

**KEY COMMENTS AND RESPONSES IN FINAL EXCHANGE RULE
March 2012**

DEFINITIONS

Comment: Several commenters stated that the definition of “qualified employer” should include a multi-employer plan as defined in ERISA Section 3(37), and that “qualified employee” should include individuals who are participants in a multi-employer plan, not just individuals who are employed by a qualified employer.

Response: We do not think that the law supports accepting the commenters’ suggested changes in the definitions of “qualified employer” and “qualified employee.” Accordingly, we have not changed the definitions in the final rule. We intend to address commenters’ concerns surround multi-employer and church plans in future guidance.

Comment: We received numerous comments regarding the types of plans that should be considered health plans eligible for certification as QHPs. A few commenters suggested that multiple employer welfare arrangements (MEWAs) be allowed to offer plans through the Exchange, be allowed to offer plans only in the SHOP and not the individual market, and be allowed to restrict enrollment to specific industry members or associations. A small number of commenters also suggested that Taft-Hartley plans and church plans be available through the Exchange. Other commenters urged HHS to ensure that all QHPs offered through the Exchange meet the same standards to ensure a level playing field and questioned the ability of self-insured employer groups to comply.

Response: We finalize the definition of a health plan as codified from section 1301(b)(1) of the Affordable Care Act, and the standards set forth for participation in an Exchange are equally applicable to any health insurance issuer seeking certification of health plans as QHPs. We intend to address issues related to multi-employer and church plans in future guidance.

FUTURE MODIFICATIONS TO STATE EXCHANGES

Comment: In relation to proposed §155.105(d) and (e), several commenters supported using a process modeled from the Medicaid and CHIP State Plan review process for the approval of the initial Exchange and subsequent changes, including the 90-day review timeframe and posting of changes on the Internet, and because they believe that the process ensures sufficient Federal oversight and transparency. In contrast, many other commenters urged HHS to use a review plan other than the Medicaid and CHIP model, contending that the State Plan review process would delay State implementation while waiting for an HHS review that could potentially take up to 180 days. The commenters suggested that the proposed approach would be unwieldy, especially where HHS requests for additional information from States would restart the 90-day period, and would inhibit States from being able to effectively establish an Exchange and respond to changing circumstances over time.

Response: We believe that initial approval of an Exchange and approval of subsequent changes should not cause unnecessary delay in Exchange implementation or future operations. Therefore, HHS will not model the review of the initial proposed Exchange Plan or future changes after the Medicaid and CHIP State Plan process. Additionally, we have changed reference of the “Exchange Plan” to “Exchange Blueprint” to avoid confusion with the Medicaid and CHIP review process. Finally, we amended §155.105(e) to provide that when a State makes a written request for approval of a significant change to Exchange Blueprint, the change may be effective on the earlier of 60 days after HHS receipt of a completed request, or upon approval by HHS. For good cause, HHS may extend the review period an additional 30 days to a total of 90 days. We note that during the review period, HHS may deny the significant change to the Exchange Blueprint.

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EXCHANGE BOARD/GOVERNANCE

Comment: A number of commenters requested clarification on whether State departments of insurance would be considered eligible contracting entities under proposed §155.110(a), citing the importance of such expertise in the operation of an Exchange.

Response: We clarify in §155.110(a)(2) of this final rule that, in addition to State Medicaid agencies, other State agencies that meet the qualifications in (a)(1) would be considered eligible contracting entities. For purposes of this final rule and Exchange operations, we interpret the term “incorporated” in (a)(1)(i) to include State agencies, such as departments of insurance, that have been established under and are subject to State law.

Comment: With respect to proposed §155.110(c)(3), a few commenters requested HHS define “represents consumer interests” and “conflict of interest.” Many commenters recommended that all Exchange boards must have at least one consumer representative or advocate and a formal consumer advisory committee. A few commenters recommended increasing the threshold for voting members that do not have a conflict of interest to something higher than a simple majority.

Response: We accept the suggestion that at least one voting member be a consumer advocate, and have amended in §155.110(c)(3)(i) of this final rule accordingly. We do not believe this change will conflict with any current Exchange boards. We have also maintained the minimum standard that a simple majority of board members not have a conflict of interest, but a State can choose to establish an Exchange with a higher threshold of non-conflicted board members.

TREATMENT OF USER FEES

Comment: Several commenters on proposed §155.160 made recommendations with respect to how user fees or other assessments collected by the Exchange should be incorporated into issuers’ medical loss ratios. Some commenters suggested that user fees should be treated as administrative costs, while others recommended that user fees be excluded from the calculation.

Response: We clarify that all calculations and reporting of user fees must be consistent with HHS’s medical loss ratio rule, published at 45 CFR 158.

Comment: A few commenters expressed concern that user fees or assessments charged in accordance with proposed §155.160 will be shifted to consumers and providers. These commenters variously recommended that any user fees passed on to the consumer be treated as rate increases, that user fees be reported separately on consumer bills, and that the final rule prohibit direct assessments on consumers. Conversely, several commenters recommended that the Exchange must report on user fees and other assessments; specifically, the amount collected and how the fees were used.

Response: Any user fees or other assessments collected by the Exchange would be reflected in issuers’ premiums, consistent with current industry practice, and would thus be considered as part of any rate review conducted by the State. We believe that having issuers report separately any user fees is unnecessary, as we expect that the Exchange will announce user fees in advance of each plan year. With respect to having Exchanges report on user fees, we recognize that transparency is important, but defer to State flexibility to establish a process to notify issuers and report on the assessment of user fees, if this is the approach taken to supporting continued operations. We encourage States to be transparent in this process.

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EXCHANGE OPERATIONS

Comment: Some commenters requested clarification on whether an Exchange is considered a business associate under HIPAA.

Response: In response to commenters' requests for clarification regarding Exchanges and HIPAA, we have added language to section §155.200 clarifying the relationship between Exchanges and QHP issuers, which are HIPAA covered entities, to help States determine the applicability of HIPAA to their Exchange. The final rule provides States with a breadth of options for designing and implementing Exchange functions and operations. Therefore, it is not possible to state the applicability of the HIPAA Privacy and Security Rules to all Exchanges. We have added §155.200(e) to clarify that an Exchange is not acting on behalf of a QHP when the Exchange engages in the minimum functions outlined in this final rule.

Because the Exchange, in performing functions under §155.200, is not operating on behalf of a particular QHP issuer, but rather is acting on its own behalf in performing statutorily required responsibilities to determine an individual's eligibility for enrollment in a QHP through the Exchange, it is not a HIPAA business associate of the QHP issuer in regard to its performance of these functions. However, an Exchange that chooses to perform functions other than or in addition to those in §155.200 may be a HIPAA covered entity or business Associate. For instance, a State may need to consider whether the Exchange performs eligibility assessments for Medicaid and CHIP, based on MAGI, or conducts eligibility determinations for Medicaid and CHIP as described in §155.302(b).

As stated in the Exchange establishment proposed rule, each Exchange should engage in an analysis of its functions and operations to determine whether the Exchange is a covered entity or business associate, based on the definitions in 45 CFR 160.103. However, we believe that clarifying our conceptualization of the relationship between an Exchange and QHP issuers will assist Exchanges in their independent evaluation of the applicability of HIPAA. Please see further discussion of privacy and security in §155.260.

STATE-FEDERAL PARTNERSHIPS

Comment: Several commenters suggested other functions for State involvement in a Partnership instead of the plan management and consumer assistance, in particular suggesting that States perform Medicaid eligibility determinations. Some commenters recommended allowing a State to retain responsibility for making Medicaid eligibility determinations in order to avoid duplicating existing State systems or curtailing traditional State responsibilities. A few commenters suggested that there be specific process to handle disputes between HHS and Medicaid regarding Medicaid eligibility if States retained that function in a Federally-facilitated Exchange, and one suggested that consumers be held harmless and enrolled in coverage during eligibility disputes. Meanwhile, other commenters urged HHS not to bifurcate eligibility determinations between Federal and State entities out of concerns about the negative implications for the consumer experience and the complications such bifurcation would create. A small number also suggested that a State with a Federally-facilitated Exchange must accept Federal eligibility determinations.

Other proposed functions for Partnership included: the certificates of exemption described in §155.200(b), quality rating system, enrollee satisfaction tools, determination of affordability and minimum value of employer-sponsored coverage, or eligibility determinations for advance payments of the premium tax credit. Other commenters suggested areas that should specifically be retained by a State in any circumstance, including State responsibility for overseeing licensure, solvency, market conduct, form approval and other operations of QHPs, overseeing licensed agents, and responding to consumer complaints.

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Response: In this final rule, we address leveraging existing State resources and expertise regarding Medicaid in subpart D. Exchange responsibilities related to the quality rating system and enrollee satisfaction survey will be outlined in future rulemaking. In addition, HHS continues to explore how to leverage existing State insurance activities in several areas, including licensure, solvency, and network adequacy. The State Exchange Implementation FAQ published on November 29, 2011 provide additional discussion in this area.

Comment: Some commenters suggested that we allow States to have a variety of options under a Partnership Exchange, while other commenters recommended that a standardized set of limited options would be the most effective way to ensure that a Partnership does not create significant administrative burden.

Response: We recognize that an unlimited number of options for organization of a Federally-facilitated Exchange would be extremely complicated to implement and operate, and believe that the options and flexibilities HHS has laid out will balance flexibility with administrative feasibility.

Comment: Some commenters urged HHS not to allow a State to operate only an individual market or SHOP component of an Exchange through a Partnership.

Response: We believe that splitting the SHOP through a Partnership is not a reasonable or feasible option at this time and have not established that as an option.

CONSUMER INFORMATION

Comment: With respect to the provider directory standard in proposed §155.205(b)(1)(viii), a number of commenters recommended that an Exchange provide an up-to-date consolidated provider directory to enable consumers to see which QHPs a given provider participates in from the Exchange Web site. A few other commenters advised HHS to ensure that the Exchange link to a QHP's Web site provider directory for timely and accurate information. Another commenter asked that the final rule clarify that an online directory meets the standard in paragraph (b)(1)(viii), and that Exchanges do not need to provide paper provider directories.

Response: HHS considered the comments received on the Internet Web site's display of provider directory information. To maintain maximum flexibility for an Exchange, the final rule does not specify whether an Exchange should collect a consolidated provider directory or link to a QHP's Web site in order to meet the standards in paragraph (b)(1)(viii). Additional comments on the provider directories are addressed in §156.230.

NAVIGATORS

Comment: We requested comment on standards related to training in the proposed rule and received a large number of responses on this issue. Several commenters suggested that HHS establish minimum standards for Navigator training, including templates for the format and content of Navigator training materials. Some commenters suggested that Navigators be trained to specifically serve the needs of varying groups, including but not limited to: low-income individuals; limited English proficient individuals; tribal organizations; individuals with disabilities; and individuals with mental health or substance abuse needs. Other commenters urged HHS to defer to States in relation to Navigator training and standards beyond those established in the proposed rule.

Response: Due in part to the sensitivity of information that will be available to Navigators, newly added §155.210(b)(2) of the final rule directs Exchanges to establish training standards that apply to all persons performing Navigator duties under the terms of a Navigator grant, including both paid and unpaid staff of entities serving as Navigators. We plan to issue training model standards in forthcoming guidance to supplement, not replace, the need for Navigator applicants to demonstrate that they can carry out the minimum duties of a Navigator as listed in §155.210(e) of the final rule. We encourage Exchanges to conduct ongoing and recurring training for Navigators.

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Comment: Many commenters proposed that States, Exchanges, or HHS should set appropriate certification or licensing standards for Navigators. A few commenters proposed that HHS set a broad range of certification or licensing standards that States or Exchanges could tailor to meet their own needs, while others suggested specific programs upon which Exchanges could model Navigator certification standards, such as the Medicare State Health Insurance Assistance Programs, ombudsman programs, area agencies on aging, and Promotoras, a community health worker model that has been adopted into many Latino communities in the United States.

Response: We understand and appreciate the concerns of commenters that recommended certification or licensure standards for Navigators; we have finalized in this rule a primary role for Exchanges and States in the creation, development and enforcement of such standards. We encourage Exchanges to set certification or licensing standards for Navigators in accordance with the guidelines set forth in this final rule and any State law(s) that may apply. However, without some minimum standards, significant variability may develop that could put consumers at a disadvantage. Therefore, HHS has added §155.210(b)(2) of the final rule to indicate that Exchanges must develop a set of training standards to ensure Navigator competency in the needs of underserved and vulnerable populations, eligibility and enrollment procedures, and the range of public programs and QHP options available through the Exchange. Additionally, given the policy set forth in §155.210(c)(1)(v) that Navigators comply with the privacy and security standards adopted by the Exchanges under §155.260, the training standards must also ensure that Navigators are trained in the proper handling of tax data and other personal information. HHS also plans to issue additional guidance on the model standards for Navigator training and best practices for certification or licensure standards.

Comment: A majority of commenters proposed that Navigators should not have to hold an agent or broker license or errors and omissions liability coverage in order to be certified or licensed as a Navigator. Conversely, a small number of commenters suggested that Navigators hold an agent or broker license as well as errors and omissions coverage and that Navigators should be subject to the same licensing and education standards established for agents and brokers.

Response: We accept the commenters' suggestion that States and Exchanges should not be able to stipulate that Navigators hold an agent or broker license, and we clarify that States or Exchanges are prohibited from adopting such a standard, including errors and omissions coverage. "Agent or broker" is defined in §155.20 as "a person or entity licensed by the State as an agent, broker, or insurance producer." Thus, establishing licensure standards for Navigators would mean that all Navigators would be agents and brokers, and would violate the standard set forth §155.210(c)(2) of the final rule that at least two types of entities must serve as Navigators. Additionally, we do not think that holding an agent or broker license is necessary or sufficient to perform the duties of a Navigator as these licenses generally do not address training, among other things, about public coverage options.

Comment: Regarding §155.205(b)(2), a majority of commenters supported the provision suggested in the proposed rule to establish that at least one of the two types of entities eligible to serve as Navigators must be a community or consumer-focused non-profit entity (76 FR 41877). Several commenters recommended expanding the list of categories to include additional entities. A small number of commenters thought States should have sole discretion over the determination of which entities may serve as Navigators. One commenter favored allowing States to determine the need for a Navigator program; another recommended using licensed insurance professionals to facilitate enrollment; and a small number stated that the standard that two types of entities must be Navigators was unnecessary and counterproductive.

Response: We accept the commenters' suggestion that at least one entity that serves as a Navigator should be a community or consumer-focused non-profit, and have amended §155.210(c)(2) to convey this policy. The categories listed in the final rule in §155.210(c)(2) represent a broad spectrum of organizations, but are not meant to be an exhaustive list of potential Navigators. As stated in §155.210(c)(2)(viii), other public or private entities that

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meet the standards of the Navigator program may be eligible to receive a Navigator grant. When establishing a Navigator program, Exchanges should plan to have a sufficient number of Navigators available to assist qualified individuals and employers from various geographic areas and with varying needs who wish to enroll in QHPs within their State.

Comment: One comment stated that a Navigator should never be an individual person, but instead a verifiable and appropriately regulated entity or institution.

Response: We believe that the standard to meet licensure and certification standards in §155.210(c), and the prohibition against health insurance issuers, and those who receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment in the Exchange, from receiving Navigator grants in §155.210(d) will serve as sufficient regulation against fraud by individuals or organizations who qualify to be Navigators.

Comment: Many commenters discussed the impact that Navigator compensation, or “consideration” as used in §155.210(c)(2) of proposed rule, would have on a Navigator’s obligation to provide impartial assistance and avoid conflicts of interest. The majority of these commenters recommended that Navigators be prohibited from receiving compensation from health insurance issuers for enrolling individuals in plans outside of the Exchange, while some commenters expressed support for the compensation restrictions as proposed. Several commenters requested that a prohibition on enrollment-based compensation from a health issuer not prohibit Navigator programs from utilizing Medicaid or CHIP funds for appropriate Navigator activities. Some commenters also recommended that such a prohibition not preclude Navigators from receiving grants from health insurance issuers for activities unrelated to enrolling individuals in plans inside of the Exchange. Many commenters requested clarification of the term “consideration.”

Response: Prohibiting Navigators from receiving compensation from health insurance issuers for enrolling individuals in health insurance plans is an important way to mitigate potential conflict of interest, and we have amended the final rule in §155.210(d)(4) to establish this prohibition. Permitting Navigators to receive such compensation would introduce a financial conflict of interest which would run counter to the focus of the Navigator program as a consumer-centered assistance resource. We clarify that this prohibition applies to Navigators broadly, including staff of an entity serving as a Navigator or entities that serve as Navigators for one Exchange while simultaneously serving in another capacity for another Exchange. Additionally, we clarify that this prohibition does not preclude Navigators from receiving grants from the Exchange that are funded through the collection of user fees.

