

# The Hilltop Institute



*analysis to advance the health of vulnerable populations*

**Overview of the July 5, 2013 Final Rule on  
Medicaid and the Children's Health Insurance Program:  
Essential Health Benefits in Alternative Benefit Plans,  
Eligibility Notices, Fair Hearings and Appeal Processes, and  
Premiums and Cost Sharing; Exchange  
Eligibility and Enrollment**

July 16, 2013

# Overview of the July 5, 2013 Final Rule on Medicaid, CHIP, and Exchanges

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## Overview of the July 5, 2013 Final Rule on Medicaid, CHIP, and Exchanges

### Introduction

On July 5, 2013, the U.S. Department of Health and Human Services (HHS) issued a final rule on *Medicaid and Children's Health Insurance Programs (CHIPs): Essential Health Benefits (EHBs) in Alternative Benefit Plans, Eligibility Notices, Fair Hearings and Appeals Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment* <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>. This rule finalizes many of the provisions of the Notice of Proposed Rulemaking (NPRM), released on January 22, 2013:

- Establishes new Medicaid eligibility provisions
- Makes changes related to electronic Medicaid and CHIP eligibility notices and delegation of appeals
- Modernizes and streamlines existing Medicaid eligibility rules
- Revises CHIP rules relating to substitution of coverage
- Amends requirements for benchmark and benchmark-equivalent benefit packages consistent with §1937 of the Social Security Act (alternative benefit plans)
- Specifies the standards related to authorized representatives
- Implements specific provisions related to notices and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan (ESP) for Exchanges
- Simplifies the Medicaid premium and cost-sharing requirements
- Provides certain transition policies for 2014<sup>1</sup>

HHS is deferring several areas of the NPRM to future rulemaking. This document provides a high-level summary of these rules and highlights key changes to the regulation since the issue of the proposed rule.

### Part A: Medicaid Eligibility Part II Final Rule

#### *Appeals Delegation*

The rule finalizes the provisions of the NPRM permitting a state Medicaid agency to delegate its authority to conduct Medicaid fair hearings to an Exchange and an Exchange appeals entity (45 CFR §431.10, 431.205(b)(431.206(d) and (e) and 431.240). The final rule also adopts proposed

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<sup>1</sup> The final rule does not address proposed provisions regarding Exchange eligibility appeals, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), certified application counselors in an Exchange, or small business health options program (SHOP) coordination with individual market Exchanges.



revisions related to modernizing the process for providing notices to applicants and beneficiaries of their fair hearing rights and decisions (§431.211, 431.213, 431.230, and 431.231).<sup>2</sup>

The final rule clarifies that Medicaid must maintain its own appeals infrastructure, even if it delegates appeals to the Exchange.<sup>3</sup> In a state-based Exchange, the state Medicaid agency may delegate authority to conduct fair hearings of modified adjusted gross income (MAGI)-based determinations to the state-based Exchange by requesting a waiver under the Intergovernmental Cooperation Act of 1968 (ICA), as long as the Exchange is a state agency and the state can ensure sufficient oversight of the delegated fair hearing process. This is significant because the rule indicates that “MAGI-based determinations” include not only the income eligibility determination, but also the non-financial conditions of eligibility, including state residency and citizenship or satisfactory immigration status. The ICA is viewed as an additional way to coordinate appeals beyond delegation under the final rules. Under such a waiver, individuals would not have the right for their Medicaid appeal to be heard by the single state agency. Further, unlike delegation under the final rule, an ICA waiver would prohibit Medicaid decisions made by that entity from being appealed to the HHS appeals entity. Making the ICA waiver distinction even more important, as opposed to its initial position in the NPRM, the Centers for Medicare & Medicaid Services (CMS) determined “not to extend authority to delegate Medicaid fair hearings to state agencies other than a state-based Exchange or an Exchange appeals entity under the [final] regulations because it is already allowed through an ICA waiver.”

Regarding the content of an appeals notice in a delegated state, the final rule notes that an individual must be given the opportunity to opt to have his or her Medicaid appeal adjudicated at a hearing conducted at the Medicaid agency, instead of having his or her appeal for both enrollment in a qualified health plan (QHP) and eligibility for advanced premium tax credit (APTC) and cost-sharing reduction (CSR) and eligibility for Medicaid addressed at an integrated hearing at the Exchange or Exchange appeals entity. No specific timeframe for exercising this right is prescribed; the final rule indicates that such notice “would be made at the time that the individual is requesting a hearing.”

The final regulation also limits a state agency’s review authority over an Exchange or an Exchange appeals entity’s decision to a review of the Exchange or Exchange appeals entity’s application of federal and state Medicaid laws and regulations. As to the election of a delegation, the final rule indicates that there is no deadline. Rather, once a state decides to delegate authority to conduct eligibility or appeals, it must indicate such an election through its state plan, establish

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<sup>2</sup> The final rule does not address proposed provisions of §431.200, 431.201, 431.205(e), 431.206(b), (c)(2), or (e) as it relates to accessibility under §435.905(b), 431.210, 431.220, 431.221, 431.224, 431.232, 431.241, 431.242, or 431.244. However, notices must continue to be provided in an accessible manner in accordance with relevant federal statutes, including the Americans with Disabilities Act and Title VI of the Civil Rights Act of 1964, as well as any applicable state laws. Further, the final rule does not address the definitions related to appeals proposed in §435.4, nor the provisions related to coordination of appeals in §435.1200.

<sup>3</sup> Of interest, in federally-facilitated Exchanges, the Medicaid agency must conduct all Medicaid fair hearings related to MAGI-based eligibility determinations made by the Medicaid agency.



a written agreement with the Exchange or Exchange appeals entity, and comply with the other requirements of the regulation. Finally, HHS clarifies that appeals systems do not qualify for enhanced funding under the rules. Instead, the match is 50 percent, as opposed to the 75 percent match for operations and maintenance of systems.

