, accurate and impartial manner** in the best interest of the applicants assisted;

Amend § 155.225(b)(5) as follows:

(5) Agrees to act **in a fair, accurate and impartial manner** in the best interest of the applicants assisted;

State Specific Standards

The proposed regulation also requests comments on whether the Exchange should have the authority to create additional standards for certification or otherwise limit eligibility of certified application counselors beyond what is proposed. We believe the Exchange should have the flexibility to set higher consumer protection standards than is proposed in the rule. For example, an Exchange should be able to go beyond requiring that CACs act in the best interest of consumers and prohibit conflicts of interest. However, such standards should be consistent with other types of assistance (i.e. Navigators) in their state.

States should be prohibited from requiring that CACs be licensed insurance brokers and agents or that they be required to carry errors and omissions insurance.

§ 155.227 Authorized Representatives

While we support the authorized representative provision (§155.227), we make the following suggestions for improvements. First, we recommend that the Exchange be required to make the powers and duties of the authorized representative clear to both the consumer and the authorized representative, as well as all other requirements of §155.227 in a manner that is easily understandable by both parties, including information on timing, scope and duration of representation.

We also recommend that the regulations clarify that the authorized representative may, but need not, be authorized to have full capacity to act on behalf of the consumer in dealings with Exchanges. There are many instances in which the consumer may wish the authorized representative to have authority over some, but not all, aspects of interaction with Exchanges. Finally, we recommend that the requirement in proposed §155.227(d)(2) that it is the applicant or enrollee's duty to notify both the Exchange and the representative that the representative is no longer authorized to act on his or her behalf be removed. There are many reasons why the second part of this requirement may be impractical or impossible, including instances where contacting the authorized representative may put the applicant or enrollee at risk of physical or other violence or where the authorized representative is unreachable. In these cases, the duty to notify the former authorized representative should fall on Exchanges, not the applicant or enrollee.

We further recommend that HHS modify proposed §155.227(a)(2) to specify that, where an authorized representative is appointed by legal documentation to act on behalf of an individual under state law, the authorized representative shall have an affirmative duty to notify the Exchange and the individual on whose behalf he or she is acting of any revocation or material change in that separate legal authority and that such a material change or revocation shall result in revocation of the authorized representative's authority to act on behalf of the consumer.

Finally, we suggest that HHS clarify the circumstances in which legal documentation may serve in the place of an affirmative representation, supported by the signature of the enrollee or applicant, to appoint an authorized representative. There are many types of powers of attorney and not all provide the holder with the authority envisioned by proposed §155.227.

§155.420 and §155.330 Special Enrollment

We applaud HHS for making coverage effective immediately in the case of birth, adoption, or placement for adoption. We support the suggestion in the Preamble, at 78 Fed. Reg. 4646, to include foster children within the special enrollment period populations.

> **Recommendation:**
>
> Change Section §155.420 (d)(2) to read:
>
> The qualified individual gains a dependent or becomes a dependent through marriage, birth adoption ~~or~~ placement for adoption **or any other type of dependent defined under state law including domestic partnerships, civil union, and foster children placement.**

In subparagraph (d)(1) we support the additional specificity on triggering events regarding minimum essential coverage. We appreciate that the triggering events include the granting of an eligible immigration status or becoming a naturalized U.S. citizen. This rule helps to ensure the immediate enrollment of a previously-ineligible and uninsured immigrants in health coverage as soon as lawful presence is acquired.

We commend the new provisions for allowing people who know they will lose employer sponsored coverage within the next 60 days to access a special enrollment period prior to the end of his/her coverage. The effective date of the coverage may still leave a gap in coverage. We urge HHS to close to the potential gap in coverage by making the new coverage effective on the first day after the termination of the prior coverage.

Recommendation:

Change §155.420(b)(ii) to read:

~~In the case of marriage or~~ In the case where a qualified individual loses **affordable or** minimum essential coverage as descried in paragraph (d)(1) of this section, the Exchange must ensure that the coverage is effective for a qualified individual or enrollee on the first day ~~of the following month~~ **following the last of day of effectiveness of prior minimum essential coverage, if the special enrollee chooses this option. For those newly enrolling or changing QHPs in circumstance other than loss of coverage or those not choosing an effective date that is the day after the termination of prior coverage, the effective date shall be on the first day of the month or the fifteenth day of the month, whichever is closest to the plan selection date.**

Add §155.420(b) (iv) to read:

In the case of marriage, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the first day of the following month.