We note that the final rule does not inherently prohibit Navigators from receiving grants and other consideration from health insurance issuers for activities unrelated to enrollment into health plans, although we remain concerned that such relationships – financial and otherwise – may present a significant conflict of interest for Navigators. We urge Exchanges to consider the ramifications of such relationships when developing conflict of interest standards for their Navigator programs.

We also clarify that “consideration,” as used in §155.210(d)(4) of the final rule, should be interpreted to both mean financial compensation – including monetary or in-kind of any type, including grants – as well as any other type of influence a health insurance issuer could use, including but not limited to things such as gifts and free travel, which may result in steering individuals to particular QHPs offered in the Exchange or plans outside of the Exchange.

Comment: Many commenters supported the Navigator duties proposed in §155.210(d), and some suggested that the duty to “maintain expertise in eligibility, enrollment, and program specifications” should include knowledge about Exchanges, Medicaid, CHIP, other private and public health insurance programs, appeals, and rules related to cost-sharing. Other commenters recommended other specific minimum duties for Navigators, including

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providing information about total plan costs, assisting consumers with applying for advance payments of premium tax credit and other cost-sharing reductions, and making consumers aware of the tax implications of their enrollment decisions.

Response: The final rule maintains most of the duties set forth in the proposed rule, except as re-assigned as §155.210(e) and reflecting edited language in §155.210(e)(3). The change in §155.210(e)(3) is a technical correction to ensure consistency with our clarification in §155.205(b)(7). Similarly, a Navigator facilitating a QHP selection for a consumer initiates the enrollment process, which is then conducted by the Exchange. Section 155.400(a)(2) of this final rule describes the subsequent step in the enrollment process, and directs Exchanges to transmit the QHP selection to the appropriate QHP issuer.

We believe that Navigators should make consumers aware of the tax implications of their enrollment decisions, and consider this to be included in §155.210(e)(1) of the final rule. Navigators should also provide information about the costs of coverage and assist consumers with applying for advanced payments of the premium tax credit and cost-sharing reductions, and we clarify that §155.210(e)(2) and §155.210(e)(3) of the final rule are intended to include such activities. We also clarify that such assistance could result in an individual receiving an eligibility determination for other insurance affordability programs. Additionally, we note that Exchanges can establish additional minimum Navigator duties and encourage Exchanges to determine whether additional Navigator duties may be appropriate.

AGENTS AND BROKERS

Comment: A number of commenters sought clarification on whether and how the involvement of agents and brokers described in proposed §155.220 may serve as Navigators under §155.210. Many commenters sought further clarification as to the distinction between the role of agents or brokers and the role of Navigators in the Exchange.

Response: In general, the responsibilities of a Navigator differ from the activities that an agent or broker. For example, the duties of a Navigator described under §155.210(e) of the final rule include providing information regarding various health programs, beyond private health insurance plans, and providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. Moreover, any individual or entity serving as a Navigator may not be compensated for enrolling individuals in QHPs or health plans outside of the Exchange; as such, an agent or broker serving as a Navigator would not be permitted to receive compensation from a health insurance issuer for enrolling individuals in particular health plans. That said, nothing precludes an Exchange's Navigator program from including agents and brokers, subject to the conditions of §155.210.

Comment: Several commenters expressed support for the proposed §155.220(a) and the level of flexibility it affords State Exchanges to determine the role of agents and brokers and web-based entities in the Exchange marketplace. Several commenters specifically expressed support for the manner in which the accompanying preamble to the proposed rule described the Exchange as accountable for the actions of web-based entities.

Response: We accept the recommendation that Exchanges have the flexibility to determine the role of agents and brokers, including web-based entities, in their marketplaces. We have retained the language in §155.220(a), which codifies the statutory flexibility that States may determine whether agents and brokers may enroll individuals, employers and employees in QHPs and provide assistance to qualified individuals applying for financial assistance.

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Comment: HHS received several comments urging us to prohibit agents and brokers, including web-based brokers, from performing eligibility determinations.

Response: The Exchange must perform eligibility determinations, subject to the standards and flexibility outlined in subpart D of this final rule. We note that an individual cannot enroll in a QHP through the Exchange, nor can a QHP issuer enroll a qualified individual in a QHP through the Exchange, unless such individual completes the single streamlined application to determine eligibility as described in §155.405 and is determined eligible. We have clarified in §156.265(b)(1) that that enrollment by QHP issuer may be considered “enrollment through the Exchange” only after the Exchange notifies the QHP issuer that the individual has received an eligibility determination, the individual is qualified to enroll in a QHP through the Exchange, and the Exchange transmits enrollment information to the QHP issuer consistent with §155.400(a). In §155.220(c)(1), we also specify that an

individual can be enrolled in a QHP through the Exchange with the assistance of an agent or broker only if the agent or broker ensures that the individual completes the application and eligibility verification process through the Exchange Web site. We acknowledge and clarify that nothing in this final rule prohibits a QHP issuer from selling QHP coverage directly or through an agent or broker, so long as the standards of §156.255(b) are met; however, such sales and enrollment are not “enrollment through the Exchange” and such enrollees are not eligible for the benefits that are tied to enrollment through the Exchange.

Comment: With respect to proposed §155.220(a), several commenters sought clarification of the role agents and brokers in enrolling individuals in QHPs. Several commenters urged us to strengthen the role of agents and brokers in the Exchange by further clarifying their ability to participate in the Exchange marketplace. With respect to the preamble discussion of web-based entities, several commenters urged HHS to permit web-based entities in particular to enroll individuals eligible for advance payments of the premium tax credit and cost-sharing reductions in QHPs so that such individuals may have access to the same avenues for QHP enrollment as those individuals who do not receive financial assistance.

Response: We accept the recommendation that we provide Exchanges with discretion to leverage the market presence of agents and brokers, including web-based entities that are licensed by the State (web-brokers), to draw consumers to the Exchange and to QHPs. We have amended §155.220 to include minimum standards for the process by which an agent or broker may help enroll an individual in a QHP in a manner that constitutes enrollment through the Exchange. This is intended to include traditional agents and brokers, as well as web-brokers. This process must include the completion by the individual of a single streamlined application to determine eligibility through the Exchange’s Web site, as described in §155.405; the transmission of enrollment information by the Exchange to the QHP issuer to allow the issuer to effectuate enrollment of qualified individuals in the QHP; and any standards set forth in an agreement between the agent or broker and the Exchange. We note that there may be various means a State may choose to integrate agents, brokers and web-brokers consistent with the standards described in this section for enrollment through the Exchange. Agents and brokers may assist individuals enrolling directly through the Exchange Web site and may serve as Navigators consistent with standards described in §155.210. We also afford Exchanges discretion to allow agents and brokers to use their own Web sites to assist individuals in completing the QHP selection process, as long as such a Web site conforms to the standards identified in §155.220(c)(3). While Exchanges that pursue this option would be able to leverage the market presence of web-brokers in drawing consumers to the Exchange and QHPs, we note that the Exchanges will also have to share data and coordinate closely with such entities.

Comment: With respect to proposed §155.220(a), many commenters urged us to set standards around the use of agents and brokers in order to ensure certain consumer protections. These suggestions included having Exchanges to monitor and oversee all agents and brokers enrolling individuals and small groups in QHPs; establishing provisions to mitigate agents’ and brokers’ incentives to steer consumers to enroll in certain QHPs or to non-QHPs; setting uniform commissions for agents and brokers or establishing that issuers must compensate agents and brokers the same amount for Exchange and non-Exchange plans; prohibiting commissions for agents and brokers

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in the Exchange altogether; establishing certain disclosures by agents and brokers, including disclosure of their commission and whether or not the agent or broker has been the subject of any sanctions; applying privacy and confidentiality standards to agents and brokers; prohibiting Exchanges from directing individuals or small groups to enroll only through an agent or broker; prohibiting advertising by agents or brokers; or prohibiting agents and brokers from the Exchange altogether.

A number of commenters also expressed concern regarding the role of third-party web-based entities enrolling individuals in QHPs. Several commenters emphasized that such external entities should be held to the same standards as the Exchange; should not be permitted to perform eligibility determinations; or should be held to certain consumer protection standards to prevent steering.

Response: We recognize the importance of consumer protections with respect to agents and broker interactions. We also recognize the States' role in licensing and overseeing agents and brokers and have allowed States to determine which standards would apply to agents and brokers acting in the Exchange, if the State chooses to permit agents and brokers to enroll individuals and small groups in QHPs through the Exchange. In order to address commenters' concerns while maintaining the State's primary role in overseeing agents and brokers, we have added paragraph (d) to ensure that agents and brokers must comply with an agreement with the Exchange under which the agent or broker would comply with the Exchange's privacy and security standards that are adopted consistent with §155.260 and §155.270. We have also added paragraph (e) to ensure that agents and brokers comply with applicable State law.

We also recognize that the role of web-brokers may evolve upon implementation of Exchanges, and that Exchanges may seek to involve web-brokers in the enrollment process using a variety of technologies. We have set forth standards in this rule to ensure that consumers enjoy a seamless experience with appropriate consumer protections if an Exchange chooses to allow web-brokers to participate in Exchange enrollment activities. In order to address commenters' particular concerns around the role of web-based entities, we note that eligibility determinations must be conducted by the Exchange and enrollment information must be transmitted to the QHP issuer by the Exchange. We have added paragraph (c)(3) to §155.220 to ensure that Web sites used by agents or brokers to enroll individuals in a manner that constitutes enrollment through the Exchange provide consumers with access to the same information as they would if they used the Exchange Web site instead. Based on several commenters' suggestion that we address agents' and brokers' ability to steer or incentivize consumers to enroll in certain QHPs, and commenters' general concern about the fact that the existence of such Web sites may confuse consumers, we have inserted standards under paragraph (c)(3) of this section to prevent such web-brokers from providing financial incentives and to establish that such Web sites must allow consumers to withdraw from the web-broker's process and use the Exchange Web site instead at any time. Furthermore, the web-brokers would also be subject to the standards inserted under paragraph (d) and (e) regarding compliance with an agreement with the Exchange and State law, respectively.

Comment: Some commenters recommended that proposed §156.265(b) prohibit agents, brokers and web-based entities from performing eligibility determinations.

Response: An agent, broker, or web-based entity cannot perform eligibility determinations as part of enrollment through the Exchange. We note that section (b)(2)(A) of 36B of the Internal Revenue Code as amended by the Affordable Care Act establishes that an individual must enroll "through the Exchange" in order to access advance payments of the premium tax credit and cost-sharing reductions. However, in §155.220(c)(1), we specify that an individual can be enrolled in a QHP through the Exchange with the assistance of an agent or broker only if the agent or broker ensures that the individual receives an eligibility determination through the Exchange Web site.

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NOTICES

Comment: While some commenters expressed support for the proposed §155.230(c) that the Exchange review notices on an annual basis, other commenters were concerned about the burdensome and costly nature of an annual review. Some commenters instead suggested that such a review occur every three years or “periodically.” Several commenters recommended that Exchanges have flexibility in how they implement provision of notices and provided specific examples (that is, flexibility in content), while one commenter advised that Federal standards should provide a floor for notices but not diminish stronger standards that the State may have for notices. Commenters who supported an annual review also suggested that Exchanges seek consumer and stakeholder input as notices are developed and changes to notices are made. Some commenters also expressed support for or sought clarification related to how a State must consult with HHS when changes are made to notices, particularly regarding the scope of such a consultation. A few commenters suggested that notices should be reviewed annually as a part of the recertification process.

Response: In §155.230(c) of the final rule, we revise the language from the proposed rule to provide that the Exchange must re-evaluate the appropriateness and usability of applications, forms, and notices without specifying the interval at which such review must occur. Due to commenters’ concerns about the feasibility and burden of an annual review and the request for flexibility regarding notices implementation, we removed the standard that this review must occur on an annual basis. We anticipate that the model notices developed by HHS will help to ensure that Exchanges include the appropriate content for their notices and reduce administrative burden and cost to Exchanges. We will consider the feasibility of reviewing notices, and notably any proposed changes made to notices, and will consider stakeholder input, particularly Exchanges and State Medicaid programs, as the model notices are developed.

PRIVACY

Comment: Many commenters recommended that the privacy and security standards in proposed §155.260 apply to application assisters, Navigators, contractors, other individuals who have access to PII gathered from individuals or available through an Exchange. One commenter asserted that the final rule should clearly affirm the obligation of these parties to abide by all Federal confidentiality and privacy laws.

Response: Individuals who have agreements with an Exchange that can collect, use, or disclose PII as part of their Exchange-related activities should comply with the final rule’s privacy and security standards. However, we do not believe the Affordable Care Act grants the Secretary the authority to regulate all individuals and entities directly. Such authority is limited to the Exchange, who can impose these standards on individuals and entities that enter into agreements with the Exchange, such as contractors, agents, and brokers, and HHS grantees, such as Navigators. We have added §155.260(b) of the final rule, which ensures that Exchanges impose privacy and security standards that are the same or more stringent than the privacy and security standards in §155.260(a) as a condition of the agreement with other individuals or entities that will receive information through the Exchange.

ELIGIBILITY REDETERMINATIONS

Comment: Of those entities that commented on the process for handling changes during the benefit year described in proposed §155.330, a number suggested limiting the scope of changes on which enrollees must report; these commenters stated that requiring reporting of any and all changes potentially impacting eligibility would substantially increase the administrative burden on both the Exchange and on enrollees. Many commenters recommended clarifying that an enrollee in a QHP who is not receiving advance payments of the premium tax

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credit or costsharing reductions would not be required to report changes in their household income or access to minimum essential coverage, as these are not considered when financial assistance is not present. Other commenters suggested limiting the reporting of changes in income; some recommended that enrollees be allowed and encouraged, but never required, to report changes in income, while others were in favor of establishing a threshold for the reporting of income changes. Generally, those commenters who suggested limiting the changes that individuals must report also suggested that enrollees should be encouraged but not required to report all other changes impacting eligibility, such as changes in income and family size.

Response: In response to commenters' suggestions, we have altered §155.330 in this final rule regarding the policy of reporting of changes during the benefit year. First, we clarify that the Exchange may not require an enrollee who did not request an eligibility determination for insurance affordability programs to report changes related to eligibility for insurance affordability programs, including changes in income or access to minimum essential coverage. We clarify that that we mean an enrollee who, as of his or her most recent interaction with the Exchange, has not requested an eligibility determination for insurance affordability programs. In response to comments regarding which changes an enrollee must report, we amended the regulation text in the final rule to reflect different standards for changes related to income. As a result, we maintain that an individual must report a change related to eligibility for enrollment in a QHP through the Exchange (that is a change in residence, incarceration or citizenship and lawful presence) within 30 days of such change; however, we allow the Exchange to establish a reasonable threshold below which an individual is not required to report a change in income. We believe that allowing the Exchange to limit the changes the enrollee must report will reduce confusion for enrollees and administrative burden on the Exchange, while still ensuring that significant changes are captured. With that said, we clarify that this provision does not allow the Exchange to not process changes in income that are reported by enrollees, regardless of whether they meet the threshold.

ENROLLMENT FORM AND ENROLLMENT PERIOD

Comment: A handful of commenters suggested that an Exchange could fulfill the standard to accept applications in person in accordance with proposed §155.405(c)(2) through its Navigator program. These commenters stated that in-person assistance may be burdensome for the States, but Navigators are a natural venue for such assistance.

Response: An Exchange has flexibility in how it structures its Navigator program and may use such a program to meet the standard for in-person application filing and to provide assistance to individuals applying for coverage through the Exchange.

Comment: Several commenters requested more State flexibility with respect to the enrollment periods identified under proposed §155.410 and §155.420. The commenters recommended States have flexibility to set their own enrollment periods and effective dates, especially those States already operating Exchanges. A few commenters requested State flexibility to extend enrollment periods, particularly for vulnerable populations.

Response: Section 1311(c)(6) of the Affordable Care Act specifically directs the Secretary to provide for initial, annual and special enrollment periods. In both the proposed and final rule, we have tried to provide State flexibility while adhering to our responsibility under the statute to establish the enrollment periods identified under section 1311(c). Therefore, we have proposed and finalized in this rule the minimum uniform enrollment periods across all Exchanges, including a special enrollment period for individuals experiencing an exceptional circumstance.

Comment: Almost all commenters supported the proposed start date of October 1, 2013 under proposed §155.410(b) for the initial open enrollment period. One State agency believed it was unrealistic to expect Exchanges to be operational prior to January 1, 2014, given the systems development challenges ahead. A few commenters requested flexibility to begin enrollment, or a "pre-qualification" period before October 1, 2013.

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Commenters recommended an initial open enrollment period lasting as few as two months and as long as three years. The majority of commenters recommended a six-month initial open enrollment period, ending on March 31, 2014, one month later than in the proposed rule. Most commenters suggested that the longer initial open enrollment period would allow more time for individuals and families to learn about their coverage options, and more time for them to select a QHP. Finally, commenters recommended that individuals who enroll during the initial open enrollment period be permitted to change plans at least once without penalty during the Exchanges' first year of operation.