## **Notices**

### **Electronic Notices (§435.918)**

The final rule directs states to provide individuals with the option to receive notices through a secure, electronic format in lieu of written notices by regular mail. However, the requirement is delayed until January 1, 2015.<sup>4</sup> Further, the final rule retains the requirement that the agency send, via regular mail, written confirmation that an individual has elected to receive electronic notices and that forthcoming notices will be delivered electronically. The written confirmation should indicate how an individual can change his or her election if it was made inadvertently or the individual wishes to change his or her mind. An electronic notice should be provided only if the individual affirmatively opts for such a notice. To guard against delivery errors, if a required electronic alert is returned as undeliverable, the agency must send the notice by regular mail within three business days of the date of the failed electronic communication.<sup>5</sup> If an electronic alert is not undelivered, the agency can assume the individual is able to access his or her notice.

### **Medicaid Enrollment Changes Needed to Achieve Coordination with the Exchange**

#### **Certified Application Counselors/Application Assistants (§435.908 and 457.340)**

Although CMS urges all states to consider working with interested organizations and providers in creating an application counselor program, the final rule indicates that “states are best able to determine the need for such a program and [CMS] do[es] not believe it is necessary to require that state Medicaid programs create such programs.” To the extent a state agency chooses to have such a program, the agency must ensure that application assistants are authorized and registered by the agency to provide assistance at application and renewal; trained in the eligibility and benefits rules and regulations governing enrollment in a QHP through the Exchange and all insurance affordability programs operated in the state, as implemented in the state; and trained in and adhere to all rules and regulations relating to the safeguarding and confidentiality of information and prohibiting conflict of interest, regulations relating to the prohibition against reassignment of provider claims, and all other state and federal laws concerning conflicts of interest and confidentiality of information (§ 435.908). Further, if the agency elects to certify application assistants, it must establish procedures to ensure that

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<sup>4</sup> States are permitted to begin using electronic notices as early as October 1, 2013.

<sup>5</sup> The agency should keep a non-delivery report, which is a system message that reports the delivery status to a sender. The date of the paper notice must reflect the date it is sent, not the date of the undelivered electronic notice.



applicants and beneficiaries are informed of the functions and responsibilities of certified application assisters; individuals are able to authorize application assisters to receive confidential information about the individual related to the individual's application for or renewal of Medicaid; and the agency does not disclose confidential applicant or beneficiary information to an application assister unless the applicant or beneficiary has authorized the application assister to receive such information. Finally, application assisters may not impose, accept, or receive payment or compensation in any form from applicants or beneficiaries for application assistance.

The final rule recognizes that it does not address the Exchange requirements regarding application counselors found at 45 CFR §155.225. However, it does indicate that state Medicaid and CHIP agencies and the Exchange are “charged under §435.1200 and §457.348 of the Medicaid eligibility final rule and proposed §155.345 of the Exchange rule to enter into agreements with each other to create a seamless and coordinated application and enrollment process across all insurance affordability programs, and the state agencies and the Exchange should consider such coordination in developing their application counselor programs.” Providing further clarification, the final rule notes that, when an application counselor is certified by one agency and not the other, “the counselor would assist the individual in submitting the single streamlined application for all insurance affordability programs to the entity by which they are certified. It is important to note that regardless of the entity to which the application counselor submits the application, the application will be evaluated for eligibility in QHPs and all insurance affordability programs.”

### **Authorized Representatives (§435.923)**

The final rule indicates that applicants and beneficiaries may designate individuals or organizations to act on their behalf and that the scope of the authorization is defined by the applicant or beneficiary.<sup>6</sup> The designation must include the applicant's signature, which can be electronic or handwritten. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or power of attorney, may serve in place of the applicant or beneficiary's designation. As to duration, the final rule indicates that applicants and beneficiaries are able to change authorized representatives at any time, and states may not impose automatic expiration of designations such that an individual would need to redesignate an authorized representative after a given period of time.

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<sup>6</sup> Applicants and beneficiaries may designate certified application counselors to serve as their authorized representatives.



## **Medicaid Eligibility Requirements and Coverage Options Established by Other Federal Statutes**

### **Presumptive Eligibility for Children and Other Individuals (§435.1102-435.1103)**

States may allow qualified entities to conduct presumptive eligibility determinations for children, pregnant women, and individuals in other eligibility categories. The final rule codifies the flexibility provided to states in the NPRM to direct qualified entities to use gross income or apply simplified methods, as prescribed by the state, to better approximate MAGI-based household income (§ 435.1102). With regard to presumptive eligibility for pregnant women, the final rule adopts the NPRM's proposal to provide one presumptive eligibility period per pregnancy (§ 435.1103).

### **Presumptive Eligibility Determined by Hospitals (§435.1110)**

The final rule adopts the NPRM's proposal to give hospitals the option to determine presumptive eligibility for Medicaid. Specifically, qualified hospitals must be permitted to make presumptive eligibility determinations based on income for all of the populations for which presumptive eligibility may be available in accordance with §435.1102 and §435.1103, as well as for populations for which income is not the only factor of eligibility (for example, individuals who may be eligible based on disability, or individuals eligible under a demonstration project approved under an 1115 demonstration). The oversight and enforcement of qualified entities that make presumptive eligibility determinations, including qualified hospitals, will remain a state responsibility. As part of this enforcement authority, states are permitted to establish state-specific standards for hospitals seeking to conduct presumptive eligibility determinations. Further, the final regulation indicates that the agency must take action, including disqualification of a hospital, if it is determined the hospital is not making or capable of making presumptive eligibility determinations or meeting the standards established by the agency.<sup>7</sup>

### **Coordinated Medicaid/CHIP Open Enrollment (§435.1205 and §457.370)**

The final rule indicates that, no matter where an applicant submits the single, streamlined application during the initial open enrollment period beginning in October 2013, he or she will receive an eligibility determination for all insurance affordability programs and be able to enroll in appropriate coverage for 2014, if eligible, without delay. Thus, the final rule requires the agency to accept the single, streamlined application and electronic account transfers from the Exchange of individuals determined or assessed to be Medicaid eligible. Likewise, the agency must be capable of transferring to the Exchange the electronic accounts of individuals who appear to be APTC/CSR eligible.

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<sup>7</sup> A hospital may only be disqualified after the agency has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.