Under §155.420(d)(6), special enrollment is triggered when "the enrollee is determined newly eligible or newly ineligible for advance payments of the premium tax credit….." Changing this category from "individual" to "enrollee" is significant and means that only current enrollees of a QHP will qualify for this special enrollment trigger. An individual who was not eligible for premium tax credits may have opted to sign up for a plan outside of the exchange and should not be shut out of the Exchange when he or she becomes eligible for premium tax credits because of a change in circumstance. If an individual signs up for health insurance in the private market, and then loses his or her job, or has a salary reduction, this individual would not be able to access his or her APTC until the next open enrollment. This is an undue hardship on individuals and would likely result in an increase in the uninsured.

Recommendation:

Allow any individual who is newly eligible for advance payment of the premium tax credits or for cost sharing reductions to trigger a special enrollment period for the individual and his or her dependents.

The exception for inadvertent or erroneous actions should not be limited to those situations where the error can be traced to an Exchange or HHS employee. For example, a QHP may commit such an erroneous action by enrolling an individual into a different plan than the one the individual enrolled through the Exchange. If an enrollment or non-enrollment is the result of any erroneous or inadvertent action, an exception should be made and a special enrollment period triggered.

Recommendation:

Change §155.420(d)(4), to read:

The qualified individual's or his or her dependents' enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous ~~and~~ **or** is the result of the error,

misrepresentation, or inaction of an officer, employee, or agent of the Exchange, **QHP** or HHS, or its instrumentalities as evaluated, and determined by the Exchange.

Finally, we recommend expanding the categories to include the following circumstances as triggers for special enrollment:

1. Consumers facing rate increases: Special enrollment should be available for those people with minimum essential coverage outside of employer sponsored insurance (ESI) who have not yet lost coverage but are facing rate increases (for example, those still enrolled in grandfathered plans) that will render the coverage unaffordable. The proposed rules require an Exchange to permit an individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access a QHP through special enrollment prior to the end of his or her coverage through an employer-sponsored plan. However, the proposed rule does not have a corollary for people enrolled in individual plans. We believe HHS should allow special enrollment for those people enrolled in non-QHPs who demonstrate (using, for example, a notice of rate increase from an issuer) that the new premium will result in coverage that is no longer affordable based on the family's income.

2. End of incarceration: At the end of a period of incarceration, a person will be eligible to participate in the Exchange and may be eligible to receive premium credits. HHS should seek to avoid any gaps in coverage for this population, especially since continuity of medications may be critically important.

   Recommendation:

   Add special enrollment periods for people with individual coverage who would have unaffordable premiums due to a rate increase, and for individuals released from jail.

§155.345(a)(7) Combined Eligibility Notice

Coordination between/among affordability programs, starting at the initial determination, is at the heart of a smooth consumer experience, though it may involve significant programmatic challenges from the Exchanges' and State Agencies' perspectives. Requiring a single determination notice, however, may force the relevant state and local agencies and the Exchange to iron out their protocols and processes from the outset for a smoother consumer experience. Making the effective date January 1, 2015 for this requirement would be out of sync with the initial open enrollment period under the ACA. We suggest that you set the date as January 1, 2014, allowing those states that cannot upgrade their technology in time for January 2014 to seek approval from HHS for delaying implementation, rather than a nationwide delay in implementation. Failure to coordinate notices is likely to result in consumer confusion and should be avoided as much as possible.

HHS solicits comments on the level of detail which should be required for inclusion in the notice. According to the rule, the notice must provide "clear and accurate information about eligibility for all insurance affordability programs, including Medicaid, CHIP, advance payments of the premium tax credit and cost-sharing reductions, as well as eligibility to enroll in a qualified health plan through the Exchange."

Recommendation:

We recommend the notice include clear information about how to get help if you do not understand the notice, including help in other languages; and a clear statement of any actions the consumer must now take. The notice should make clear that enrollees are not required to take their tax credit in advance. All or a portion of it may be delayed until taxes are filed. We strongly urge that iterative consumer testing be conducted on these notices to ensure they are achieving their intended goals.