Response: In this final rule, we maintain the start date of October 1, 2013 for the start of the initial open enrollment period. Although coverage will not be effective until January 1, 2014, we believe that individuals and families need time to explore their coverage options and QHPs need time to process plan selections. We have extended the initial open enrollment period by one month – from February 28, 2014 to March 31, 2014. HHS's experience with the initial open enrollment period for Medicare's Prescription Drug Benefit Program supports an extended period. We have not extended the initial open enrollment period past March 31 in order to limit the risk of adverse selection, as expressed by commenters.

Comment: Several commenters representing State agencies and health insurance issuers expressed concern about effective dates proposed in §155.410(c). The commenters asserted that the specified minimum of eight days between plan selection and coverage effective date was too short, and that they needed as many as 30 days to make coverage effective. Commenters recommended that we ensure there is sufficient lag time between QHP selection and effective dates.

Response: Based on the commenters' recommendation to allow more time between QHP selection and effective dates, we have modified the proposed QHP selection cutoff date in this final rule from the 22nd to the 15th of the month. As described in more detail below, we have also provided flexibility for Exchanges to work with QHP issuers to make coverage effective more quickly.

Comment: Many commenters, namely consumer and patient advocates, were concerned that the proposed effective dates under §155.410(c) and §155.410(f) would lead to coverage gaps for individuals losing coverage mid-month. The commenters offered alternative effective dates, including twice monthly, continuous, and retroactive. Many commenters responded positively to our solicitation for comments on whether to allow mid-month or flexible effective dates for qualified individuals willing to forgo advance payments of the premium tax credit until the 1st of the following month, or who are ineligible for such payments. Others requested that coverage be guaranteed for the 1st of the month for all qualified individuals, even when they select a QHP on the last day of the previous month. Finally, a few commenters recommended printable, temporary insurance cards that individuals could use until the enrollment process was completed.

Response: We recognize the need to minimize coverage gaps, especially for vulnerable populations. However, the suggested alternatives could have negative consequences for Exchanges and QHP issuers, by increasing costs and administrative burden. Because the initial open enrollment period will be the Exchanges' first experience with enrollment, and many newly-eligible individuals will be seeking to enroll at the same time, we believe it is important to maintain administrative processes consistent with health insurance issuers' experience, while at the same time including flexibility for improvement as Exchanges and QHP issuers enhance their capabilities.

In response to commenters' concerns, we have added two new options for earlier initial open enrollment period effective dates in §155.410(c)(2) of this final rule. We have also added the same options for special enrollment period effective dates in §155.420(b)(3) of this final rule. An Exchange may adopt one or both options, provided that it demonstrate to HHS that all of the participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in §155.410(c)(1)(ii) through §155.410(c)(1)(iii). We include this qualification because QHP issuers may need to implement administrative changes to accommodate the modified effective dates. We note

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that individuals seeking the earlier effective date described in §155.410(c)(2)(i)(B) must waive the benefit of advance payments of the premium tax credit and cost-sharing reductions if coverage is effectuated mid-month. However, individuals do not have to accept this earlier effective date. As an example, if all QHP issuers in State X agree that they can effectuate coverage eight days after QHP selection, and individual A makes a QHP selection on January 17th, 2014, the issuer may effectuate the coverage on January 25th, provided that the individual is willing to forgo advance payment of the premium tax credit for the seven days of coverage in January.

Comment: In response to our request for comment in the preamble of proposed §155.410(d) on whether we should set a standard for the timing of the annual open enrollment notice, most commenters supported a standard for the Exchange to send a notice of annual open enrollment 30 days prior to the start of enrollment, though one patient advocacy organization recommended 60 days' notice.

Response: We have added a standard in this final rule in §155.410(d) that the Exchange send the notice no earlier than September 1st, and no later than September 30th of each year, in preparation for an October 15th annual open enrollment. Because subpart D of this final rule directs the annual redetermination notice to be combined with the annual open enrollment notice, we have allowed a 30 day window for States to produce and mail the combined notice. We believe that 60 days is too far in advance of annual open enrollment for enrollees to remember to take action.

Comment: In response to our request for comment on the issue of auto-enrollment, several State agencies supported the rule's lack of auto-enrollment standards, because they perceived it as permitting flexibility. A few commenters explicitly opposed auto-enrollment. The remainder of the commenters supported the option for Exchanges to auto-enroll individuals who become unintentionally uninsured, but they expressed concerns over limiting an individual's right to choose his or her own QHP. Most commenters recommended that an Exchange send multiple notices to individuals facing potential auto-enrollment, and provide a 30 to 90-day period for individuals to change QHPs after being auto-enrolled.

Response: We have established flexibility for the Exchange to auto-enroll qualified individuals when the Exchange demonstrates to HHS that it has good cause to do so under §155.410(g) of this final rule. We expect to issue guidance outlining generally the circumstances under which HHS will approve Exchange auto-enrollment. HHS will also monitor auto enrollment practices across Exchanges for appropriateness and effectiveness.

SPECIAL ENROLLMENT PERIODS

Comment: Many commenters expressed general concerns about adverse selection. The commenters requested that individuals be limited to only one special enrollment period per month, and recommended limiting individuals' movement between QHPs during some or all special enrollment periods.

Response: While we recognize the need to limit the risk of adverse selection, we do not believe it is necessary to limit special enrollment periods, given the nature of the types of special enrollment periods. We received similar comments on the issue of limiting enrollees' movement between QHPs during open and special enrollment periods, and have responded to them in preamble for §155.410(e) and §155.420(f), respectively.

Comment: Several commenters recommended 30-day special enrollment periods, under proposed §155.420(c), consistent with the HIPAA standard, while several others supported the proposed 60-day periods, consistent with several special enrollment periods under the Medicare Prescription Drug Benefit Program. Several commenters recommended extending the periods for as long as 120 days, particularly for vulnerable populations.

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Response: Regarding the length of Exchange special enrollment periods outlined in §155.420(c) of the final rule, our experience with the Medicare Prescription Drug Benefit program informs our decision to adopt the 60-day window, which generally conforms with several special enrollment periods in the Medicare Prescription Drug Benefit Manual that extend for two months beyond the month of a triggering event. We believe that this approach will give consumers the time they need to explore their coverage options through the Exchange, following a change in life circumstances. We have not extended the length of the enrollment period due to concerns about adverse selection. Exchanges may grant special enrollment periods in advance of a triggering event, so long as the effective date of coverage does not occur before the triggering event, and so long as there is no overlap in coverage for which the individual receives advance payments of the premium tax credit or cost-sharing reductions while enrolled in other minimum essential coverage.

Comment: Several commenters, namely health insurance issuers, asked HHS not to add any additional special enrollment periods to those listed in proposed §155.420(d). Several other commenters recommended additions to the rule, including special enrollment periods for certain changes in plan provider networks, exhaustion of the COBRA disability extension, denial of services due to a provider's moral or religious opposition, and pregnancy.

Response: The Affordable Care Act establishes that Exchange special enrollment periods follow those specified in section 9801 of the Code and part D of title XVIII of the Act. The additional special enrollment periods suggested by commenters are not specified in the Code, nor are they similar enough to those available under the Act for HHS to include them in the final rule. Therefore the final rule implements the statute without additions. We note, however, that the special enrollment period for exceptional circumstances in §155.420(d)(9) of this final rule provides an additional opportunity for enrollment when unforeseen circumstances arise.

Comment: Regarding proposed §155.420(d)(1), for individuals losing minimum essential coverage, many commenters sought clarification about what coverage it included. Several commenters questioned whether an individual would be eligible for this special enrollment period if offered COBRA, and how the policy related to proposed §155.420(e) and the Treasury proposed rule. Many commenters also sought assurance that loss of coverage included loss of coverage through Medicaid, CHIP and the BHP. One health insurance issuer recommended that loss of Medicaid or CHIP only be included if it is the result of a reported change in household income to an Exchange that disqualifies the individual or family from Medicaid or CHIP. A few health insurance issuers supported the language in proposed §155.420(d)(1) specifying loss of "minimum essential coverage," as opposed to any coverage, because it limits adverse selection by prohibiting individuals from dropping their substandard coverage when they became sick or injured. A few other commenters recommended Exchange flexibility to offer special enrollment periods to individuals losing non-minimum essential coverage.

Response: The Exchange establishment proposed rule preamble provides several examples of loss of coverage, including loss of Medicaid and CHIP, in accordance with section 9801(f)(3) of the Code. The examples remain accurate for this final rule. We have further clarified §155.420(e) in this final rule by specifying that loss of coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). This clarification aligns the special enrollment more closely with section 9801 of the Code. An individual could lose eligibility for Medicaid or CHIP as a result of a reported change in household income, or as a result of other circumstances.

Qualified individuals are eligible for the loss of minimum essential coverage special enrollment period described in §155.420(d)(1), even if offered COBRA. The Treasury proposed rule defines COBRA coverage as minimum essential coverage only if the individual enrolls in such coverage. Therefore, if an individual elects and enrolls in COBRA, he or she cannot qualify for this special enrollment period until exhausting COBRA, as described in §155.420(e), but if the individual does not elect COBRA, he or she may take advantage of the Exchange special enrollment period. Regarding the recommendation to allow Exchanges to offer this special enrollment period to individuals losing non-minimum essential coverage, we have not adopted this policy in deference to the status the statute gives to minimum essential coverage.

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Comment: Regarding the special enrollment period for individuals gaining or becoming a dependent as described in proposed §155.420(d)(2), many commenters made arguments for either limiting or for expanding the list of life events through which an individual becomes or gains a dependent. Several commenters recommended adding domestic partners, partners joined in civil unions, or dependents gained through guardianship. Several other commenters recommended that State law determine the types of dependents allowed.

Response: For the same reasons as described above, we do not find legal grounds for expanding the definition of dependents for the purpose of the special enrollment period described in §155.420(d)(2). Therefore, we retain this provision in this final rule without modification.

Comment: Regarding the special enrollment periods for errors in enrollment, and for contract violations, outlined in proposed §155.420(d)(4) and §155.420(d)(5) respectively, several commenters sought clarification on the kinds of events that would trigger them, and how individuals would demonstrate such events. A few health insurance issuers recommended appeals processes, either in conjunction with, or instead of these special enrollment periods. They recommended various limitations on the special enrollment period for errors in enrollment, and one commenter recommended that it be removed from the rule all together. Several other commenters sought clarification as to which entities are considered “agents of the Exchange or HHS,” and recommended that at least QHPs be included as such agents.

Response: The special enrollment periods in §155.420(d)(4) and §155.420(d)(5) of this final rule are generally consistent with those offered under the Medicare Prescription Drug Program, as noted above. We expect Exchanges to develop guidance and standard operating procedures for considering requests for this special enrollment period. We encourage Exchanges to do so in consultation with health insurance issuers and other stakeholders. HHS may also provide future guidance to help Exchanges in operationalizing this special enrollment period.

Comment: Regarding the special enrollment period for individuals newly eligible or ineligible for advance payments of the premium tax credit, outlined in proposed §155.420(d)(6), a couple of commenters sought clarification as to whether an individual newly released from incarceration would qualify for the special enrollment period, even if he or she did not qualify for advance payments of the premium tax credit or did not experience a change in cost-sharing reductions.

Response: Qualified individuals newly released from incarceration are eligible for the special enrollment period afforded to individuals who gain access to a new QHP as a result of a permanent move, as outlined in §155.420(d)(7) of this final rule and as described further below.

Comment: A couple of commenters recommended that the special enrollment period for individuals newly eligible or ineligible for advance payments of the premium tax credit, outlined in proposed §155.420(d)(6), clarify that individuals may not qualify for this special enrollment period if they become eligible for an increase or decrease in their existing advance payments of the premium tax credit. Conversely, one commenter responding to HHS’ request for comment recommended that this kind of special enrollment period be offered to all individuals who experience a change in income resulting in recalculation of their advance payments of the premium tax credit.

Response: The final rule specifies that individuals may only qualify for this special enrollment period in §155.420(d)(6) if they are newly eligible or ineligible for advance payments of the premium tax credit, and we do not believe clarification is necessary, as requested by the commenter. That said, if an individual experiences a change in his or her existing payments of the premium tax credit in tandem with a change in level of cost-sharing reductions, the individual could qualify for this special enrollment period.

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Comment: Several commenters recommended that a special enrollment period be triggered by the date of a permanent move described in §155.420(d)(7), while others recommended it be triggered by the date the individual reports the move to the Exchange, with a time-limited time window in which to report it. In cases where an individual's eligibility for employer-sponsored coverage terminates or changes, in response to proposed §155.420(d)(1) and (d)(6) respectively, several commenters recommended that the period be triggered by the date the employee learns of the termination or change. Other commenters recommended that it be triggered by the actual date of the termination of or change in coverage. In cases where an individual becomes newly eligible for advance payments of the premium tax credit or experiences a change in cost-sharing reductions, in response to proposed §155.420(d)(6), several commenters recommended that the period be triggered by the date the individual experienced a change in circumstances, while others recommended it be triggered by the date of the Exchange's official eligibility determination. Several other commenters recommended less structured approaches, such as leaving the trigger up to the consumer with the change in circumstances, or allowing the particular circumstances to dictate the trigger. Many commenters also recommended that individuals be permitted to seek special enrollment periods in advance of a known triggering event.

Response: We expect to issue guidance to help Exchanges determine how to define the triggering events and consider the recommendations received. We believe it is critical to establish a balance between minimizing gaps in coverage and the need to avoid coverage overlaps when premium tax credits are involved. Exchanges may grant special enrollment periods in advance of a triggering event, so long as the effective date of coverage does not occur before the triggering event, and so long as there is no overlap in coverage for which the individual receives advance payments of the premium tax credit or cost-sharing reductions while enrolled in other minimum essential coverage.

Comment: While a few health insurance issuers supported the limits on special enrollment periods outlined in proposed §155.420(f), most commenters either opposed the provision outright, or recommended additional exceptions, such as exceptions for pregnant women, or for the special enrollment periods described in proposed §155.420(d)(2), §155.420(d)(4), §155.420(d)(5), and §155.420(d)(8). One commenter noted that because the special enrollment periods were generally not tied to changes in an individual's health status, they did not pose a risk of adverse selection.

Response: We have removed §155.420(f) from the final rule because special enrollment periods are generally not tied to changes in an individual's health status, and are unlikely to increase the potential for adverse selection. Just as qualified individuals are free to move between metal levels during the initial and annual open enrollment periods, they are also free to do so during special enrollment periods.

TERMINATION OF COVERAGE

Comment: A handful of commenters thought that provisions of section 2703 of the PHS Act were in conflict with the termination provisions contained in the Exchange establishment proposed rule in §155.430(d)(2) because the proposed rule outlined dates of termination when an enrollee gains other minimum essential coverage. Commenters interpreted this to mean that an individual must terminate his or her Exchange coverage and said that issuers cannot terminate an individual's coverage because they gain access to other minimum essential coverage.

Response: We removed language indicating that a QHP must terminate an enrollee's coverage should they gain access to other minimum essential coverage in the final rule. Therefore, we do not believe there is a conflict with section 2703 of the PHS Act. We note, however, that the enrollee would no longer be eligible for advance payments of the premium tax credit or cost-sharing reductions if they have access to other minimum essential coverage.

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Comment: Several commenters requested that CMS put in place “safeguards” so as to minimize or eliminate coverage gaps for individuals who become newly eligible for Medicaid, CHIP, or the BHP. Other commenters requested that individuals not have their Exchange coverage terminated when they become eligible but do not enroll in Medicare. Many other commenters recommended that the final rule state that individuals cannot be automatically terminated from Exchange coverage should they be found eligible for Medicaid, CHIP, or the BHP.

Response: In order to address these concerns, we have added §155.430(d)(2)(iv) to the final rule to specify that if an individual enrolls in Medicaid, CHIP, or the BHP and wishes to terminate his or her Exchange coverage, then the last day of Exchange coverage is the day before such other coverage begins. We note that neither the proposed nor the final rule state that individuals will automatically be terminated from Exchange coverage should they be found eligible for Medicare. We also note that we remove proposed §155.430(d)(4) from this final rule because the provisions are no longer necessary given the termination dates outlined in §155.430(d)(1-6) of the final rule.

Comment: Several commenters noted that the proposed termination effective date in §155.430(d)(3) was inaccurate as it was prospective, when rescission is by definition retrospective.

Response: We removed §155.430(d)(3) in the final rule to eliminate a date of termination for a rescission in accordance with §147.128. The termination of coverage date will vary based on the situation.

Comment: HHS received many comments about enrollment periods in accordance with §155.410 and §155.420, which are summarized and addressed in those sections of the final rule. One commenter remarked specifically on proposed §156.260 and requested that HHS clarify whether a QHP could refuse enrollment to an applicant previously proven to have committed fraud.

Response: A QHP issuer may not refuse enrollment to a new applicant who has previously proven to have committed fraud. We note that section 2703(b) of the PHS Act, with which QHP issuers must comply, includes an exception to the guaranteed renewability standard in certain instances of fraud, but includes no parallel exception for new coverage. We further note that §156.270(a) permits QHP issuers to rescind coverage under certain circumstances.