The final rule indicates that all applicants must have the opportunity to have their Medicaid eligibility assessed based on existing Medicaid rules for 2013, as well as for prospective enrollment effective on January 2014. Regarding immediate eligibility, the agency must inform the individual who submitted the single, streamlined application that coverage may be available in 2013, but that a different application is required; use the streamlined application; or use a combination of the first two options by targeting those individuals who are more likely to be found eligible under the 2013 rules, and directing those who are less likely to be eligible under the 2013 rules to a separate application. To avoid having to operate two sets of rules for children, parents and caretaker relatives, pregnant women, and other non-disabled, non-elderly adults who may be eligible for Medicaid enrollment, the final regulation allows states to begin using the new MAGI-based methodology for these populations effective October 1, 2013.<sup>8</sup>

## **CHIP Changes**

### **CHIP Waiting Periods (§457.340, §457.350, §457.805, and §457.810)**

The final rule codifies the limitation of waiting periods to a maximum of 90 days, to be consistent with the waiting periods under §1201 of the Affordable Care Act (ACA).<sup>9</sup> Also, the rule permits exemptions from the waiting period, including cases in which a child has lost eligibility for and enrollment in Medicaid or another insurance affordability program; the premium for family coverage that includes the child exceeds 9.5 percent of household income; the cost of coverage for the child exceeds 5 percent of household income; a child's parent is determined eligible for APTC for enrollment in a QHP through the Exchange because the employer-sponsored insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR § 1.36(B)-2(c)(3)(v); change of employment; the child has special health needs; and the child lost coverage due to the death or divorce of a parent. States' waiting periods must also meet notification requirements. The final rule clarifies that, effective January 1, 2014, states must continue to monitor substitution of CHIP for employer coverage, but specific strategies to prevent such substitution are no longer required.

### **CHIP Premium Lock-Out Periods (§457.570)**

The final rule adopts the NPRM's maximum 90-day lock-out period for nonpayment of CHIP premiums. Further, the final rule indicates that the lock-out period must end once a family has paid the premium or enrollment fee. The final rule also requires reasonable notice of non-payment, limits the use of lock-outs for non-payment of premiums, and prohibits states from

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<sup>8</sup> See State Health Official Letter #13-003: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014 at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-003.pdf>.

<sup>9</sup> States may eliminate their waiting period.



requiring payment of outstanding premiums at the end of the lock-out period before re-enrollment.<sup>10</sup>

### **Premium Assistance (§435.1015)**

Premium assistance may provide an option for states to coordinate coverage for households with mixed eligibility for Medicaid, CHIP, and/or QHPs offered in the Exchange. The final rule codifies the last sentence of §1905(a), which authorizes payment of “other insurance premiums for medical or any other type of remedial care or cost thereof” to support enrollment of individuals eligible for Medicaid or CHIP in plans in the individual market, including enrollment in QHPs doing business in the Exchange. To be eligible, the final rule indicates that the insurer is obligated to pay Medicaid for all health care items and services for which the insurer is legally and contractually responsible under the individual health plan. Further, the agency must furnish all benefits covered under the state plan that are not available through the individual health plan. The individual must not incur any cost sharing in excess of that allowed in Medicaid.<sup>11</sup> Also, the total cost of purchasing coverage, including administrative expenditures, the cost of paying all cost-sharing charges in excess of the amounts imposed by the agency, and the cost of providing the required benefits must be comparable to the cost of providing direct coverage under the state plan.<sup>12</sup> Finally, a state may not require an individual to receive benefits through the premium assistance model and must inform individuals that it is their choice to receive either direct coverage under the Medicaid state plan or coverage through an individual health plan.

HHS noted that some states have expressed interest in submitting 1115 demonstration waivers to require enrollment in premium assistance. HHS will consider approving a limited number of premium assistance demonstrations.

### **Changes to MAGI and MAGI Screen**

Under the final rule, the 5 percent disregard under §1902(e)(14)(I) of the ACA applies to income determinations relative to Medicaid eligibility, but not to determining in which eligibility group an individual should be placed (42 CFR §435.110). The final rule provides additional clarification, noting that the 5 percent disregard should be applied to the highest income standard under which an individual may be determined eligible using MAGI-based methodologies. Thus, in states with a separate CHIP program, the income disregard should be applied to the highest Title XIX eligibility group available to the child, as well as to the separate CHIP program to cover similarly situated children at a higher income standard. Due to the possible complications of implementing this change, the final regulation indicates that CMS will approve eligibility

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<sup>10</sup> A state may not require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment once the State-defined lock-out period has expired, regardless of the length of the lock-out period.

<sup>11</sup> States must inform individuals how to access additional benefits not provided by the insurer, as well as how to receive cost-sharing assistance.

<sup>12</sup> States implementing premium assistance must describe their cost-effectiveness methodology and, to the extent that such a methodology relies on annual per person costs, re-run the analysis at least annually.



determination systems, even if, as of January 1, 2014, the system applies the 5 percent disregard across the board to all individuals whose eligibility is determined using MAGI-based rules, based on a state's assurance that, by January 1, 2015, the state will update the system to apply the disregard only to a determination of eligibility for Medicaid under MAGI-based rules.

### ***Single State Agency Delegation of Eligibility Determinations to the Exchange (§431.10-431.11)***

The final rule limits single state Medicaid agencies to delegating eligibility determinations to Exchanges that are government agencies maintaining personnel standards on a merit basis. For purposes of delegation, the final rule indicates that CMS is treating a quasi-governmental entity or public authority running an Exchange and employing merit system protection principles as a government agency, such that delegation to it would be permitted.

### ***Conversion of Federal Minimum Income Standards (§435.110 and 435.116)***

The final rule adopts the NPRM's proposal to require conversion of the federal minimum income standard for §1931 of the Social Security Act to comport with the new rules regarding MAGI that will take effect on January 1, 2014.