Appeals

§ 431.221 Request for a hearing

We fully support and commend HHS' decision to treat an appeal to the Exchange appeals entity of a decision on eligibility for advanced payment of the premium tax credits or cost sharing reduction as also including an appeal of any denial of eligibility for Medicaid. As noted in the Preamble, this eliminates the need for two hearing requests and eliminates the very strong possibility of confusion and an applicant or beneficiary missing the deadline to appeal a Medicaid denial. It is one of the most important protections in these new rules.

We are concerned that different timelines for requesting a hearing related to tax credits/cost sharing amounts and Medicaid eligibility may cause difficulties for individuals who also need a Medicaid hearing. Existing regulations provide for "a reasonable time not to exceed 90 days" for an applicant or beneficiary to request a Medicaid hearing. 42 C.F.R. § 431.221(d). Accordingly, a number of states allow less than 90 days. In contrast, the proposed regulations allow 90 days to request a hearing of an Exchange eligibility determination. 78 Fed. Reg. 4720 (proposed 45 C.F.R. § 155.520(b)). This creates the possibility that an individual could miss a Medicaid appeal deadline.

Recommendation:

Add the following language at the end of § 431.221(a)(5):

Such a request for a Medicaid hearing shall be deemed timely, regardless of the State's deadline for requesting a Medicaid hearing.

We also support HHS' decision to allow an individual to request a hearing in a variety of ways. We believe, however, that certain safeguards are necessary. While it is simpler for a hearing request to be made by telephone, the possibility that such a request will be misunderstood or lost is much greater than a written request. Accordingly, we recommend that HHS require state agencies and contracting entities to confirm such requests in writing as part of their procedures.

We also suggest a language clarification. The regulation refers only to appeals "to the Exchange appeals entity" and does not refer to appeal of the denial of eligibility for enrollment in a qualified health plan (QHP). These omissions do not appear to be intentional, because the Preamble indicates that this rule applies more broadly. *See* 78 Fed. Reg. at 4598.

Recommendation:

Amend § 431.221(e) as follows**:**

". . .the agency must treat an appeal to the ***Exchange or*** Exchange appeals entity of a determination of the eligibility for ***enrollment in a QHP*****,** advanced payment of premium tax credit**,** or cost sharing reduction, as a request for hearing under this section."

We also recommend that this regulation contain language specifying that an individual may choose to have a Medicaid hearing before a hearing on Exchange-related issues.

Recommendation:

After § 431.221(e), add new subsection:

(f) The agency must establish procedures that will enable individuals who have the right to an Exchange appeal and a Medicaid fair hearing to elect to have the Medicaid hearing first.

§ 431.223 Denial or Dismissal of a Request for Hearing

HHS has proposed no changes to this section. We believe, however, that additions are necessary to protect individuals from unintentionally or mistakenly dismissing a Medicaid appeal.

This subsection provides that a request for a hearing may be withdrawn upon the individual's written request. No other details are provided. In contrast, §155.530 requires an Exchange appeals entity to provide notice of dismissal, including information about how the dismissal may be vacated. We commend this provision because it provides crucial protections against inadvertent or erroneous dismissal of an appeal. Such protections are, however, equally important for individuals with hearing requests pending at the Medicaid agency. In a state that has not delegated authority to the Exchange appeals entity to hear Medicaid appeals, an individual's request for an Exchange appeal will automatically trigger a Medicaid appeal. Such an individual needs protection from unintentional or erroneous dismissal just as much as one with a Medicaid appeal pending before the Exchange appeals entity. Confusion is even more likely because appeal requests will be pending at two different agencies. The Exchange and the Medicaid agency should conduct consumer testing and monitoring to ensure that when consumers fail to act on informal resolution process that they are doing so based on an informed understanding of the consequences.

We recommend that the protections of § 155.230(b) be applied to hearing requests pending before the Medicaid agency. We further recommend that the rule provide for dismissals to be vacated with good cause.

Recommendation:

We propose adding the following subsections to §431.223:

(c) If an appeal is dismissed under paragraph (a) of this section, the agency must provide timely notice to the applicant or beneficiary, including –

(1) the reason for the dismissal;

(2) an explanation of the dismissal's effect on eligibility; and

(3) an explanation of how good cause can be shown why the dismissal should be vacated in accordance with paragraph (d) of this section.