Comment: A significant number of commenters voiced concerns that the proposed policy in §156.270(d) that directed QHP issuers to pay all appropriate claims during the 3-month grace period would exacerbate adverse selection and increase premiums across enrollees. Several commenters representing the insurance industry specifically noted that under the proposed policy, rates would be built with an assumption that some portion of enrollees would pay months of premium for 12 months of full coverage.

Several alternatives were suggested, such as allowing QHP issuers to pend claims after the first 30 days of non-payment, which would allow the issuer to put a hold on claims until the end of the grace period, at which point such claims would be paid if the premiums were paid, or denied if the premiums were not paid. Another commenter suggested allowing QHP issuers to deny coverage for certain categories of services, such as elective, non-emergency procedures, additions of new household members, or new prescription drugs. Other commenters suggested that each Exchange be allowed to determine the payment policy, and some recommended that Exchanges be responsible for helping to pay outstanding premiums or for seeking payment of outstanding premiums from an individual.

Response: We did not accept the recommendation that each Exchange set its own standard. Advance payments of the premium tax credit are directly tied to the grace period. Thus the grace period’s parameters will have an impact on potential Federal tax liability of consumers and on Federal administration of the advance payments of the premium tax credit. As a result, it is critical that the Federal government establish a uniform grace period policy

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to balance the potential impacts on the consumer's tax liability, coverage liability for issuers and providers, and appropriate administration of advance payments of the premium tax credit.

However, we are persuaded that the proposed standards should be adjusted in this final rule to decrease the opportunities for risk manipulation, adverse selection, and premium increases. In §156.270(d)(1) and (d)(2) of the final rule, we now direct QHP issuers to pay all appropriate claims for services provided during the first month of the grace period. We believe that the first month of non-payment is the month in which an enrollee is the most likely to resume timely payments, and thus is the time period in which it is most important to ensure seamless coverage. As such, issuers should adjudicate claims as they would for any enrollee that pays his or her premium in full. However, we acknowledge that as the amount owed by an enrollee increases during the 3-month grace period, the risk of non-payment increases as well. To decrease the financial risk to issuers, and to individuals as described below, the final rule now permits QHP issuers to pend claims in the second and third months. We note that QHP issuers may still decide to pay claims for services rendered during that time period in accordance with company policy or State laws, but the option to pend claims exists. If the individual settles all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and third months could be denied. The grace period under this final rule represents an extended time for enrollees to catch up on premium payments before coverage is terminated. Several considerations informed this amended approach.

First, the statutory 3-month grace period is substantially longer than many current grace periods and only applies to recipients of advance payments of the premium tax credit, assuming they have paid at least one monthly premium. In light of this fact, a grace period policy that is significantly different from the rest of the market could produce markedly different premiums between the Exchange and non-Exchange markets. The final rule approach helps mitigate these concerns by aligning the grace period claims payment standards more closely with current industry practices.

Second, in accordance with section 36B of the Code, individuals may incur a tax liability for any advance payments of the premium tax credit that are paid on their behalf for a month that such individual did not pay his or her portion of the premium. Under the policy in the proposed rule, an individual would potentially be liable for three months of advance payments of the premium tax credit, which could be substantial in some instances. Given the potential for a large tax liability on the part of enrollees receiving advance premium tax credits that fail to pay their residual premiums to QHP issuers, we believe that a retroactive termination date is appropriate to mitigate excessive individual financial exposure. Under the final rule policy, an individual's financial exposure would be limited to the first month's advance payment of the premium tax credit if the individual did not pay his or her portion of the premium for that month. We have provided several examples below to illustrate how the new grace period policy would work:

Grace Period Examples:

Assumptions for a monthly premium:

- Premium: **\$500**
- Advance premium tax credit share of premium: **\$450**
- Enrollee share of premium: **\$50**
- First month of grace period: **March**
- Individual pays enrollee share of premium for January and February coverage.

Example #1: Individual misses \$50 payment that is due February 28 for March coverage. Individual realizes mistake and pays \$100 on March 31st for March and April coverage, satisfying all obligations for premium payments through the end of March.

- o Issuer adjudicates claims for March consistent with normal practices (that is, for nongrace periods)
- o Individual will have full coverage for March and April
- o Individual has paid full premium for March and April as is eligible for premium tax credit for March and April.

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Example #2: Individual misses \$50 payment that is due February 28 for March coverage and misses \$50 payment that is due March 31st for April coverage. Individual Pays \$150 on April 30 for March, April and May coverage.

- o Issuer adjudicates claims for March
- o Coverage continues for April and May (2nd and 3rd months of the grace period), but:
 - ☑ Providers are notified of the potential for a denied claim
 - ☑ Issuer pends claims for services performed in April and May until individual pays outstanding premiums.
 - ☑ Individual has paid full premium for March, April and May as is eligible for premium tax credit for March, April and May.

Example #3: Same facts as Example #2 except that individual does not pay enrollee's share of premium for March, April or May.

- o Coverage terminated retroactively to March 31
- o Issuer can deny claims for services rendered during April and May. Providers could then seek payment directly from the individual for any services provided during that time.
- o Individual may have additional tax liability attributable to the \$450 for the advance payment of the premium tax credit paid on his or her behalf for March's coverage. The exact amount of additional tax liability would be determined in accordance with the rules for tax credit reconciliation under section 36B of the Code.

Comment: Several commenters supported the proposed standards in §156.270(d) that QHP issuers pay all appropriate claims during the 3-month grace period for enrollees receiving advance payments of the premium tax credit. Commenters said this would protect providers that render services to such enrollees during the grace period. A few commenters were also concerned about the timing of claims, and suggested that QHP issuers be obligated to pay claims based on the date the service was rendered, and not the date the claim was submitted.

Response: We understand that pended claims increase uncertainty for providers and increase the burden of uncompensated care. The obligation to pay all appropriate claims established in the proposed rule was intended to protect providers during an extended grace period. However, given the significant concerns regarding premium increases and the potential tax liability to consumers, we were concerned that this approach did not strike the right balance. Because we share providers' concerns about incurring claims during the grace period that are not ultimately paid, we now establish in §156.270(d)(3) of the final rule that QHP issuers notify providers who submit claims for services rendered during the second and third months of the grace period that any such claims will be pended, and potentially not reimbursed by the QHP issuer if the individual does not settle outstanding premium payments. We believe that there are technology-based approaches to provide this notification. We also clarify in §156.270(d)(1) that the application of the grace period to claims is based on the date the service was rendered, and not the date the claim was submitted.

Comment: Several commenters requested clarification on whether the grace period described in proposed §156.270(d) would be triggered by a full non-payment of premium or a partial non-payment of premium.

Response: The 3-month grace period applies whenever the QHP issuer has received payment of less than the full amount of the enrollee's share of the premium for a given month. It is our understanding that issuers have varying practices related to the triggering of a grace period, with some issuers initiating a grace period for any payment that is not the full premium and others initiating a grace period only if the individual has not submitted an amount above some threshold. However, in order to be consistent with policy related to the advance payments of the premium tax credit, the enrollee must pay the full amount of his or her portion of the premium or the grace period would be triggered.

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Comment: Several commenters voiced concerns about the potential for gaming during the grace period described in proposed §156.270(d). Commenters suggested that we take action to prevent people from habitually paying 9 months of premiums, stopping premium payment for 3 months, and then enrolling in a new QHP to start the process over again. Commenter suggestions included: requiring payment of all outstanding premiums before enrollees can change issuers, enroll in a different QHP, or re-enroll in a QHP; establishing a 60-day waiting period for individuals who have been terminated for coverage due to non-payment of premiums but seeking re-enrollment in another QHP; allowing issuers to seek reimbursement for claims paid during the grace period from enrollee after termination; issuing a late enrollment penalty or establish a pre-existing condition exclusion period for individuals seeking re-enrollment after termination due to non-payment of premiums; prohibiting enrollment in a QHP until the following open enrollment period; prohibiting someone who has been terminated due to nonpayment of premiums from qualifying for a special enrollment period later in the year; imposing penalties for repeat offenders, increasing premiums; allowing QHP issuers to collect the first and last month's premium at the time of application; and finally, limiting grace periods to one year. Other commenters recommended that States have the flexibility to establish their own protections against opportunistic consumer behavior.

Response: We did not adopt the recommendations regarding non-issuance of coverage for individuals who have outstanding premium payments for a previous QHP because we believe that there are implications for rescissions, guaranteed issue, and pre-existing condition policies. HHS will continue to explore options for incentivizing appropriate use of the grace period, either through future rulemaking or in the context of general insurance market reforms. We will also consider the implications for automatic redeterminations and reenrollment in instances where individuals have had their coverage terminated for non-payment of premiums. Gaming will not only affect issuers, but also represents potential for misuse of the advance payments of the premium tax credits. Given the compelling Federal financial stake in grace period, HHS will monitor this issue moving forward and will continue to work on the development of policies to prevent misuse of the grace period.

Comment: Many commenters voiced support of the continued issuance of advance payments of the premium tax credit on behalf of enrollees during the 3-month grace period, as proposed in §156.270(e). Some commenters suggested that if QHP issuers were allowed to terminate coverage retroactively, then QHP issuers should be directed to return the advance payments of the premium tax credits.

Response: We have maintained the proposed rule policy that QHP issuers must continue to receive advance payments of the premium tax credit being paid on behalf of an enrollee in a grace period. In addition, we included in §156.270(e)(2) an instruction for QHP issuers to return advance payments of the premium tax credit for the second and third months of the grace period for individuals who exhaust the grace period without paying outstanding premiums, because such individuals will have their coverage terminated retroactively to the end of the first month of the grace period. We note that, consistent with section 36B of the Code, individuals may owe a tax liability as a result of advance payments of the premium tax credit paid on their behalf during a month in which they did not pay their portion of the premium. Under the final rule, individuals will have a liability as a result of the advance payment of the premium tax credit for the first month of the grace period if they never pay their portion of the first month's premium. If an individual exhausts the grace period without paying all outstanding premiums, QHP issuers can terminate coverage retroactive to the end of the first month of the grace period and deny claims that were pending. An issuer who terminated coverage in this fashion would be obligated to return the advance payments of the premium tax credit made on behalf of the individual for the second and third months of the grace period.

Comment: Some commenters requested clarification of the proposed policy in §156.270(g) regarding whether a partial payment could extend the grace period once it has already been triggered, or if only full payment of all outstanding premiums would allow an individual to resolve a grace period. Commenters supported the resetting of the grace period only when all outstanding payments are made.

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Response: The grace period may only be reset if an individual has paid all outstanding premiums. We believe that a “rolling” grace period that moves the initial date of the grace period in correlation with any payment made by an individual would be not only confusing to consumers but administratively burdensome, particularly in light of the revised payment policy described in paragraph (d). Therefore, in this final rule, we have added language to clarify this policy in §156.270(g). Once a grace period has been initiated by a QHP issuer, the individual has three months to settle all outstanding premium payments, at which time the grace period is either resolved and pended claims are paid or the individual’s coverage is terminated.

Comment: Commenters requested clarification on the proposed policy in §156.270(g) regarding whether a QHP issuer could terminate coverage retroactively to the last date of payment, or whether the termination was prospective from the end of the 3-month grace period. Commenters also requested clarification regarding how advance payments of the premium tax credit and payments to providers would be reconciled if the date of termination were retroactive.

Response: We clarify in final §156.270(g) that if an individual exhausts the grace period without settling all outstanding premium payments, then the QHP issuer can terminate coverage retroactively to the first day of the second month in the grace period. We understand that many States allow issuers to terminate to the last paid date of coverage. In addition, HHS issued rules concerning rescissions of health insurance coverage, under which issuers are permitted to cancel coverage retroactively due to a failure to timely pay premiums (PHS Act section 2712; 45 CFR §147.128). However, the final Exchange standards for QHP issuers add more consumer protections than the generally applicable PHS Act’s standards. During the first month, full coverage will be provided and the QHP issuer will be able to keep the advance payment of the premium tax credit. As a result, we treat the last day of the first month of the grace period as the “last paid date.” We note that the enrollee may be obligated to repay the advance payment of the premium tax credit for the first month in the form of an additional tax liability if the individual does not pay the enrollee’s portion of the premium. For purposes of claims payment, the QHP issuer must treat the first month of the grace period as if the full premium has been paid.

However, the QHP issuer may pursue collection of the individual’s portion of the premium; if the individual pays the unpaid enrollee portion of the premium, the individual would retain the potential to be eligible for the premium tax credit for that month.

SHOP EXCHANGE

Comment: Some commenters requested that, in the case of a State that establishes either a SHOP or an Exchange serving the individual market, but not both, the Secretary certify this as an Exchange in accordance with the Affordable Care Act.

Response: Section 1311(b) of the Affordable Care Act envisions an Exchange that both facilitates the purchase of QHPs and provides for the establishment of a SHOP. We interpret this to mean that a State that fails to fulfill both standards has not established an Exchange in accordance with the Affordable Care Act.

Comment: Some commenters proposed that the SHOP may want to fulfill additional functions outside the scope of the proposed rule in order to offer employers a streamlined experience when managing their employee benefits. These commenters proposed that the SHOP sell other types of insurance, administer COBRA on behalf of participating employers, administer flexible spending accounts, assist small employers in setting up Section 125 plans, and oversee wellness programs.

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Response: Section 155.1000(b) directs the Exchanges to only offer health plans that have been certified as QHPs. We will take these comments into account as we consider future guidance on the offering of other products on the Exchange.

Comment: One commenter discussed the possible use of health reimbursement arrangements from multiple employers as a means of purchasing coverage through the SHOP, aggregating premium contributions from multiple employers to support the employee's purchase of a QHP.

Response: The possible use of different forms of health reimbursement arrangement to purchase coverage through the Exchange or the SHOP is beyond the scope of this final rule, and will be addressed in future guidance.

Comment: We received several comments regarding the proposed exclusion of a premium calculator from the minimum functions for the SHOP in proposed §155.705(a)(3). Some commenters requested that a premium calculator be included, arguing that it assists employers in estimating their total costs. Other commenters noted that instead of providing individuals with an estimation of their cost of coverage after any applicable tax credits or cost sharing reductions, a premium calculator in the SHOP may show employees their premiums after any applicable employer contributions.

Response: We believe that a premium calculator will assist employees in determining their cost of coverage after any applicable employer contribution at little to no additional burden on SHOPS or employers. Therefore, we have added new §155.705(b)(11) in this final rule to clarify that a SHOP must provide a premium calculator to qualified employers. To support States in developing a premium calculator for the SHOP, HHS will provide model computer code.

Comment: We received numerous comments in response to proposed §155.705(b)(2) and (3) on the employee and employer choice provisions. Many commenters supported additional employee choice options, such as offering plans across cost-sharing levels. Other commenters supported more limited employee choice options, often expressing concern that allowing employee choice across cost-sharing levels and even within a cost-sharing level would result in substantial risk selection. Some commenters supported broad employer choice to offer either a wider or narrower range of employee choices, including offering a single QHP. Several commenters suggested that the Affordable Care Act directs the SHOP to give employers the option to offer a single QHP. One commenter suggested initially implementing a pure employer choice model with no employee choice. A few commenters suggested adding a defined contribution model to the list of additional choice options from the preamble to the proposed rule.

Response: We believe the proposed rule appropriately balances the employee choice standards of the Affordable Care Act with flexibility for SHOPS to allow employers greater choice in their plan offering options. Under this model, employees will likely have more plan choice than they currently have in the small group market, where traditionally an employer offers only one plan to its employees. However, nothing in the Affordable Care Act limits a SHOP's ability to offer an employer additional options, including choice across cost-sharing levels. We believe that States and SHOPS are best positioned to strike the proper balance among competing priorities: flexibility, meaningful consumer choice, and protection of the market against risk selection. Thus, we have retained the proposed wording of §155.705(b)(2) and (b)(3) in the final rule.

We also note specifically that the SHOP may allow employers to offer only one plan to its employees. We believe this is supported by section 1312 of the Affordable Care Act, which defines a "qualified employer" as a small employer that elects to make all full-time employees eligible for one or more QHPs offered in the small group market through the Exchange.

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However, we do not believe that this definition establishes that the SHOP must give employers the option to offer only a single plan. With regard to the comments on defined contribution, we note that the method through which an employer offers QHPs to its employees is independent of how the employer chooses to contribute toward the premium cost of coverage.

Comment: One commenter expressed concern that allowing employers to enroll their qualified employees into a single QHP may trigger the application of ERISA, and that the Affordable Care Act was intended to supersede ERISA and provide stronger Federal and State protections to consumers.

Response: Issues on the application of ERISA are within the purview of Department of Labor. In this rule, we clarify that a SHOP may permit employers to offer employees a single QHP.

Comment: Some commenters responding to proposed §155.705 requested clarification regarding procedures for dispute resolution for potential scenarios where the SHOP failed to remit payment to QHP issuers in a timely manner or failed to collect the correct amount from employers. One commenter recommended that proposed §155.720(d) allow a grace period for employees and employers for making premium payments based on evidence of a “good faith” effort.