## **Part B: EHBs in Alternative Benefit Plans**

Section 1937 of the Social Security Act provides states with the flexibility to amend Medicaid state plans to use "Alternative Benefit Plans," or benefit packages other than the standard Medicaid state plan, for certain populations as defined by the state, based on one of four benchmark or benchmark-equivalent packages:

- Federal Employees Health Insurance Benefit Plan, Standard Blue Cross/Blue Shield Preferred Provider Option
- State employee health coverage
- Health insurance plan offered through the health maintenance organization with the largest insured commercial, non-Medicaid enrollment in the state
- Secretary-approved coverage, which is a benefit package the Secretary has determined provides coverage appropriate to meet the needs of the population

Benchmark-equivalent coverage must be at least actuarially equivalent to one of these four benefit packages. Section 1937 requires benchmark-equivalent plans to cover certain categories of services. In the proposed rule, HHS made the following revisions to the benefit provisions of §1937:



- Required that the newly eligible adult population receive an alternative benefit plan; states may offer different alternative benefit plans to subpopulations within the newly eligible group.
- Exempted former foster children from mandatory enrollment in an alternative benefit plan (§440.315).
- Added mental health services and prescription drugs to the list of services that must be offered in benchmark-equivalent coverage (§440.335 and §440.347).
- Required alternative benefit plans to cover family planning services and supplies (§440.345).
- Required the provision of EHBs in alternative benefit plans beginning in 2014. The process for selecting the Medicaid EHB is consistent with the EHB selection process in the individual and small group markets. In selecting the EHB for Medicaid alternative benefit plans, HHS notes that the base benchmark plan for defining the Medicaid EHB may be different from the base benchmark plan selected for the individual and small group market (§440.347).
- Required alternative benefit plans to cover the full range of EHB preventive services.
- Directed that benefits comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (§440.345).
- Added a new provision requiring states to publish public notices no less than two weeks prior to submitting a state plan amendment for an alternative benefit plan. The two-week requirement is removed in the final rule and replaced with “reasonable opportunity to comment (§440.386).”
- Updated the definition of the medically frail exemption category; the final rule further adds “chronic substance use disorders” to this definition (§440.315).

The proposed rule also requested comment on the approach to defining habilitative services. In the final rule, HHS adopts the requirement that the services covered by the base benchmark are the minimum for EHB coverage (§440.347). If the benchmark does not cover habilitative services and devices, states may determine the required EHB services that are in the habilitative category. HHS notes that the existing definitions of habilitative services in §1915(c) and (i) of the Social Security Act are not necessarily applicable to the population covered under the alternative benefit plan. HHS also clarifies that states may choose to offer habilitative services and devices in no more restrictive amount, duration, and scope than is applied for rehabilitative services and devices. This provision only applies to the Medicaid program and has no bearing on the provision of habilitative services in the individual and small group markets.

In response to comments, HHS notes that states may use the Secretary-approved coverage option to significantly align the benefits for the new adult eligibility group with the regular Medicaid state plan benefit package. HHS also clarifies that states may substitute EHBs in alternative



benefit plans, and substitution may occur benefit by benefit. States may also substitute multiple benefits that, when combined, are actuarially equivalent to a single benefit.

Regarding the mental health parity requirement, HHS received numerous comments about coverage of services provided by institutions for mental diseases (IMDs). HHS reiterates that the payment exclusion for services provided to individuals residing in IMDs continues to apply to all individuals participating in alternative benefit plans. HHS notes that many commercial products do cover residential services in IMD settings, and federal matching funds will not be available for these services for Medicaid enrollees.

HHS adopts most provisions as proposed, with some technical and clerical revisions. HHS notes *that it will not* pursue compliance actions against states that are working toward, but have not achieved, full compliance with these provisions by January 1, 2014.

## **Part C: Exchanges: Eligibility and Enrollment**

### ***Definitions (§155.20)***

In this section, HHS makes technical corrections to the definitions of “APTC” and “application filer,” so that such terms refer to the appropriate statutory provision of the ACA and related regulation. HHS proposed to add the definition of “catastrophic plan” through referencing the appropriate statutory provision of the ACA. HHS finalizes these provisions as proposed.

### ***Approval of a State Exchange (§155.105)***

HHS finalizes this provision as proposed with only minor technical corrections.

### ***Functions of an Exchange (§155.200)***

In the NPRM, HHS proposed to include a reference to subpart F, which would require the Exchange to also perform the minimum functions with regard to appeals. HHS notes its intent to finalize this modification at a future date when subpart F is finalized. In the interim, HHS maintains previous language from the Exchange final rule.

### ***Authorized Representatives (§155.227)***

In this section, HHS proposed to add language that establishes minimum requirements for the designation of authorized representatives who would act on behalf of an applicant or enrollee in applying for coverage through the Exchange. The Exchange, in adhering to the minimum requirements, must:

- Permit an applicant or enrollee, subject to applicable privacy and security requirements, to designate an individual or organization to act on his or her behalf for the purposes of



(1) applying for an eligibility determination, (2) applying for an eligibility redetermination, and (3) carrying out ongoing communications with the Exchange.

- Ensure the authorized representative agrees to maintain, or be legally bound to maintain, the confidentiality of the applicant's or enrollee's information provided by the Exchange. This includes applicable authentication and data security standards.
- Ensure the authorized representative is responsible for fulfilling all responsibilities within the scope of authorized representation.
- Require that the authorized representative comply with any applicable state and federal laws concerning conflicts of interest and confidentiality of information.
- Permit an applicant or enrollee to designate an authorized representative at the time of application or other times to assist in completing the application via the website, telephone through a call center, via mail, or in person. If the applicant does not designate such representative at the time of application, he or she will also have an opportunity to do so through electronic, paper formats, or other methods.
- Permit an applicant or enrollee to authorize a representative to (1) sign the application on his or her behalf, (2) submit an update or respond to a redetermination for the individual, (3) receive copies of the individual's notices and other communication from the Exchange, and (4) act on behalf of the individual in all other matters with the Exchange.
- Permit an applicant or enrollee to change or withdraw an authorization at any time. Similarly, an authorized representative may withdraw his or her representation by notifying the Exchange and the applicant or enrollee.
- Permit an applicant or enrollee to have representation through operation of state law; that is, court orders establishing legal guardianship or a power of attorney can serve in the place of the individual's signature.
- Must not restrict the option to designate an authorized representative to only certain groups of applicants or enrollees.
- Must ensure that an authorized representative acting as either a staff member or volunteer of an organization signs an agreement stating that he or she meets the certification standards as an application counselor.