(d) The agency may vacate a dismissal if an individual makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

§155.555 Employer appeals process

We respond to the question posed in the Preamble, at 78 Fed. Reg. 4655 about how to protect employee rights in an employer appeal. We strongly urge HHS to adopt option one which preserves the employee's rights to appeal a change in eligibility reflected in the redetermination notice generated after an employer appeal. Employees might be intimidated to participate in the employer's appeal and others will not understand the finality of the employer's appeal if option two is adopted. An employee needs to have their own appeal rights regarding their own eligibility. Option one preserves consumers' due process rights while option two bounds the employee to the result of the employer appeal – an appeal which proceeds without an opportunity for a face-to-face hearing and without an opportunity for the employee to appeal a pro-employer decision. As a matter of due process and of the procedures set out in the ACA, HHS should choose the alternative of giving an employee whose benefits are in jeopardy the chance to have a face-to-face hearing before those benefits are terminated.

§457.570 Disenrollment

We support the proposed rules requiring reasonable notice of non-payment, limiting the lockout period to 90 days, and disallowing states from requiring payment of outstanding premiums at the end of the lockout period before re-enrollment. In particular, we strongly support that the agency **must** review the family's circumstances (§435.570(b)) to determine if their income has declined, making the child eligible for Medicaid or a lower cost-sharing category.

We believe the proposed rule should be strengthened to capture the intent noted in the Preamble that "prohibiting a child from enrollment after the family pays the unpaid premium or enrollment fee is counter to promoting enrollment in and continual coverage."

Recommendation:

We recommend that the final rule specifically state that if a family pays its outstanding premium before the end of the lockout period, the child will be reinstated back to the effective end date with no gap in coverage. Additionally, in states that have approved state plans providing continuous eligibility, there should be no disruption to the continuous eligibility period.

Recommendation:

Providing multiple ways to pay premiums and sending multiple, non-threatening payment due reminders are helpful in encouraging payment. We suggest that CMS consider future sub-regulatory guidance to States to promote best practices in premium payments.

§457.805 State Plan Requirement: Procedures to Address Substitution Under Group Health Plans.

We strongly disagree with the continuation of any waiting period in CHIP for children who have been recently enrolled in a group health insurance plan. In practice, the proposed policy to allow families to wait up to 90 days to enroll their children in CHIP may result in many children unnecessarily remaining uninsured. While the proposed rule suggests that these uninsured children could temporarily enroll in APTC-funded coverage while awaiting CHIP, we see no evidence that either the Federal government or States have the capacity to smoothly implement such a plan. To the contrary, the policy represents an administrative mess of red tape for families that could result in many children falling through the cracks and remaining uninsured. Moreover, even if some children are able to temporarily secure coverage via the Exchange while awaiting CHIP, it is deeply problematic to design a system of coverage for CHIP-eligible children that actually promotes disruptions in the continuity of their care. The proposed policy is entirely inconsistent with the vision of universal coverage under the ACA and makes little or no policy sense, but rather promotes churn, interrupts continuous coverage, makes it difficult for the FFE to implement because of differing state CHIP waiting period rules, compromises quality of care, and falls severely short of the ACA's goal of comprehensive coverage for millions of children.

If these regulations must stand, we believe the proposed limitation on the length of waiting period and the mandated exceptions improve current policy. Furthermore, we believe it is imperative that CHIP agencies track when these children would be eligible and initiate action to enroll in CHIP. We do not believe the regulations as proposed make clear the expectation for coordination.

Recommendation:

The final rule should include a requirement that states coordinate eligibility after the child has met the waiting period requirements as noted in this statement in the Preamble: "For individuals subject to a waiting period, under proposed revisions at §457.350(i)(3), states also would need to notify such program of the date on which such period ends and the individual is eligible to enroll in CHIP."

In addition, we are concerned that current federal regulations allow states to adopt other anti-substitution provisions that are inconsistent with the new post-ACA universe, such as requirements that children not have access to employer-based coverage on a prospective basis. If such coverage is unaffordable, it would result in children not having any routes to coverage.

Recommendation:

HHS should review states' other anti-substitution policies to determine whether there are issues – beyond waiting periods – that would inappropriately keep children out of health insurance, including any policies that deny coverage based on access to employer-based coverage that may be unaffordable.

On behalf of Consumers Union, we welcome the opportunity to comment on these important regulations. We are encouraged that provisions of the Proposed Rule will enhance and streamline Exchange operations, and provide coordination with Medicaid and CHIP. Thank you for considering our recommendations designed to achieve those goals.

Sincerely,

Laurie Sobel
Senior Attorney