Response: Because States vary dramatically in statutory and regulatory standards related to non-payment or late payment of premiums, we do not believe a Federal uniform standard and process could effectively prevent such errors. Instead, we encourage SHOPS to create standard operating procedures regarding the payment and remittance of premiums. We also recommend that SHOPS standardize grace periods across QHPs. Because proper oversight of the flow of funds is essential, we direct the SHOP to maintain records and evidence of standard accounting procedures in order to allow for effective auditing of the premium aggregation service.

Comment: Several commenters supported the flexibility of the employer and employee eligibility standards in proposed §155.710, including allowing employers with worksites in the service areas of multiple SHOPS to offer coverage to their employees through the SHOP serving the employees’ worksites. Some commenters requested clarification regarding the coordination of information necessary for the effective implementation of such an eligibility standard. Other commenters requested clarification of how employer groups can calculate premiums in a way that mitigates the effects of age rating in instances where workers obtain coverage through more than one Exchange. Finally, one commenter recommended that employee eligibility be limited to the State in which the employer’s headquarters is located.

Response: We recognize the benefits of allowing employers in multiple States flexibility regarding the SHOPS in which they may opt to enroll. We believe this eligibility standard does not establish a significant level of coordination between SHOPS, though nothing in this section would preclude a SHOP from establishing processes or standard operating procedures to coordinate across service areas. Employers electing to participate in multiple SHOPS must meet the eligibility standards of each SHOP in which they wish to participate and prior to 2017 may not employ more than 100 employees in total in accordance with section 1312(f)(2) of the Affordable Care Act. We acknowledge, however, that standards related to the calculation of premiums in the small group market may vary from State to State in a manner that does not allow differences in cost due to age or location to be spread easily among all employees across State lines.

Comment: Several commenters to proposed §155.720(b) recommended that the final rule afford States further flexibility with respect to enrollment timelines. A few commenters suggested that the SHOP base its timelines on eligibility rules for enrollment on the current market practices. A few commenters recommended that the final rule exclude any target dates and guidelines in §155.720, while another commenter recommended that the rule establish basic guidelines and leave the selection of exact dates to the SHOP. Yet another commenter expressed

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concern that the proposed rule did not provide sufficient flexibility for industries that typically begin coverage on October 1 and recommended that SHOPS be permitted to provide special group enrollment for those groups or amend the rule to afford States greater flexibility to address those circumstances. Conversely, another commenter proposed that §155.720 include target dates and guidelines so that multi-State employers are subject to consistent rules. One commenter supported similar enrollment processes and timelines across QHPs to allow qualified employees the greatest opportunity to select preferred plans and ease administrative burden for multi-State employers.

Response: We believe that §155.720 provides adequate flexibility for a State to develop its process in a way that is most suitable to local situations. Thus, we have not included specific dates in the section and have allowed States flexibility to address specific needs concerns, including current market environment and special industries.

Comment: Many commenters on proposed §155.725(e) recommended that the annual employee open enrollment period last at least 30 days. Some commenters recommended that open enrollment should be standardized for all QHPs. Several supported a notification period for employees before the annual enrollment period. One commenter recommended the employer, and not the SHOP, decide the open enrollment period, and a few commenters recommended the Federal government defer to States to establish open enrollment periods.

Response: We have added language to §155.725(e) of this final rule establishing a standardized open enrollment period of at least 30 days. We note that States will have the flexibility to establish open enrollment periods based on the specific market landscape of the State, and believe that §155.725 provides that flexibility. We further believe that employees should receive a notification in advance of the open enrollment period and have added a standard in new §155.725(f) that the SHOP provide notification to qualified employees of the open enrollment period in advance of the period.

DEFINITION OF SMALL BUSINESS

Comment: Many commenters addressed the question of whether businesses consisting entirely of sole proprietors, 2 percent S-corporation shareholders, and their family members, with no common law employees, should be eligible to purchase coverage through a SHOP. Several commenters were in favor of either including sole proprietors in the definition of eligible employer or allowing States to decide whether to expand their definition of a small group to encompass sole proprietors, stating that this would be analogous to the HIPAA interpretation that States could extend HIPAA protections to more employers. Other commenters suggested deferring to State definitions of small group to avoid confusion and minimize possible differences between the SHOP and the outside market.

Many commenters supported allowing sole proprietors to choose either Exchange individual market or SHOP coverage. Some commenters suggested deferring to State law to allow those States to continue offering small group coverage to sole proprietors. Many other commenters supported the proposed rule's exclusion of sole

proprietors from the small group market, noting that the current rationale for allowing sole proprietors to purchase in the small group market — to provide access to a guaranteed issue product with modified community rating — will not be relevant in 2014 because of individual market reforms. Several of these commenters suggested that the final rule make clear that sole proprietors are eligible for coverage in the Exchange. Two commenters suggested using the COBRA standard to determine the number of employees, which would also exclude sole proprietors. Other commenters who supported the rule as proposed suggested that allowing sole proprietors and S-corporation owners a choice between markets would create possible adverse risk selection.

Response: The Affordable Care Act and the proposed rule base their definitions of “employer,” “employee,” “small employer,” and “large employer” on the definitions in the Public Health Service Act (PHS Act). Section 2791 of the

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PHS Act incorporates by reference the definition of employee in section 3(6) of ERISA. Further, section 2791 provides that an employer is defined by reference to section 3(5) of ERISA. To be an employer eligible to purchase coverage through the SHOP, the employer must employ at least one common law employee. Under 29 CFR 2510.3-3, an employee would not include a sole proprietor or the sole proprietor's spouse.

We find no authority to interpret what constitutes a group health plan differently than set forth in the proposed rule. And, we note that even though both markets will have guaranteed issue and similar rating rules, enrollment of individuals is limited to the annual open enrollment period while enrollment of groups can occur throughout the year. We have therefore retained the definitions in proposed §155.20, and our interpretation of what constitutes a group health plan.

Comment: A number of commenters addressed the issue of how employees should be counted in determining employer size. Commenters noted that States use different methods to calculate employer group size when determining small group market eligibility. Several commenters noted that there are also different Federal methods for determining employer size for different purposes, and that these differing methods may be confusing to small employers. While some commenters supported the proposed approach, to count all full time and part time employees, other commenters suggested specific alternatives, including but not limited to a fulltime equivalent method like that used in section 4980H of the Code, as added by section 1513 of the Affordable Care Act, to determine whether an employer is a large employer; the full-time equivalent method used to determine whether Federal COBRA continuation of coverage standards apply; or counting full-time employees only. Finally, a number of commenters suggested that each Exchange defer to the applicable State's method of determining group size or transitioning from current State methods of counting employees to a Federal method.

Response: CMS has previously issued guidance on determining employer size that includes part-time employees in the count. For example, the method described in the preamble to the proposed rule would count part-time employees as full employees. A second method proposed in a 2004 proposed rule issued by the Department of the Treasury, the Department of Labor, and HHS, in which the number of full-time equivalent employees is determined. Because of the range of comments received to the proposed rule and because the method of counting employees has implications that extend beyond the operation of the SHOP, we are not finalizing at this time a rule for determining employer size. We are considering future rulemaking to address the method of determining employer size for purposes of deciding whether an employer is a small employer or a large employer.

MULTI-STATE PLANS

Comment: A few commenters requested that HHS redefine a multi-State plan in proposed §155.1000(a) as a plan that is described under section 1334 of the Affordable Care Act to ensure continuous alignment between this final rule and forthcoming regulations on multi-State plans promulgated by the U.S. Office of Personnel Management (OPM).

Response: We believe the commenters' approach would better align this final rule with forthcoming regulations on multi-State plans. Therefore, we are revising the regulation text in final §155.1000 to reference section 1334 of the Affordable Care Act. The final rule in this subpart has been revised throughout to acknowledge the role of OPM in certifying multi-State plans.

Comment: Several commenters requested additional information on how the Office of Personnel Management will administer multi-State plans. Commenters proposed specific recommendations, including that OPM deem existing health plans that operate in multiple States as multi-State plans, or that multi-State plans include protections for certain types of benefits (for example, benefits related to end-stage renal disease).

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Response: The standards and processes related to multi-State plans will be addressed in forthcoming regulations implementing section 1334 of the Affordable Care Act promulgated by OPM. These issues are outside the scope of this final rule, which only addresses multi-State plans in connection with Exchange obligations to recognize multi-State plans as certified by OPM.

Comment: Many commenters expressed support for the provisions in §155.1010(b) of the proposed rule related to the deemed certification of multi-State plans and emphasized the importance of creating a level playing field for all QHPs within an Exchange. Several commenters recommended that the final rule clarify that multi-State plans and CO-OPs will be treated identically to other plans; for example, multi-State plans and CO-OPs would comply with any additional certification criteria established by an Exchange, and could be excluded in States that selectively contract.

Response: The final rule establishing the CO-OP program, “Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program,” published at 76 FR 77392 (December 13, 2011) directs CO-OPs to comply with all standards generally applicable to QHP issuers. We anticipate that specific standards for multi-State plans will be described in future rulemaking by OPM in accordance with section 1334 of the Affordable Care Act. We note that the Affordable Care Act specifically provides a deeming process for multi-State plans and CO-OPs. Based on this fact, we do not believe these plans can be excluded from participation, including in Exchanges that adopt selective certification approaches.

Comment: Several commenters requested that the final rule clarify whether a multi-State plan may cover non-excepted abortion services if its service area includes one or more States where coverage of such services is prohibited by State law.

Response: Specific standards for multi-State plans will be described in future rulemaking published by OPM in accordance with section 1334 of the Affordable Care Act.

CONTRACTING WITH STATE AGENCIES

Comment: A few commenters requested that Exchanges be permitted to contract with other State agencies, such as the State department of insurance, to certify, recertify, and decertify QHPs for participation in the Exchange.

Response: Exchanges may enter into agreements with eligible entities in accordance with §155.110, including other State agencies, to perform Exchange functions such as QHP certification. The Exchange is responsible for establishing processes for QHP certification, recertification, and decertification. The Exchange may choose to carry out these functions by contracting with the State department of insurance or another appropriate entity, but must retain ultimate accountability for the certification and review of QHPs in accordance with §155.110.

RATE INCREASES

Comment: Many commenters expressed support for the standard in proposed §155.1020(a) that an Exchange ensure that any rate increase justification is prominently posted on the QHP issuer’s Web site. Several commenters requested clarification of the meaning of “prominently” posted or made specific recommendations that, for example, the Exchange Web site link to the justification on the issuer’s Web site, that the Exchange Web site separately post the justification, or that the Exchange Web site include a pop-up “warning” to enrollees who select a QHP for which there was a recent rate increase.

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Response: In the final rule, we have amended §155.1020(a) to direct the Exchange to provide access to the rate increase justification posted on the issuer's Web site. We believe that this additional standard would provide greater transparency, and make it easier for consumers to access information about rate increases when considering QHPs. We note that nothing in this final rule would preclude an Exchange from separately posting an issuer's justification or otherwise informing consumers about rate increase justifications, as suggested by commenters.

Comment: Many commenters suggested ways Exchanges could consider rate increase justifications under proposed §155.1020(b). Some commenters favored a rigorous rate review process that would go beyond the functions currently performed by State regulators, such as by collecting additional information from QHP issuers implementing rate increases (for example, evidence of efforts to control costs through value-based benefit designs). In contrast, several other commenters recommended that the final rule reaffirm the traditional role of States in reviewing rates. Commenters further urged HHS to minimize the potential for duplication and inconsistency by encouraging the Exchange to leverage a State's program under section 2794 of the PHS Act to review rates. One commenter requested that the final rule clarify that an Exchange's ability to act in response to a rate increase would be limited to deciding whether to make a QHP available through the Exchange.

Response: We encourage the Exchange to leverage existing State rate review processes to the extent appropriate. As we highlighted in the preamble to the proposed rule, such coordination could include posting or adopting the same format used for rate justifications submitted to the State. However, we note that in some cases an Exchange may engage in more in-depth consideration of QHP issuers' justifications when determining whether to make a QHP available on the Exchange. As a result, we do not limit the ability of Exchanges to conduct additional reviews of rate increase justifications, although we recommend that Exchanges consider the administrative burden on issuers associated with any such reviews. We note that an Exchange's consideration of rate increases is limited to whether a QHP should be made available on the Exchange.

Comment: In response to the provision in proposed §155.1020(b) that an Exchange consider rate increases, many commenters requested that HHS clarify how the Exchange must incorporate such review into the QHP certification process. A few commenters recommended that excessive rate increases be considered cause for refusal of certification or decertification. Conversely, one commenter recommended that Exchanges initially not consider rate increases in the certification of QHPs, and that in later years the level of review would be proportional to the size of the rate increase. Finally, a few commenters requested that the final rule clarify how HHS will oversee Exchange review of rate increases.

Response: An Exchange may choose from a variety of approaches with respect to QHP issuer rate increases. For example, an Exchange may exercise the discretion provided in §155.1000(c)(2) by opting to not make available QHPs implementing rate increases that the Exchange determines are not sufficiently justified. Other Exchanges may choose to rely more heavily on the process and determinations made by the applicable State regulator. Therefore, we are not prescribing a specific process or standard that the Exchange must follow in its consideration of rate increase justifications in this final rule.

Comment: One commenter requested that the final rule clarify the applicability of the provisions in this section to multi-State plans.

Response: Standards and processes related to multi-State plans will be addressed in future rulemaking by OPM in accordance with section 1334 of the Affordable Care Act. Because OPM will administer contracts with multi-State plans, we anticipate that OPM may collect certain data, including rate and benefit data, from multi-State plans. To avoid duplicate reporting and minimize administrative burden, we have amended proposed §155.1020(b) and (c) to clarify that OPM will provide a process for rate increase consideration of multi-State plans and a process for multi-State plans to submit rate and benefit information, respectively.

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Comment: Two commenters requested the meaning of the standard in proposed §155.1020(b)(1)(iii) that an Exchange consider any excess of rate growth outside versus inside the Exchange. One commenter requested clarification of whether HHS will establish a uniform, national limit on rate increases. Another commenter requested that HHS clarify the meaning of premium price controls. One commenter recommended that the final rule discourage or prohibit the Exchanges from holding down rates and creating “spillover” increases outside the Exchange or in other States, for multi-State plans. Finally, one commenter recommended that the rate review function inside and outside of the Exchange be combined.

Response: As indicated in the preamble to the proposed rule, we encourage Exchanges to work closely with State departments of insurance when considering issuer rate increases. With respect to §155.1020(b)(1)(iii), we note that an Exchange should consider the rate of growth in rates for similar products that are offered outside versus inside the Exchange, which may help the Exchange in its consideration of rate increase justifications. The term premium price controls is not defined in section 1311(e) of the Affordable Care Act, which this provision implements. We note that review of rate information in accordance with this section is the responsibility of the Exchange; therefore, we are not defining the term “premium price controls” or setting a national limit in this final rule.

Comment: A few commenters requested that the final rule clarify the content and timing of reporting of the rate and benefit information described in proposed §155.1020(c). One commenter recommended that the information be reported twice per year. Several commenters urged HHS to direct the Exchange also collect information on benefit exclusions.

Response: We intend to clarify the format and content of data submission in accordance with this section in future guidance. Because the purpose of the collected information is to support the QHP certification process, the timing is implicit in the operation of this provision in conjunction with §155.1010(a). We note that we interpret §155.1020(c)(1) to direct Exchanges to collect rate information for pediatric dental benefits offered in accordance with section 1302(b)(1)(J) of the Affordable Care Act, and for any benefits in excess of the other benefits offered under section 1302(b) of the Affordable Care Act. Exchanges will need to be able to identify such information to support the administration of advance payments of the premium tax credit.

Comment: Several commenters supported the provision in proposed §156.210(a) that QHP issuers set rates for an entire benefit or plan year. Conversely, some commenters recommended an exception for plans participating in the SHOP, or to accommodate Federal or State regulatory changes.

Response: All QHPs, including those participating in the SHOP, must offer a set rate for an entire benefit or plan year. We note that while QHP issuers in SHOP may establish new rates quarterly or annually, issuers must charge the same contract rate for a plan year. We note that most Federal and State regulatory changes are proposed well in advance of becoming effective, so the number of regulatory changes that would take effect in the middle of a benefit or plan year will be limited. Therefore, no exceptions are provided in the final rule.

ACCREDITATION

Comment: We received many comments in response to our proposed standard to allow Exchanges to determine a uniform period following certification by which QHP issuers must be accredited. A number of commenters agreed with our proposal that the States should be given flexibility to determine this timeline. Several other commenters disagreed with our proposal to allow Exchanges to set the timeline for accreditation for QHPs and requested that HHS establish a Federal timeline for accreditation that all Exchanges must follow. Several commenters suggested appropriate accreditation timelines for HHS to establish. Another commenter suggested that allowing QHP certification without accreditation runs counter to the intent of the law and State autonomy in determining the accreditation timeline fails to offer adequate consumer protection.