HHS finalizes these provisions as proposed, with the following corrections:

- Authorized representatives are permitted to assist individuals in applying for exemption from the shared responsibility payment.
- The Exchange is required to provide information about the powers and duties of an authorized representative both to the individual and the authorized representative.



- The Exchange must permit an individual to authorize a representative to perform fewer than all of the activities, provided the Exchange tracks the specific permissions of each authorized representative.
- The Exchange, not the individual, must notify the authorized representative when an applicant or enrollee notifies the Exchange that he or she is no longer represented by his or her previously authorized representative.
- Authorized representatives are required to notify the Exchange and the individual when they no longer have legal authority to act on the individual's behalf.
- The designation of an authorized representative must be made in a written document signed by the individual.

HHS notes that, if the application is transferred to the state Medicaid agency, the authorized representative designation will be transferred as well.

### ***General Standards for Exchange Notices (§155.230)***

This section provides the general framework for notices required to be sent by the Exchange to individuals or employers. The general standards for notices include:

- An explanation of the action reflected in the notice, including the effective date of the action
- Any factual findings relevant to the action
- Citations to, or identification of, the relevant regulations supporting the action
- Contact information for available customer service resources
- An explanation of appeal rights, if applicable

HHS notes that the contents of these notices are subject to privacy and security provisions, which include the limitations on disclosure of information. Proposed language requires an Exchange (both individual and small business health options program [SHOP]) to provide notices electronically or through standard mail. The individual, employee, or employer selects the means of delivery. HHS finalizes the provisions as proposed, with the following modifications:

- Technical amendments specify the electronic notice standards for an individual and SHOP Exchange.
- An individual Exchange may choose to delay the implementation of the process with regard to sending a mailed confirmation of an individual's selection to receive electronic notices.
- An employer or employee in any SHOP may elect to receive electronic notices, provided that such notices meet applicable requirements.



HHS notes that it is working with states to identify all key messages that should be communicated to individuals through notices and other Exchange processes.

### ***Definitions and General Standards for Eligibility Determinations (§155.300)***

In this section, HHS proposed technical corrections to the definitions of the following:

- Minimum value: describes coverage in an eligible ESP. It means that the ESP meets the standards for coverage of the total allowed costs of benefits.
- MAGI: has the same meaning as it does in 26 CFR 1.36B-2(e)(2) (therefore this definition cites the Internal Revenue Service’s regulations)
- Qualifying coverage in an eligible ESP: describes coverage in an eligible ESP that meets the affordability and minimum value standards.

HHS finalizes these provisions as proposed, with a modification to remove the definition of “adoption taxpayer identification number.”

### ***Options for Conducting Eligibility Determinations (§155.302(a), (b), and (d))***

In this section, HHS modifies certain provisions that were promulgated as interim final with request for comments. First, an Exchange may fulfill its minimum functions under this section by executing all eligibility functions directly or through contracting arrangements. Second, any contracting arrangement for Medicaid and CHIP eligibility determinations is required to meet standards when such contracting entity is a governmental entity (e.g., state Medicaid agency, single state agency, or federal agency administering supplemental security income [SSI]). HHS finalizes these provisions as proposed, with the following modifications:

- Any contracting arrangement for Medicaid and CHIP eligibility determinations must meet specified standards when such contracting entity is governmental.
- An Exchange appeals entity, in addition to the Exchange, is required to adhere to the Medicaid or CHIP eligibility determination decision made by the Medicaid or CHIP agency.
- The agreement between the Exchange and the state Medicaid and CHIP agency specifying their responsibilities for Medicaid or CHIP eligibility determinations must be made available to HHS upon request.

At this time, HHS is not finalizing §155.302(c), relating to the Exchange implementing an eligibility determination for APTCs and CSRs by HHS. As a result, HHS is leaving the text of this provision as an interim final rule as published.



## ***Eligibility Standards (§155.305)***

In this section, HHS proposed language regarding temporary absence. Specifically, the Exchange cannot deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if he or she meets the standards for a temporary absence from the Exchange's service area and intends to return once the purpose of the absence has been achieved.

This final rule codifies the eligibility standards for QHP enrollment through the Exchange in a catastrophic plan. Eligibility is based on age or having in effect a certificate of exemption from the shared responsibility payment. All Exchanges would be required to conduct eligibility determinations for individuals seeking to enroll in a catastrophic plan. In addition, HHS proposed clarifications stating that an Exchange may provide APTCs on behalf of a tax filer only if one or more applicants, whom are claimed as a personal exemption or spouse, are enrolled in a QHP that is not a catastrophic plan. HHS finalizes these provisions as proposed, with the following modifications:

- Removing the clause, “unless another Exchange verifies that the individual meets the residency standard of such Exchange”
- Requiring that an applicant be eligible to enroll in a QHP through the Exchange in order to be eligible for a catastrophic plan through the Exchange.

HHS notes that there will be cases in which individuals may establish residency for the purposes of Exchange enrollment in multiple Exchange service areas simultaneously. These include scenarios in which a parent expects to claim a child living in another state on his or her tax return. This child may enroll in a QHP through the Exchange either in the child's state of residence or the parent's state of residence.

## ***Eligibility Process (§155.310)***

In this section, HHS finalizes the certification program as part of the process of determining whether an employer must remit a shared responsibility payment. The Internal Revenue Service (IRS) would develop methods for determining if one or more employees were enrolled in a QHP and would qualify for APTCs or CSRs. The certification program would address (1) individuals who receive APTCs and CSRs and (2) individuals claiming the APTC only on their tax returns. HHS finalizes this provision as proposed, with the following technical correction:

- Only applicants who are eligible to enroll in a QHP through the Exchange must attest as to whether information affecting their eligibility has changed since the most recent eligibility determination prior to ascertaining their eligibility for an enrollment period.



## **Verification Process Related to Eligibility for Enrollment in a QHP through the Exchange (§155.315)**

In this section, HHS proposes modifications and technical corrections to verification processes relating to (1) the validation of an individual's social security number, (2) circumstances that trigger the "inconsistency process," requiring the Exchange to examine inconsistencies in information used to determine eligibility, and (3) eligibility and enrollment in a catastrophic plan through the Exchange.

First, this final rule clarifies the procedures for an Exchange when the Social Security Administration indicates an individual is deceased. In the event that the Exchange cannot verify information required to determine eligibility, the individual must be given a period of 90 days from the date of the Exchange notice to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration.

Second, the rule amends the "inconsistency process" described in the Exchange final rule, finalizing some changes as proposed and further modifying others. HHS changes the waiting period from two days to one day. Therefore, if electronic data are unavailable or not reasonably expected to be available within one day of the initial attempt to reach the data source, the Exchange would be required to (1) determine the applicant's eligibility based on the information available from specified data sources, or (2) accept the applicant's attestation regarding the factor of eligibility reliant on the unavailable data source. During the clerical error resolution and inconsistency periods, the Exchange can proceed with eligibility determinations and eligibility for enrollment in a QHP, and receive APTCs and CSRs. This section contains a new paragraph, §155.315(f)(6), which specifies that such a waiting period is not applicable to support verifications for residency or minimum essential coverage (other than minimum essential coverage in an ESP). Where data are unavailable for these factors of eligibility, the Exchange must accept the applicant's attestation.

Finally, this section of the final rule outlines the verification process relating to eligibility determinations for enrollment in a QHP that is a catastrophic plan. The Exchange is required to verify such applicant's attestation to be eligible by:

- Verifying the applicant's age through acceptance of attestation or examining electronic data sources available to the Exchange that have been approved by HHS for this purpose. If information regarding the individual's age is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange is required to examine information in other data sources available to the Exchange that have been approved by HHS for such purpose.
- Verifying the applicant has a certification of exemption in effect from the requirement to maintain minimum essential coverage.



- To the extent that the Exchange is unable to verify information required for eligibility determinations, it is required to follow specified procedures to resolve inconsistencies of information for determining eligibility.

HHS notes that an individual would not be determined eligible for enrollment through the Exchange in a QHP that is a catastrophic plan until verification of necessary information can be completed. HHS finalizes these provisions as proposed, with previously mentioned technical corrections.

HHS confirms that data from the IRS, Social Security Administration, and HHS should be available every day for the purposes of verification of eligibility information. HHS notes that the Exchange would have flexibility to continue checking whether data sources have become available leading up to the triggering of (and during) the inconsistency period. HHS notes that details regarding the Exchange appeals process will be addressed in subsequent rulemaking.

### ***Verification Process for Insurance Affordability Programs (§155.320)***

In the proposed rule, HHS explained the methods for verifying projected household income and employer-sponsored coverage under this section. HHS proposed that, when the data show that the attested income is significantly higher than the income computed based on available data, the Exchange should proceed with the “inconsistency process” explained in 45 CFR §155.315(f). The proposed rule also explained that, when the attested income is 10 percent lower than the income computed by available data, the Exchange should follow the “inconsistency process” explained in 45 CFR §155.315(f).

In this final rule, HHS is now allowing Exchanges “temporary, expanded discretion to accept the attestation” of projected annual household income without further verification. Specifically, when the income is more than 10 percent below the household income that is computed using the applicable data sources, the Exchange must either (1) follow the “inconsistency process” explained in 45 CFR §155.315(f) for a statistically valid sample of the population that would be subject to similar procedures or, if an individual is not part of the sample, (2) accept the attestation of projected annual household income without further verification. When a state utilizes the second option, HHS notes that it expects the state to monitor its sampling process closely and “adjust the targeting and size of the sample population” as needed to ensure that the verification process is effective. HHS maintains, as stated in the proposed rule, that an Exchange should accept self-attestation in cases in which attested projected income is greater than the income computed by the electronic data sources.

With regard to employer-sponsored coverage verification, the proposed rule stated that, when information related to employee enrollment in an ESP is unavailable, the Exchange must select a statistically significant random sample and handle inconsistencies related to employment or household income through the sampling process. In the sampling process, the Exchange would first notify the applicant who is selected as part of the random sampling that the Exchange will



contact any employer identified on the applicant's application to verify eligibility for an ESP. The Exchange would still be required to proceed with all other elements of eligibility determination for enrollment and ensure that APTC and CSR are provided to individuals who are otherwise eligible. The Exchange, in the meantime, would make reasonable attempts to contact any employer identified on the application via phone or mail.

This final rule maintains all provisions related to verifying enrollment in an ESP, with one important clarification: HHS will not be able to complete verifications of ESP for year one. Instead, the Exchange will be able to rely on HHS for this verification during open enrollment for the 2015 plan year. Therefore, to provide relief for state-based Exchanges that were relying on HHS to complete this verification, HHS is delaying the above-described random sampling requirement, which will now be required during the open enrollment period for the 2015 plan year.

### ***Eligibility Redeterminations During a Benefit Year (45 CFR §155.330)***

The final rule maintains provisions from the proposed rule related to redeterminations during a benefit year. The proposed rule explained that the Exchange must conduct periodic examinations of data sources to confirm eligibility for determinations of Medicare, Medicaid, CHIP, and the basic health plan, only for enrollees who are being provided APTC/CSRs, and not all QHP enrollees. Further, the Exchange must notify enrollees of their redeterminations *and* CSR changes as a result of the change they report in their circumstances or the periodic examination of the data sources. In this final rule, HHS clarifies that the Exchange is not required to provide plan-specific information related to CSRs as a result of the redetermination, but must explain overall implications of the changes in CSRs.

The final rule also maintains the proposed language related to coverage effective dates for eligibility changes, described below, as a result of appeals decisions, events related to eligibility redeterminations, and changes affecting only enrollment and premiums. Specifically:

- For appeals decisions that change eligibility, the change in coverage is effective on the first day of the month following the date of the notice of the appeal decision; when an appeal is retroactive, coverage is effective on the date stated in the decision.
- For eligibility redeterminations, the change in coverage is effective on the first day of the month following the individual's redetermination notice.
- For changes affecting only enrollment and premiums, the change in coverage is effective on first day of the month following the date on which the Exchange is notified of the change.