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Response: We maintain our regulation text as stated in the proposed rule. We believe that this proposal is consistent with our efforts to ensure that Exchanges have the discretion to implement QHP issuer standards that best meet the needs of their Exchange enrollees. To draw new issuers to the Exchange, we note that an Exchange may want to provide issuers with additional time beyond initial certification to become accredited. Section 1311(c)(1)(D)(ii) of the Affordable Care Act clearly provides for the Exchange to establish the timeframe.

Comment: We received a single comment to our proposed provision in §155.1045 requesting that plans be allowed to select their own accrediting entity. We also received a comment suggesting criteria that the Secretary should use to recognize accrediting entities.

Response: We expect to engage in future rulemaking to adopt a process and criteria for the recognition of accrediting entities.

NETWORK ADEQUACY

Comment: A few commenters requested that HHS clarify how the network adequacy standards will be monitored and enforced. Commenters recommended that the Exchange report on oversight of network adequacy, or use specific tactics to monitor network adequacy (for example, secret shopper events, monitoring of appointment wait times).

Response: Many States direct health insurance issuers to evaluate the adequacy of their provider networks on an ongoing basis and monitor network adequacy in their traditional role of regulating health insurance. We encourage Exchanges to coordinate with State departments of insurance in monitoring QHP networks for sufficient access, and this final rule provides Exchanges with discretion to establish their own monitoring procedures to assure ongoing compliance. We anticipate that Exchanges will identify a variety of tools and strategies to monitor QHP compliance with all certification standards, including standards related to network adequacy. Accordingly, we are not prescribing specific oversight and enforcement strategies in this final rule.

Comment: Many commenters offered feedback on the network adequacy standard, initially included in proposed §155.1050. Some commenters supported the flexibility provided to States in the proposed rule, noting that such flexibility could facilitate the alignment of markets inside and outside of the Exchange. Conversely, many commenters recommended that HHS establish a national, uniform standard for network adequacy. These commenters offered numerous standards HHS could adopt, including the NAIC Managed Care plan Network Adequacy Model Act, or the current standards for Medicare Advantage plans, Medicaid managed care plans, or TRICARE plans. Finally, a few commenters generally requested that HHS clarify the meaning of “sufficient number” of providers.

Response: A number of competing policy goals and considerations come into play with examinations of network adequacy: that QHPs must provide sufficient access to providers; that Exchanges should have discretion in how to ensure sufficient access; that a minimum standard in this regulation would provide consistent consumer protections nationwide; that network adequacy standards should reflect local geography, demographics, patterns of care, and market conditions; and that a standard in regulation could misalign standards inside and outside of the Exchange. In balancing these considerations, we have modified §156.230(a)(2) in this final rule to better align with the language used in the NAIC Model Act. Specifically, the final rule establishes a minimum standard that a QHP’s provider network must maintain a network of a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay. We believe this modification provides additional protection for consumers by communicating our expectations with respect to the number and variety of providers that should be present in a QHP’s provider network. Further, the modified standard establishes a baseline (“all services...without unreasonable delay”) against which network adequacy can be measured. We note that nothing in the final rule limits an Exchange’s ability to

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establish more rigorous standards for network adequacy. We also believe that this minimum standard allows sufficient discretion to Exchanges to structure network adequacy standards that are consistent with Standards applied to plans outside the Exchange and are relevant to local conditions. Finally, placing the responsibility for compliance on QHP issuers, rather than directing the Exchange to develop standards, is more consistent with current State practice.

Comment: Several commenters urged HHS to codify the potential additional standards listed in the preamble to the proposed rule (access without unreasonable delay, reasonable proximity or providers to enrollees' homes or workplaces, ongoing monitoring process, and out-of-network care at no additional cost when in-network care is unavailable), with the largest number of commenters expressing support for the provision of out-of-network care at no additional cost when in-network care is unavailable. Other commenters recommended specific alternatives to these elements, such as a "60 minutes or 60 miles" or "15-20 minutes" standard.

Response: Based on comments, we have modified §156.230(a)(2) in this final rule to codify the standard that services must be available without unreasonable delay. With respect to the other specific suggestions offered by commenters, we are concerned that the proposed standards may not be compatible with existing State regulation and oversight in this area. We believe that the modification to final §156.230(a)(2) strikes the appropriate balance between assuring access for consumers and recognizing the historical flexibility and responsibility given to States in this area.

Comment: Many commenters recommended that the network adequacy provisions include specific provider types, such as pediatricians, tribal health care providers, mental health professionals, teaching hospitals, or women's health care providers.

Response: While QHP networks should provide access to a range of health care providers, we are concerned that mandating inclusion of a list of specified provider types would detract from the larger issue of broadly ensuring access to the full range of covered services (that is, essential health benefits). Accordingly, we have modified §156.230(a)(2) of this final rule to require QHP issuers to maintain networks that include sufficient numbers and types of providers, including providers that specialize in mental health and substance abuse, to ensure access to all services. We specifically highlight mental health and substance abuse services because we recognize that the essential health benefits will create new demands for access to mental health and substance abuse services, and that such services have traditionally been difficult to access in low-income and medically underserved communities. By highlighting mental health and substance abuse providers in the network adequacy standard, we seek to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities. In addition, we are clarifying in §155.1050 of this final rule that, because inclusion of essential community providers is related to network adequacy, a QHP issuer may not be prohibited from contracting with any essential community provider described in final §156.235(c). We urge States to consider local demographics, among other elements, when developing network adequacy standards and note that nothing in the final rule would preclude an Exchange from identifying specific provider types that are particularly essential in a State.

Comment: A few commenters recommended that the final rule direct QHP networks to maintain growth capacity, or the ability to accept additional enrollees or utilization.

Response: We believe that the higher standard in §156.230(a)(2) of this final rule helps address the commenters' concerns. Further, we believe that the reference to section 2702(c)(2) of the PHS Act, included in section 1311(c)(1) of the Affordable Care Act, implies Congressional intent to protect current enrollees from unreasonable delays in access to care if QHPs expand enrollment too quickly. Therefore, we are not prescribing a uniform growth capacity standard for all Exchanges in the final rule, though we note that an individual Exchange would be able to set such a standard.

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PROVIDER DIRECTORIES

Comment: Several commenters recommended that additional items be included in QHP provider directories described under proposed §156.230(b), such as each provider's specialty, affiliation, licensure, or languages spoken. A few commenters requested that HHS establish that the provider directory must be easily searchable for Indian Health Service/Tribal/Urban (I/T/U) providers. Finally, a few commenters recommended that provider directories include nonphysician providers.

Response: Consistent with current industry practice, we expect QHP issuers' provider directories to include information on each provider's licensure or credentials, specialty, and contact information, which could include any institutional affiliation. The Exchange may establish additional data elements that QHP issuers must include, such as identifying Indian Health Service/Tribal/Urban (I/T/U) providers.

We note that while a provider directory could include appropriate non-physician providers, we afford Exchanges discretion regarding their inclusion in the provider directory. A provider directory that includes providers whose scope of practice is limited should generally identify the services that the provider is contracted to perform, for example, by displaying such providers only when consumers search for certain services (i.e., primary care).

Comment: Multiple commenters recommended that the Exchange consolidate QHP provider directories as described in the preamble to the proposed rule. Conversely, some commenters recommended maximum flexibility for QHP issuers to submit provider information.

Response: We encourage, but do not direct, Exchanges to consolidate QHP provider directories to make it easier for consumers to locate the QHPs in which their providers participate. Exchanges may also want to establish links to the provider directory on a QHP issuer's Web site.

Comment: Several commenters requested that HHS clarify how frequently QHP issuers must update provider directories under proposed §156.230(b). Recommendations offered by commenters ranged from in real time to annually. A few commenters raised concerns about the proposed standard that directories identify providers who are not accepting new patients, noting that this could result in continuous updates.

Response: We afford each Exchange with discretion to provide guidance to QHP issuers with respect to the updating of provider directories, including how frequently issuers must identify providers who are no longer accepting new patients. We urge Exchanges to consider the appropriate balance between supporting consumer choice and the burden on QHP issuers associated with this standard (which we should be lower for electronic directories than for hard copy directories). Further, in establishing such standards, we expect Exchanges to consider the information needs of current versus potential enrollees.

Comment: A few commenters recommended that HHS establish that provider directories developed in accordance with proposed §156.230(b) must offer meaningful access to individuals with limited English proficiency and/or disabilities, for example by making directories available by phone.

Response: We note that, because they are made available to enrollees, provider directories must meet the standards for applications, forms, and notices established in §155.230 of this final rule, which include accommodations for individuals with limited English proficiency and/or disabilities.

Comment: A few commenters suggested that QHP issuers be directed to notify enrollees if their particular provider drops out of the network.

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Response: Although a provider’s contracting status has significant implications for patients - especially those who regularly see a particular provider for treatment of a chronic or complex condition - we do not set a uniform standard for notification of individual patients if their providers drop out of the QHP’s network. Such a uniform standard on QHPs might not be consistent with practices in the non-Exchange market, and would raise QHP administrative costs.

ESSENTIAL COMMUNITY PROVIDERS

Comment: HHS received many comments seeking clarity on the proposed standard in §156.235(a) that QHPs include in their provide networks a “sufficient” number of essential community providers. Many commenters recommended that QHP issuers include in their provider networks all essential community providers in the area; contract with any willing essential community provider; or contract with certain types of providers, such as family planning providers. Some commenters suggested HHS define sufficiency based on specific ratios of enrollees to providers, maximum travel times, or the Need for Assistance worksheet used by the Health Resources and Services Administration¹². One commenter suggested that HHS base the sufficiency standard in part on the Health Professions Shortage Areas, Medically Underserved Areas and Medically Underserved Populations designated by the Health Resources and Services Administration.

In contrast, other commenters supported the proposed rule and urged HHS to maintain a broad definition of “sufficient” that allows Exchanges to establish standards appropriate for their States. A number of commenters urged HHS to strike a balance between having QHP issuers provide enrollees with adequate access to care from essential community providers and allowing QHP issuers to employ innovative network designs that improve quality and contain costs.

Response: Based on comments received, we believe that additional clarification of the “sufficiency” standard is necessary. Accordingly, we have modified final §156.235(a) to direct that each QHP’s network have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Exchange’s network adequacy standards. We believe that this approach more clearly articulates our expectations with respect to sufficiency than the standard included in the proposed rule with respect to essential community providers while continuing to balance the accessibility of essential community providers with network flexibility for issuers. We emphasize that Exchanges have the discretion to set higher, more stringent standards with respect to essential community provider participation, including a standard that QHP issuers offer a contract to any willing essential community provider. HHS intends to monitor the effectiveness of this provision in ensuring access to essential community providers, and it may be subject to further modification.

Comment: HHS received several comments suggesting that QHP issuers be exempt from the standard in proposed §156.235(a) to include essential community providers in their provider networks if the Exchange’s service area does not include low-income or medically-underserved populations.

Response: Section 1311(c)(1)(C) of the Affordable care Act directs all QHP issuers to include essential community providers in their provider networks; therefore, we have not amended the regulation to provide the exemption suggested by the commenter. Further, we note that the statute and final rule acknowledge that essential community providers may not be available throughout a QHP’s service area. We believe that the inclusion of “where available” in both places creates flexibility for QHP issuers to contract with essential community providers in a manner that reflects the relative availability of these providers and the needs of local communities.

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Comment: Several commenters supported an exemption from the standards in this section for staff-model health plans or integrated delivery system-based health plans, though one commenter urged HHS to make such an exemption contingent upon the organization demonstrating that its provider network still provides meaningful access to all forms of care to potential enrollees in the service area. One commenter suggested that HHS establish a provision similar to Medicaid's "freedom of choice" provision in 42 U.S.C. 1396(a)(23) in order to allow enrollees in staff-model QHPs to receive covered services from other providers if needed at no additional cost to the enrollee; the commenter specifically cited concerns that a religiously-sponsored integrated delivery health plan may not offer a full range of reproductive health services. Conversely, several commenters opposed any exemption for staff-model or integrated delivery system plans.

Response: Based on comments, we are persuaded that the obligation to contract with essential community providers should address the unique contracting structure of staff-model health plans and integrated delivery system-based health plans that provide a majority of services "in-house." We are concerned that establishing a standard for such plans to contract with essential community providers would result in these plans having to alter their business models, which may obviate the benefits of integration. In the proposed rule, we noted that we were weighing whether to provide consideration for plans that solely provide services "in-house". In light of comments, however, we recognize that staff model and highly integrated delivery system plans do not provide services solely "in house"; rather, as a practical matter, they must provide some level of out-of-network services (for example, emergency services) and often must contract with Centers of Excellence or certain specialists to provide patients with access to highly specialized services. As a result, we have added under final §156.235(b) a provision directing Exchanges to offer an alternate standard for plans with a majority of services furnished by "inhouse" providers. Under the alternate standard, health insurance issuers that provide a majority of covered professional services through employed physicians or through a single contracted medical group may demonstrate their ability to provide an equivalent level of service accessibility for low-income and medically underserved individuals. We note that this alternate standard does not permit an Exchange to grant any QHP issuer a wholesale exception to standards related to essential community providers.

Comment: In response to the discussion in the preamble to the proposed rule, many commenters urged HHS to clarify the term "generally applicable payment rates" and ensure that essential community providers are reimbursed at a reasonable level by establishing minimum reimbursement standards for all essential community providers. Suggestions for such a benchmark included the Medicaid prospective payment system (PPS) rate under 42 USC 1396a(bb), Medicare rates, or a reimbursement rate at least equal to the issuer's negotiated rate with a similarly situated non-essential community provider. Commenters also recommended that QHPs offer "generally applicable payment rates" by service line to ensure that plans do not mask low rates for particular services by providing higher rates for less-utilized service, or otherwise discriminate against essential community providers in contract negotiations.

Response: QHP issuers should not discriminate against essential community providers through contract negotiations, or otherwise attempt to circumvent the obligation to include such providers in-network by offering unfavorable rates. In this final rule, we are not specifically establishing that a generally applicable payment rate be based on a particular benchmark or be calculated using a particular method (for example, by service line), but clarify that "generally applicable payment rate" means, at a minimum, the rate offered to similarly situated providers who are not essential community providers as defined in this section.

Comment: In response to the discussion in the preamble to the proposed rule, many commenters offered feedback on the appropriate payment rates for Federally-qualified health centers, or FQHCs. Several commenters supported payment of Medicaid PPS rates to all FQHCs some commenters advocated that Exchange provide wrap-around payments to FQHCs, as is currently the practice in State Medicaid programs. Other commenters supported payment of the issuer's generally applicable payment rates, while other commenters recommended allowing payment of mutually agreed upon rates. A few commenters offered unique suggestions not explicitly contemplated in the proposed rule, such as negotiating based on Medicare rates or permitting States to establish payment rates for essential community providers.

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Response: The Affordable Care Act, at section 1302(g), establishes payment of FQHCs at the applicable Medicaid PPS rate. However, the Affordable Care Act also supports, at section 1311(c)(2), payment of essential community providers, including FQHCs, at the QHP issuer's generally applicable payment rate. We are amending the regulation text in final §156.235(e) to codify both sections 1302(g) and 1311(c)(2) of the Affordable Care Act. We interpret these two provisions to mean that a QHP issuer must pay an FQHC the relevant Medicaid PPS rate, or may pay a mutually agreed upon rate to the FQHC, provided that such rate is at least equal to the QHP issuer's generally applicable payment rate.

RATING AREAS

Comment: Many commenters supported the service area standard in proposed §155.1055(a). However, several commenters recommended alternative standards, such as that all QHPs must serve the entire Exchange service area, the entire State, areas smaller than a county, or contiguous areas. Some commenters suggested that HHS refrain from requiring QHPs to offer coverage Statewide to ensure that local health plans may participate, while others encouraged Exchanges to align standards with market-wide standards.

Response: Under the proposed and final rule policy, Exchanges have the ability to establish or evaluate QHP service areas in such a way that would allow for participation by local health plans, provided that such standard is established without regard to the factors listed in §155.1055(b). We recommend that Exchanges consider aligning QHP service areas with rating areas established by the State in accordance with section 2701(a)(2) of the PHS Act. To the extent QHPs operate within such uniform service areas, this policy would facilitate consumers' ability to compare premiums of QHPs, promoting competition within the Exchange market. Furthermore, aligning QHP service areas with rating areas may simplify consumer understanding and Exchange administration of eligibility determinations for premium tax credits, which may be complex if QHP service areas are highly individualized.

Comment: Several commenters expressed concern that allowing Exchanges to set unique service area standards would conflict with existing State standards that are meant to prevent against discriminatory service areas.

Response: We acknowledge that some States already have in place service area standards that protect against red-lining and other "cherry-picking" practices where the issuer only offers plans to geographic areas that are expected to have lower risk. We believe that §155.1055 of this final rule provides a sufficiently broad standard such that an Exchange operating in a State with equally or more protective service area standards that prevent discrimination could use those standards for QHP issuers as well. To the extent that the broad standard here is more protective than existing State law, however, the Exchange must apply this regulatory standard to QHPs.