Again, when changes occur after the 15<sup>th</sup> day of the month, the Exchange may establish a date beyond which the change is effectuated – not on the following month, but the month after (i.e., on the first day of the second calendar month after the change occurs). Still, the Exchange must



effectuate changes on the first day of the month following the change when it results in a decrease in APTC or a decrease or increase in CSR.

### ***Annual Eligibility Redeterminations (45 CFR §155.335)***

The final rule maintains the language of the proposed rule, which explained that the Exchange will conduct eligibility redeterminations on an annual basis for all qualified individuals, rather than those individuals only enrolled in QHPs. This covers individuals who submitted an application prior to the open enrollment period and were determined eligible for enrollment in a QHP, but did not meet the criteria for a special enrollment period. Conversely, the Exchange is not required to perform an eligibility redetermination when a qualified individual does not select QHP before a redetermination and is not enrolled in a QHP at any time during the benefit year before the redetermination. Information regarding the content of the annual redetermination notice will be addressed in future rulemaking.

### ***Coordination with Medicaid, CHIP, the BHP, and PCIP (45 CFR §155.345)***

This rule finalizes the proposed method of coordination between the Exchange and other affordable coverage programs. Under this section of the proposed rule, HHS had stated that the Exchange must provide coordinated notices prior to January 1, 2015, and combined notices beginning on January 1, 2015.

HHS notes that it anticipates the initial eligibility determination notices will be consolidated for family members who apply together. Further, HHS will finalize the notice of the combined Exchange-Medicaid notice through future rulemaking.

### ***Special Eligibility Standards and Process for Indians (§155.350)***

In this section, HHS proposed a technical correction with regard to the household income threshold for an Indian to be eligible for CSRs (300 percent of the federal poverty level [FPL]). The correction changes the reference from §36B of the Internal Revenue Code to the applicable Treasury regulation. HHS finalizes this provision as proposed.

### ***Enrollment of Qualified Individuals into QHPs (§155.400)***

In this section, HHS clarified that the Exchange would be required to send updated eligibility and enrollment information to HHS promptly and “without undue delay, in a manner and timeframe as specified by HHS.” HHS finalizes this provision as proposed.

HHS notes that each Exchange can maintain flexibility to determine its own issuer reporting requirements relative to enrollment transactions, consistent with applicable laws and regulations. Moreover, this provision only addresses the requirement that Exchanges report updated eligibility and enrollment information to HHS.



## **Special Enrollment Periods (§155.420)**

In this section, HHS clarified the scope of special enrollment periods and further specified the usage of “dependent” when referring to any individual who may become eligible for coverage because of a relationship to a qualified individual enrollee. In other words, if an individual qualifies for special enrollment, then his or her family also qualifies.

This final rule requires the Exchange to provide a special effective date:

- In the case of birth, adoption, placement for adoption, or placement in foster care. The effective date for the qualified individual or enrollee would be the date of such event.
- In the case of marriage or when a qualified individual loses minimum essential coverage. The effective date for a qualified individual or enrollee would be the first day of the following month.
- In the case of a qualified individual or enrollee who becomes eligible for a special enrollment period because:
  - The qualified individual or such dependent’s enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS.
  - The enrollee or his or her dependent adequately demonstrate that their QHP substantially violated a material provision in its contract in relation to the enrollee
  - The qualified individual or enrollee, or his or her dependent, demonstrates that the individual meets other exceptional circumstances as the Exchange may provide.

The Exchange is required to ensure that coverage is effective on the appropriate date, based on the circumstances of the special enrollment period. The effective date must be either (1) the date of the triggering event or (2) the regular effective date based on date of QHP selection. Specifically, if QHP selection occurs between the 1<sup>st</sup> and 15<sup>th</sup> day of any month, the Exchange is required to ensure a coverage effective date on the 1<sup>st</sup> day of the following month. If QHP selection occurs between the 16<sup>th</sup> and last day of any month, the coverage effective date must be the 1<sup>st</sup> day of the second following month. The Exchange must adhere to the modified effective dates relating to APTCs and CSRs.

If the triggering event is the decertification of a QHP, the date of such event is the date of notice of decertification. In all other cases in which a qualified individual or dependent loses minimum essential coverage, the date of loss of coverage is used. The Exchange is required to provide a special enrollment period for any enrollee (or his or her dependent) in the same QHP who is determined to be newly eligible or newly ineligible for APTCs, or who experiences a change in eligibility for CSRs.



A qualified individual (or his or her dependent) who is enrolled in qualifying coverage in an ESP and is determined to be newly eligible for APTCs can qualify for a special enrollment period prior to the date on which he or she would cease to be eligible for qualifying coverage in an eligible ESP. Similarly, a qualified individual (or his or her dependent) who is enrolled in an eligible ESP that does not provide qualifying coverage, must be afforded a special enrollment period and be allowed to terminate his or her existing coverage. HHS notes that the Exchange is required to allow individuals access to this special enrollment period up to 60 days prior to the end of their ESP coverage to prevent potential coverage gaps. HHS finalizes these provisions as proposed.

HHS notes that the Exchange will not have information regarding actual premiums at the time of an initial eligibility determination notice, since an individual will not have selected a plan at that point.

### **Termination of Coverage (§155.430)**

In this section, HHS clarified the scenario of enrollee-initiated terminations. Through periodic data matching, an Exchange may find an enrollee eligible for other minimum essential coverage. As a result, the enrollee will become ineligible for APTCs. At the time of plan selection, the Exchange must provide a qualified individual with the opportunity to choose to remain enrolled in a QHP if the Exchange identifies that he or she has become eligible for other minimum essential coverage, and the enrollee does not request a termination. Changes in APTCs and CSRs, including terminations, must adhere to the proposed regular effective dates. HHS finalizes these provisions as proposed.

HHS notes that Exchanges are free to provide additional opportunities for individuals to request determination or to remain enrolled in a QHP without APTCs or CSRs, upon losing eligibility for such benefits. Individuals are free to terminate enrollment in a QHP through the Exchange at any time, but it will not terminate retroactively. Individuals who wish to begin other coverage in a QHP through the Exchange must do so within an open or special enrollment period. Each Exchange has the flexibility to decide whether to allow enrollees for whom coverage has been effectuated to change QHPs during any remaining time in an open or special enrollment period.

HHS modifies this section in order to align the coverage termination standards of Exchanges and QHP issuers. HHS also clarifies that QHP issuers are required to promptly notify both enrollees and the Exchange of the termination reason and termination effective date when the QHP initiates such termination.

### **Part D: Medicaid Premiums and Cost Sharing**

This section changes the rules for Medicaid premiums and cost sharing by deleting the entirety of current premium and cost-sharing rules at §447.5-447.82 and replacing them with a new §447.5-447.57.



## **Definitions (§447.51)**

The proposed rule added new definitions of premiums (to include enrollment fees and other similar charges) and cost sharing (to include deductibles, copayments, coinsurance, and other similar charges). HHS adopts these new definitions as proposed. The proposed rule also requested comments as to whether HHS should add definitions of “inpatient stay” and “outpatient services.” In response to comments, HHS is adding definitions of these terms:

- Inpatient stay: the services received during a continuous period of inpatient days in either a single institution or multiple medical institutions, including a return to an inpatient medical institution after a brief period, when the return is for treatment of a condition present at the initial visit.
- Outpatient services: for purposes of cost sharing, any service or supply not meeting the definition of an inpatient stay.

The final rule also includes some minor technical revisions to definitions.

## **Maximum Nominal Cost Sharing (§447.52)**

This section of the rule provides states with the option to impose cost sharing on certain populations. The proposed rule updated the maximum nominal cost sharing for individuals with income below 100 percent of the FPL to \$4 for outpatient services and requested comment on the maximum amount for inpatient services. Based on comments, the final rule revises the maximum nominal amount for inpatient services to \$75. HHS is adding new language to allow a transition period for states with existing cost sharing above \$75. These nominal amounts will be updated annually based on the consumer price index for urban consumers (CPI-U), beginning on October 1, 2015.

The proposed rule permitted higher cost sharing for individuals above 100 percent of the FPL by allowing states to impose cost sharing up to 10 percent to 20 percent of the cost of the service. The proposed rule also allowed states to target different cost-sharing levels for different groups of individuals. The final rule clarifies that, if states use the option to establish different cost sharing for individuals at different income levels, they must ensure that lower income individuals have lower cost sharing than higher income individuals.

## **Cost Sharing for Drugs (§447.53)**

The proposed rule permitted states to establish differential cost sharing for preferred and non-preferred drugs up to:

- \$8 for non-preferred drugs for individuals below 150 percent of the FPL



- 20 percent of the cost the agency pays for the non-preferred drug for individuals above 150 percent of the FPL
- \$4 for preferred drugs for all income groups

This cost sharing may be imposed on populations that are otherwise exempt from cost sharing. HHS adopts these cost-sharing amounts as proposed. HHS revises the rule to clarify that, if a prescriber determines that the non-preferred drug is medically necessary, the state must have a timely process for limiting cost sharing for that drug to the preferred amount.

### ***Cost Sharing for Emergency Department Services (§447.54)***

The proposed rule permitted states to impose up to \$8 in cost sharing for non-emergency use of an emergency department (ED) for individuals up to 150 percent of the FPL and did not limit cost sharing for individuals above 150 percent of the FPL. This cost sharing may be imposed on populations that are otherwise exempt. HHS finalizes this provision as proposed, with only minor technical corrections. The proposed rule also requires hospitals to provide the individual with the name and location of an alternative non-emergency service provider and ensure that the alternative provider can provide services to the individual in a timely manner with the imposition of lesser or no cost sharing. In response to comments, HHS replaces the word “ensure” with “determine” in the final rule.

HHS notes that it is not making any revisions to further prescribe how states should distinguish between emergency and non-emergency conditions for cost-sharing purposes and remains open to state proposals. HHS also adds a new paragraph requiring hospitals to inform the individual of the amount of his or her cost sharing for the non-emergency ED service.

### ***Premiums (§447.55)***

The proposed rule permitted states to impose premiums on individuals above 150 percent of the FPL, including pregnant women, the medically needy, and children with disabilities. HHS slightly revises the rule to increase the maximum sliding scale premium amount for the medically needy from \$19 to \$20 and to clarify that, if premiums are imposed on medically needy individuals on a sliding scale, the agency must impose a higher premium for individuals at higher income levels.

HHS also revises a drafting error to clarify that states have the option to terminate any individual, except for the medically needy, who has failed to pay all or part of his or her premium obligation. The state may not terminate prior to 60 days after the failure to pay. HHS also adds a new paragraph in the final rule to indicate that no further consequences may be applied to non-payment of Medicaid premiums, including lock-out periods. HHS makes other minor technical corrections.



### ***Limitations on Premiums and Cost Sharing (§447.56)***

The proposed rule exempted the following groups from premiums and cost sharing: certain children, foster children, certain pregnant women, individuals in hospice, certain individuals residing in institutions, American Indians/Alaska Natives, and individuals in breast and cervical cancer programs. Cost sharing may not be imposed for the following services: emergency services, family planning services and supplies, children’s preventive services, and pregnancy-related services. Aggregate premiums and cost sharing may not exceed 5 percent of household income. HHS adopts these provisions as proposed, and adds “provider-preventable” services to the list of exempted services. HHS also adds language to clarify that the 5 percent cap applies to all premiums and cost sharing incurred by individuals in the household, at all income levels.

The proposed rule further required that states use an automated system to track the 5 percent cap. Based on comments, HHS replaced the word automated with “effective” and noted that states have the flexibility to develop their own processes, as long as the process does not rely on beneficiary documentation.

In the NPRM, HHS solicited comment as to whether it should require renewal of the American Indian/Alaska Native exemption. In this final rule, HHS decides not to require such a renewal. HHS makes other minor technical corrections.

### ***Beneficiary Public Notice Requirements (§447.57)***

The proposed rule codified existing policies that ensure public access to effective notice of Medicaid premiums and cost sharing. HHS adopts this section as proposed, with the addition of a requirement for states to provide additional public notice if proposed cost sharing is substantially modified during the state plan amendment approval process.





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