Comment: One commenter requested examples of the "necessary" or "nondiscriminatory" standards in proposed §155.1055(b). Another commenter suggested that the Medicare Advantage precedent would be useful in determining whether service of part of a county would fall under necessary or non-discriminatory standards. Two commenters suggested that HHS specifically incorporate the parameters relating to a small geographic service area contained in the Medicare manual.

Response: We believe that the Medicare Advantage "county integrity rule" described in 42 CFR 422.2 (defining service area) is a useful resource for evaluating service areas, and we noted in the preamble to the proposed rule that the service area standard in §155.1055 mirrors the standard established by Medicare Advantage (76 FR 41866, at 41894 (July 15, 2011)). While we believe that the standards set forth by Medicare Advantage guidance provide examples of how to apply this standard, we note that States have discretion to interpret "necessary, nondiscriminatory, and in the best interest of qualified individuals and qualified employers." For example, if a State has an existing service area standard that ensures service areas are not discriminatory and are in the best of the consumer, then the Exchange could decide to establish its service areas to be the same as the existing State standard. However, this provision provides authority for an Exchange to set stricter QHP standards if it observes service areas that specifically exclude certain areas.

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Comment: A number of commenters requested clarification on the difference between a service area and a rating area.

Response: A rating area, as described in §156.255(a) and section 2701(a)(2) of the PHS Act, is a geographic area established by a State that provides boundaries by which issuers can adjust premiums in accordance with section 2701(a)(1)(A)(ii) of the PHS Act. In contrast, a service area is the geographic area in which an individual must reside or be employed (in accordance with standards outlined in §155.305 and §155.710) in order to enroll in a given QHP. As noted previously, we recommend that Exchanges consider aligning QHP service areas with rating areas to foster competition, promote consumer understanding, and reduce administrative complexity.

Comment: One commenter recommended that HHS encourage States to establish service areas in accordance with proposed §155.1055 as soon as possible using county or other existing area boundaries, noting that new regional boundaries will increase administrative and logistical complexity of assembling a provider network.

Response: QHP issuers will need to understand QHP standards as early as practicable, and we encourage Exchanges to be transparent and clear about standards as far in advance of QHP certification as possible. As noted above, Exchanges do not need to establish new service area boundaries if existing service areas are not discriminatory.

Comment: Several commenters voiced concern about the lack of an overarching standard that Exchanges ensure a sufficient number of health plans in all geographic areas of an Exchange.

Response: In general, we clarify that the expectation of §155.105(b)(3) is that, to the extent possible, an Exchange must ensure that QHPs are available throughout the entire State. We encourage Exchanges to establish or negotiate service areas with QHP issuers to ensure that residents living in the Exchange service area have access to QHPs.

STAND-ALONE DENTAL PLANS

Comment: With respect to proposed §155.1065(b), one commenter interpreted section 1311(d)(2)(B)(ii) of the Affordable Care Act to mean that an Exchange must allow a stand-alone dental plan to offer coverage in an Exchange. The commenter requested clarification on whether the partnering of a QHP with stand-alone dental plans as their subcontractors for pediatric dental care would be consistent with this provision.

Response: We interpret the phrase regarding the offering of stand-alone dental plans “either separately or in conjunction with a QHP” to mean that the Exchange must allow standalone dental plans to be offered either independently from a QHP or as a subcontractor of a QHP issuer, but cannot limit participation of stand-alone dental products in the Exchange to only one of these options.

Comment: A number of commenters expressed concern regarding the applicability of cost-sharing limits and annual and lifetime limits to stand-alone dental plans. Commenters requested clarity on whether such limits applied, and cautioned that if stand-alone dental plans do not have to comply with the same out-of-pocket, annual, and lifetime limit standards that would apply QHPs, then there would be an unlevel playing field.

Response: We accept the recommendation of commenters that cost-sharing limits and the restrictions on annual and lifetime limits should apply to stand-alone dental plans for coverage of the pediatric dental essential health benefit. The Affordable Care Act directs any issuer that must meet the coverage standards in section 1302(a) to cover each of the ten categories; thus, any issuer covering pediatric dental services as part of the essential health

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benefits must do so without annual or lifetime limits as defined under the Affordable Care Act and its implementing guidance, even if such issuers are otherwise exempt from the provisions of Subparts I and II of Part A of Title XXVII of the PHS Act (including PHS Act section 2711) under PHS Act section 2722. We note that for any benefit offered by a stand-alone dental plan beyond those established under section 1302(b)(1)(J) of the Affordable Care Act, standards specific to the essential health benefits would not apply. We plan to provide more detail in the future regarding how a separately offered pediatric dental essential health benefit would be considered under standards that apply to a full set of essential health benefits.

Comment: With respect to proposed §155.1065(b), several commenters specifically recommended that stand-alone dental plans be directed to offer a child-only pediatric dental plan. The commenters were concerned that an Exchange with only family dental coverage options and QHPs that do not have to cover the pediatric dental benefit would decrease the enrollment of children in dental coverage, as the advance payment of the premium tax credit would only be applicable to the pediatric dental essential health benefit. Others were concerned that the standalone dental plans would not have capacity to cover all potential enrollees which, combined with the exemption for QHPs to not offer the pediatric dental coverage when stand-alone dental plans are available, would create insufficient access to child-only options.

Response: In this final rule, §155.1065(a)(3) would apply the standard of §156.200(c)(2) to offer child-only plan to stand-alone dental plans certified to be offered through the Exchange. In the new paragraph §155.1065(d), we direct an Exchange to consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage. By “sufficient access,” we mean to convey that Exchanges should ensure that, when combined, stand-alone dental plans have the capacity (in terms of solvency and provider network) to provide child-only coverage to all potential children enrolling in coverage through the Exchange.

Comment: A set of commenters addressed the request for comment in the proposed rule on whether the final rule should establish that QHPs must separately offer and price coverage for the pediatric dental essential health benefit so that consumers have the potential to enroll in dental coverage that is different from the dental benefits offered by the QHP they selected. Some suggested a standard for QHPs to separately price and offer pediatric dental coverage so consumers could make direct comparisons based on premium, cost-sharing, and benefits. Other commenters stated that it would be easier for consumers if the benefits were bundled. A number of commenters also recommended that HHS direct QHPs to offer medical-only options without pediatric dental coverage.

Response: If an Exchange determines that having QHPs separately offer and price pediatric dental coverage is in the interest of the consumer, as described in §155.1000(c), then the Exchange may establish such standard that as a condition of QHP certification. Otherwise, QHPs are not uniformly directed to separately price and offer pediatric dental coverage under this final rule.

Comment: A few commenters urged HHS to allow health plans outside of the Exchange to have the same exemption as QHPs inside the Exchange, in that health plans would not have to cover pediatric dental if a stand-alone plan existed in the market.

Response: This request is outside the scope of this final rule, which addresses explicitly the standards for QHPs. Section 1302(b)(4)(F) of the Affordable Care Act specifically addresses the exemption in terms of QHPs offered through an Exchange.

Comment: Several commenters suggested that a way to indicate to QHPs that they will not have to cover pediatric dental coverage would be to issue a request for proposals to standalone dental plans in advance of the QHP certification process.

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Response: We have not set any operational standards in §155.1065. Each Exchange has discretion in determining how to implement this provision.

Comment: With respect to proposed §155.1065(c), many commenters voiced support for allowing an Exchange to direct issuers of stand-alone dental plans to comply with any QHP certification standards and consumer protections, with some specifying network adequacy and cost-sharing standards. Many commenters stated that certification standards are necessary to ensure a level playing field between pediatric dental coverage offered through QHPs or stand-alone products. A few commenters requested that HHS direct Exchanges to establish uniform certification and recertification standards for medical and stand-alone dental plans. A small number of commenters recommended that HHS not establish standards for stand-alone dental plans, or specified certain standards that should not apply, such as quality and accreditation. One commenter suggested that QHP issuers not have to comply with any standard that does not apply to stand-alone dental plans for the offering of pediatric dental coverage.

Response: We are persuaded by comments suggesting that stand-alone dental plans comply with QHP certification standards, as such standards will help ensure a consistent level of consumer protections as QHPs. Accordingly, we have added a new provision to §155.1065(a)(3) establishing that stand-alone dental plans must comply with QHP certification standards, except for those certification standards that cannot be met because the stand-alone dental plans covers only pediatric dental benefits. For example, to the extent that accreditation standards specific to stand-alone dental plans do not exist, such plans would not have to meet §155.1045. We also note that the Exchange may establish certification standards that are specific to the unique nature of stand-alone dental plans. For example, an Exchange can set a different network adequacy standard for stand-alone dental plans than for medical plans. For the purposes of this provision, any application of QHP standards to stand-alone dental plans by the Exchange would only apply to stand-alone dental plans offered through the Exchange.

Comment: A small number of commenters sought clarification on whether stand-alone vision plans could be offered through the Exchanges. Other commenters also sought clarification about the offering of other types of insurance that are not health plans, such as disability insurance.

Response: HHS is still evaluating this issue and plans to provide more details regarding the offering other coverage through an Exchange in future guidance.

RECERTIFICATION

Comment: With respect to the recertification process described in proposed §155.1075(a), many commenters provided feedback on our proposal to permit Exchanges to establish the frequency of recertification. While some commenters supported the flexibility provided in the proposed rule, others recommended that HHS establish the frequency for recertification and offered specific recommendations about the recertification interval, such as every one year, three years, or as-needed based on certain “triggering” events.

Response: We believe that Exchanges are best positioned to establish the frequency of or other parameters for recertification that reflect local market conditions or existing State regulatory processes. We believe varying intervals for recertification and approaches could be appropriate in some circumstances, and therefore are not establishing a uniform frequency for recertification in this final rule.

Comment: Multiple commenters recommended that specific elements be considered during the recertification process described in proposed §155.1075(a), such as a QHP issuer’s complaint history, sanctions imposed by State regulators, or interaction with tribes and/or American Indian/Alaska Native populations. Commenters also suggested that the recertification process include a review of the QHP’s network and engagement with essential community providers.

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Response: An Exchange must establish a recertification process that includes a review of the minimum certification criteria outlined in §155.1000(c) of the final rule, and must monitor QHPs for ongoing compliance with certification criteria, as specified in §155.1010(d). At its discretion, an Exchange may establish additional recertification criteria or review processes, if the Exchange believes such criteria will improve the consumer experience.

Comment: While some commenters supported the proposed recertification deadline of September 15th of the applicable calendar year as indicated in proposed §155.1075(b), others recommended greater flexibility for States or an alternate deadline, such as August 15 of each year.

Response: Recertification should be completed, and the appropriate parties notified, in advance of the open enrollment period so that consumers, issuers, and Exchanges have sufficient time to prepare for and make decisions about the upcoming plan year. In the proposed rule, we set forth the dates for the initial and annual open enrollment periods. In this final rule, we believe it is also appropriate to establish the annual deadline for recertification. We believe that the proposed deadline of September 15th provides sufficient time for Exchanges and issuers to participate in a robust recertification process, and also ensures that consumers will be fully informed of their plan choices at the start of each open enrollment period. Therefore, we are finalizing the proposed recertification deadline of September 15th in this rule.

DECERTIFICATION

Comment: With respect to the decertification process proposed in §155.1080(b), some commenters supported the flexibility given to Exchanges to design the decertification process in the proposed rule, while other commenters suggested specific approaches to decertification. A few commenters requested that the final rule identify “triggering events” for decertification, such as a determination that a QHP’s network is inadequate; others requested that HHS provide additional clarification on when decertification would be appropriate.

Response: We continue to provide Exchanges discretion in designing the decertification process and making decertification decisions. The final rule establishes that an Exchange may decertify a QHP at any time for failure to comply with the minimum certification standards described in §155.1000(c), and any additional certification standards established by the Exchange. We believe that this flexibility is necessary to allow an Exchange to tailor its process for compliance and decertification to be appropriate for the market conditions in the State. The Exchange is responsible for establishing the decertification process, including the approach used to identify plans that are out of compliance with certification standards or the associated sanctions.

Comment: One commenter requested additional information on whether multi-State plans may be decertified through the process described in proposed §155.1080(b).

Response: The Affordable Care Act establishes a deeming process for multi-State plans; as a result, we clarify that multi-State plans are exempt from the Exchange’s recertification and decertification processes.

Comment: A few commenters requested that the final rule clarify that QHPs decertified in accordance with proposed §155.1080(c) may retain non-Exchange membership.

Response: Decertification would not affect enrollees who purchased QHP coverage directly or not through the Exchange, because such members’ enrollment occurred outside the Exchange. However, such a plan could no longer be marketed as a QHP following decertification and the population enrolled in that plan through the Exchange would be provided a special enrollment period to transfer to a different QHP in accordance with §155.420(d) and §155.430(b)(2)(iv). While the Exchange regulates enrollment through the Exchange, any sanctions or other actions related to a QHP’s non-Exchange membership would be at the discretion of the State insurance commissioner.

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CHILD-ONLY PLANS

Comment: Many commenters offered feedback on the standard for QHP issuers to offer a corresponding child-only plan for any QHP offered through the Exchange, described in proposed §156.200(c)(2). Several commenters recommended that HHS permit individuals up to age 26 to enroll in child-only coverage; two commenters recommended that instead of offering a separate child-only plan, QHP issuers be directed or permitted to accept enrollees of any age into a QHP offered to single qualified applicants.

Response: Section 1302(f) of the Affordable Care Act directs a QHP issuer that offers a non-catastrophic plan on the Exchange to offer an identical child-only plan. We clarify that a QHP issuer could satisfy this standard by offering a single QHP to qualified applicants seeking child-only coverage, as long as the QHP includes rating for child-only coverage in accordance with applicable premium rating rules. Section 1302(f) further specifies that for purposes of this standard, a child-only plan is available to individuals under age 21 at the beginning of the benefit year. We lack the authority to alter the age limitation for enrollment into a child-only plan.

MEDICAID MCOs

Comment: With respect to proposed §156.200 in general, several commenters recommended that certain issuers, such as Medicaid managed care organizations, church plans and union plans, be permitted to offer certified QHPs on a limited-issue basis.

Response: As established in section 1301(a) of the Affordable Care Act, all QHPs must be offered by licensed health insurance issuers that are subject to the guaranteed issue provisions, effective January 1, 2014. Under section 2702 of the PHS Act, these issuers must issue coverage to any individual who applies for coverage in a particular health plan. Though the statute allows issuers to stop accepting new enrollees to preserve financial solvency or due to provider network capacity under section 2702(c) and (d), respectively, the issuer must close off enrollment, or begin accepting new enrollees again, uniformly rather than selectively. We note that HHS will address the authority under 2702 under separate rulemaking. We recognize the potential for significant movement of individuals between the Exchanges and Medicaid, as well as the potential for members of a family to be covered separately under the Exchange, Medicaid, and CHIP. We recognize that QHPs offered by Medicaid managed care organizations (MMCOs) may be able to play an important role in keeping family members covered under a common issuer and in the same provider network, promoting continuity of coverage, and mitigating the potential negative effects of “churning” between Medicaid and the Exchanges. HHS may provide additional guidance on this topic in the future. Additionally, we intend to address commenters’ concerns surround multi-employer plans in future guidance.

Comment: A few commenters recommended that each Exchange include at least one QHP that is also a Medicaid MCO to minimize enrollee churn. A handful of commenters recommended that the Exchange be directed to deem Medicaid MCOs and other safety net health plans as QHPs. Similarly, one commenter recommended that safety net health plans be permitted to achieve licensure gradually while participating in the Exchange.

Response: Medicaid MCOs must meet the same standards as other plans to become QHPs. However, we note that Exchanges have discretion to develop specific certification criteria in a manner that might facilitate participation by Medicaid MCOs, including the establishment of the accreditation timeline as specified in §155.1045 and the setting of QHP service areas in §155.1055. We also note that there may be opportunities to leverage the Exchange Web site in a manner that would allow the Exchange to identify issuers that participate in both the Exchange and Medicaid managed care.

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MARKETING

Comment: Many commenters offered feedback on whether the final rule should include a broad prohibition against deceptive marketing practices. A number of commenters supported such a prohibition and suggested specific Federal standards that HHS could adopt, such as Medicare Advantage, Medicare Prescription Drug Program, or Medicaid standards. Conversely, many commenters supported State flexibility with respect to marketing rules and oversight. A few commenters expressed concern that a Federal standard could be overly restrictive.

Response: States have significant experience with, and existing infrastructure to support, monitoring and oversight of health plan marketing activities. The National Association of Insurance Commissioners (NAIC) has provided guidance to the States in the form of the Model Unfair Trade Practices Act. The Model Act has been adopted by 45 States and the District of Columbia. The NAIC has also issued an Advertisements of Accident and Sickness Insurance Model Regulation, which has been adopted by 42 States. Both the Model Act and Model Regulation are extensive and position States to address misleading or deceptive practices. As a result, we are finalizing the marketing standards with the flexibility afforded in the proposed rule.

Comment: Many commenters offered standards or clarifications for inclusion in proposed §156.225(b), such as a list of discriminatory versus acceptable marketing practices; a prohibition on inducements and other tactics prone to abuse; secret shopper events; focus group testing of marketing materials; and standardized compensation for agents and brokers in the Exchange.

Response: We note that the above tactics could be appropriately included in an Exchange's monitoring and oversight activities, as well as its marketing rules. While we are not establishing that an Exchange implement specific standards for the reasons described in the preceding response, we encourage Exchanges to consider a variety of standards, tools, and strategies to promote transparent and consumer-oriented conduct in the Exchange.

Comment: Several commenters encouraged HHS to establish a level playing field with respect to marketing inside and outside of the Exchange. Specifically, a few commenters recommended that the final rule clarify that QHP issuers must comply with all State laws and regulations that govern marketing other health insurance products, such as statutes prohibiting unfair or deceptive acts or practices.

Response: We note that adopting the proposed rule's approach would ensure QHPs conform to any standards, laws, or regulations that govern the marketing of non-QHP health insurance products in a State.

Comment: Several commenters recommended that HHS direct Exchanges to report on oversight activities related to marketing. A few commenters additionally recommended that an Exchange Blueprint detail the Exchange's proposed approach to marketing oversight.

Response: Exchanges are responsible for ensuring compliance with the marketing standards of this section. States have significant experience in regulating marketing of health insurance issuers, and Exchanges may leverage the current monitoring practices of States with respect to marketing of health insurance. As a result, we are not imposing an additional reporting obligation for Exchanges in this area.

COMPLAINTS

Comment: A handful of commenters recommended that HHS establish a mechanism to receive consumer complaints related to marketing practices.

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Response: Consumers who encounter marketing practices that they believe are deceptive or improper should be able to report such practices to the Exchange or State regulator, as appropriate. Because the Exchange is responsible for monitoring marketing of QHPs and taking any appropriate action, we believe that establishing a separate Federal complaint reporting mechanism is unnecessary.

**INTERIM FINAL RULE – COMMENTS REQUESTED
(comments due 45 days after posted in *Federal Register*)**

e. Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs (§155.220)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (a)(3) of this section as an interim final provision, and we are seeking comments on it.

§155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

(a) General rule. A State may permit agents and brokers to –

- (1) Enroll individuals, employers or employees in any QHP in the individual or small group market as soon as the QHP is offered through an Exchange in the State;
- (2) Subject to paragraphs (c), (d), and (e) of this section, enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange; and
- (3) Subject to paragraphs (d) and (e) of this section, assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

b. Options for conducting eligibility determinations (§155.302)

Based on comments and feedback to the proposed rule, we are revising the rule to include this section as an interim final provision, and we are seeking comments on it.

Comment: We received a number of comments expressing support for a policy in which eligibility processes were integrated across the Exchange, Medicaid, and CHIP in order to ensure a seamless experience for consumers. Commenters further stressed the importance of a single entity conducting all eligibility determinations. We also received comments asking that States be permitted to rely on the Federal government for certain eligibility functions, and that State Medicaid and CHIP agencies be permitted to exercise final control over eligibility determinations for Medicaid and CHIP based on applications submitted to the Exchange, particularly when the State does not operate an Exchange. In particular, commenters asked that the Federal government offer to perform eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, based on an argument that this is not a current part of State processes, should be uniform across States, and is connected to the advance payment of premium tax credits with Federal funds. Another commenter suggested that rather than have the Federal government assume responsibility for an entire eligibility function, we should isolate certain components of the eligibility function.

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Response: While a fully-integrated eligibility process will best achieve a seamless experience for applicants, we adopt the suggestion of the commenters who requested a more flexibility for States regarding Medicaid and CHIP eligibility determinations. With appropriate standards, this approach could both maintain the seamless consumer experience while allowing States to design the eligibility process to best match their current systems and capacity.

Accordingly, while the majority of subpart D continues to refer to all functions being carried out by the Exchange, in new §155.302 of this final rule, we specify that the Exchange may fulfill these provisions through different options or combinations of options, subject to standards described in §155.302(d). The standards in §155.302(d) are intended to ensure that this approach to eligibility determinations still affords applicants a seamless path to enrollment in coverage and that it does not increase administrative burden and costs; we use certain performance standards identified in paragraphs (b), (c) and (d) and the agreements among the relevant agencies to achieve this. We clarify that these options are separate and distinct from the “State Partnership” model described in the preamble of §155.200 of this final rule. We intend to provide further guidance on the implementation of these options, including the roles and responsibilities of the various parties, in the future.

First, in §155.302(a), we clarify that the Exchange may fulfill its minimum functions under this subpart by either executing all eligibility functions, directly or through contracting arrangements described in §155.110(a), or through one or both of the approaches identified in paragraphs (b) and (c) when other entities determine the eligibility of applicants for insurance affordability programs.

Second, in §155.302(b), we identify that the Exchange may conduct an assessment of eligibility for Medicaid and CHIP rather than an eligibility determination for Medicaid and CHIP. Such an arrangement is permissible provided that the Exchange makes such an assessment based on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with Medicaid and CHIP regulations, without regard to how such standards are implemented by the State Medicaid and CHIP agencies. That is, the assessment must follow verification rules and procedures that could be adopted by a State Medicaid or CHIP agency, although the use of this option is not contingent on the State Medicaid or CHIP agency doing so.

In paragraph (b)(2), we provide that notices and other activities that must be conducted in connection with an eligibility determination for Medicaid or CHIP are conducted by the Exchange consistent with the standards identified in this subpart or by the applicable State Medicaid or State CHIP agency consistent with applicable law.

In paragraph (b)(3), we outline the procedures the Exchange must follow when, based on the assessment conducted consistent with the standards in paragraph (b)(1), the Exchange finds an applicant potentially eligible for Medicaid or CHIP. We note that “potentially eligible” does not mean that the individual’s income, as determined by the Exchange, necessarily is at or below the applicable Medicaid or CHIP MAGI-based income standard. We would expect in the interagency agreements between the State Medicaid and CHIP agencies and the Exchange, the Exchange’s determination of which applications will be transferred for further action by the Medicaid and CHIP agencies will depend in part on the extent to which their verification procedures are consistent with those followed by the State Medicaid and CHIP agencies. The Exchange would transmit such an individual’s information to the State Medicaid or CHIP agency in accordance with paragraph (b)(3) for additional processing, although the Exchange would consider him or her as ineligible for Medicaid or CHIP for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notified the Exchange that the individual was eligible for Medicaid or CHIP. We will work with Exchanges to establish a reasonable application of the term “potentially eligible” taking into account an Exchange’s assessment procedures.

In paragraph (b)(4), we describe the procedures that the Exchange must follow when, based on an assessment conducted in accordance with paragraph (b)(1), the Exchange finds that an applicant is not potentially eligible for Medicaid or CHIP based on the applicable Medicaid and CHIP MAGI-based income standards. The Exchange must consider such an applicant as ineligible for Medicaid or CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, and notify the applicant and provide him or her

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with the opportunity to withdraw his or her application for Medicaid and CHIP. To the extent that an applicant withdraws his or her application for Medicaid and CHIP (for example, if he or she is approved for advance payments based in part on an assessment that he or she is not potentially eligible for Medicaid and CHIP), the applicant would not receive a formal approval or denial of Medicaid and CHIP; the alternative is for the applicant to request that the Exchange transmit the application to the State Medicaid and CHIP agency for additional processing.

As noted above, in addition to providing the applicant with the opportunity to withdraw his or her application for Medicaid and CHIP, in paragraph (b)(4)(i)(B), the Exchange must notify and provide the applicant with the opportunity to request a full determination of eligibility for Medicaid and CHIP by the applicable State Medicaid and CHIP agencies. For an applicant who requests a full Medicaid and CHIP determination, the Exchange must transmit all information as provided as part of the application, update, or renewal that initiated the assessment and any information obtained or verified by the Exchange to the State Medicaid and CHIP agency. The Exchange must also consider such an applicant as ineligible for Medicaid or CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notifies the Exchange that the applicant has been determined eligible for Medicaid or CHIP.

The arrangement under paragraph (b) would also provide that the Exchange must adhere to the eligibility determination made by the Medicaid or CHIP agency, and that the Exchange and the applicable State Medicaid and CHIP agencies enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP. We expect that these agreements will establish the responsibilities across the parties, and we will work with States to help develop such agreements. We note that we include rules related to assessments of eligibility for Medicaid and CHIP in paragraph (b)(1), to reinforce this concept. The standards and responsibilities of the Exchange, which we include for this agreement, complement the standards in 42 CFR 435.1200(d) of the Medicaid final rule. In accordance with these standards, we expect that when an assessment is conducted by the Exchange and transmitted to the State Medicaid or CHIP agency, and the Exchange is providing advance payments pending an eligibility determination for Medicaid and CHIP, the Exchange will receive a notification of the final determination of eligibility for Medicaid and CHIP made by the receiving agency. Together, these standards aim to avoid the duplication of requests for information from applicants and verification of information, and ensure timely eligibility determinations despite the 'hand-offs' to different agencies or entities. Furthermore, we believe the inclusion of the functions and the standards for the agreements described in §155.302 are consistent with our goal of ensuring a seamless eligibility process. We also note that while defining what constitutes eligibility for minimum essential coverage for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions is outside the scope of this regulation, we clarify that our understanding is that if the Exchange conducts an assessment in accordance with paragraph (b) of this section and does not find that an applicant is eligible for Medicaid and CHIP, such finding is sufficient to meet the eligibility criteria specified in §155.305(f)(1)(ii)(B) with respect to Medicaid and CHIP.

Third, in §155.302(c) of the final rule, we describe that the Exchange must implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions made by HHS. We also describe that such an arrangement must provide that all verifications, notices, and other activities conducted in connection with determining eligibility for advance payments of the premium tax credit and cost-sharing reductions are conducted by either the Exchange in accordance with all of the applicable standards described in this subpart or by HHS in accordance with the agreement between HHS and the Exchange. We also direct that the Exchange transmit all applicant information and other information obtained or verified by the Exchange to HHS. The Exchange would then adhere to HHS's determination for advance payments of the premium tax credit and cost-sharing reductions. The Exchange and HHS would also need to enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions. As with the option described in §155.302(b), we include particular standards and responsibilities which are designed to eliminate duplicative requests for information from applicants and ensure timely eligibility determinations.

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In §155.302(d) we outline the standards to which the Exchange must adhere when assessments of eligibility for Medicaid and CHIP based on MAGI and eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions are made in accordance with paragraphs (b) and (c); such standards include that all eligibility processes are streamlined and coordinated across applicable agencies, that such arrangement does not increase administrative costs and burden on applicants, enrollees, beneficiaries, or application filers, or increase delay, and that applicable requirements under part 155 and section 6103 of the Code are met.

Lastly, we note that all of the above configuration options will necessitate coordination between the Exchange, HHS, and the State Medicaid and CHIP agency. We will work closely with States to develop operational solutions that will result in a high-quality eligibility process, which in turn will result in achievement of our shared coverage goals and a sustainable Exchange.

Summary of Regulatory Changes

We are finalizing the following provisions at §155.302 and requesting comment. In paragraph (a), we provided that the Exchange may choose to satisfy the standards of subpart D directly or through contracting arrangements, or through one or a combination of options described in paragraphs (b) and (c), subject to additional standards outlined in paragraph (d). If the Medicaid or CHIP agency retains final control of eligibility determinations for Medicaid and CHIP, in paragraph (b), we described that notwithstanding the standards of this subpart the Exchange may conduct assessments of eligibility for Medicaid and CHIP based on MAGI rather than the eligibility determinations for Medicaid and CHIP provided that: the Exchange makes such an assessment based on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with 42 CFR parts 435 and 457, without regard to how such standards are implemented by the State Medicaid and CHIP agencies; notices and other activities conducted in connection with an eligibility determination for Medicaid or CHIP are performed by the Exchange consistent with the standards identified in this subpart or the State Medicaid or CHIP agency consistent with applicable law; when the Exchange assesses an individual as potentially eligible for Medicaid or CHIP, the Exchange transmits all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid or CHIP agency via secure electronic interface; when the Exchange finds an individual not potentially eligible for Medicaid and CHIP, the Exchange considers the applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions and must notify such applicant, and provide him or her with the opportunity to either withdraw his or her application for Medicaid and CHIP or request a full determination of eligibility for Medicaid or CHIP by the State Medicaid and CHIP agencies. When an applicant requests a full determination of eligibility for Medicaid and CHIP, the Exchange must transmit all information obtained or verified by the Exchange to the State Medicaid and CHIP agencies promptly and without undue delay and consider such an applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notifies the Exchange that the applicant is eligible for Medicaid or CHIP. Furthermore, under the arrangement described in paragraph (b), the Exchange must adhere to the eligibility determination for Medicaid or CHIP made by the State Medicaid or CHIP agency, and the Exchange and the State Medicaid and CHIP agencies must enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP. We note that in such an arrangement if the Exchange the State Medicaid and CHIP agencies are using the same information technology infrastructure formal transmissions may not be needed.

In paragraph (c), we establish that notwithstanding the standards of this subpart the Exchange may implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions made by HHS. Under such option we provide: that verifications, notices, and other activities necessary in connection with an eligibility determination for advance payments of the premium tax credit and cost-sharing reductions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS, in accordance with the agreement between the Exchange and HHS; the Exchange transmits all information provided as a part of the application, update, or renewal that initiated the eligibility determination, and any information obtained or verified by the Exchange, to HHS via secure electronic interface, promptly and without undue delay; the Exchange

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adheres to the eligibility determination for advance payments of the premium tax credit and cost-sharing reductions made by HHS; and the Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions.

In paragraph (d), we outline the standards to which assessments and eligibility determinations described in paragraph (b) and (c) must adhere, including that eligibility processes are streamlined and coordinated across insurance affordability programs; such arrangement does not increase administrative costs and burdens on individuals or increase delay; and any applicable standards under §155.260 or §155.270, §155.315(i), and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of information will be met. All such changes adopted for this section of the final rule are described in responses to comments for §155.302.

c. Eligibility standards (§155.305)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (g) of this section as an interim final provision, and we are seeking comments on it.

In §155.305, we proposed to codify the eligibility standards for enrollment in a QHP and for insurance affordability programs. Specifically, we proposed that the Exchange determine an applicant eligible for enrollment in a QHP if he or she meets the basic standards for enrollment in a QHP outlined in the Affordable Care Act, including that the individual must be a citizen, national, or a non-citizen who is lawfully present, not incarcerated, and be reasonably expected to remain so for the entire period for which enrollment is sought. We solicited comments regarding the language that an individual be “reasonably expected,” for the entire period for which enrollment is sought, to be a citizen, national, or non-citizen lawfully present, and on how this policy can be implemented in a way that is straightforward for individuals to understand and for the Exchange to implement.

We also proposed that in order to be eligible to enroll in a QHP, an individual must intend to reside in the State in the service area of the Exchange. We clarified that this residency standard is designed to apply to all Exchanges, including regional and subsidiary Exchanges. In general, we proposed to align the Exchange residency standard with the Medicaid residency standards proposed in 42 CFR 435.403 of the Medicaid proposed rule (76 FR 51148). We clarified that this residency standard does not require an individual to intend to reside for the entire benefit year. We also proposed that the Exchange follow additional Medicaid residency standards (which were proposed in the August 17, 2011 Medicaid rule at 42 CFR 435.403) and the policy of the State Medicaid or CHIP agency to the extent that an individual is specifically described in that section and not under paragraphs (a)(3)(i) or (ii).

We proposed that for a spouse or a tax dependent who resides outside the service area of the tax filer’s Exchange, the spouse or tax dependent will be permitted to either: (1) enroll in a QHP through the Exchange that services the area in which he or she resides or intends to reside; or (2) enroll in a QHP through the Exchange that services the area in which his or her tax filer intends to reside or resides, as applicable. We also solicited comment on any standards regarding in-network adequacy for out-of-State dependents that we should consider in a different section of the proposed rule. We also noted that that HHS intends to allow State Medicaid agencies to continue to have State-specific rules with respect to residency for students under the Medicaid program, and solicited comments on whether different residency rules should be maintained for enrollment in a QHP or whether a unified approach should be adopted.

We proposed that the Exchange determine an applicant eligible for an enrollment period if he or she meets the criteria for an enrollment period, as specified in §155.410 and §155.420. We also proposed that the Exchange determine applicants’ eligibility for Medicaid and CHIP. Specifically, we proposed that the Exchange determine eligibility for Medicaid based on categories utilizing the applicable Medicaid MAGI-based income standard, and that the Exchange determine eligibility for CHIP if an applicant meets the standards of 42 CFR 457.310 through 457.320 and has a household income within the applicable CHIP MAGI-based income standard. Additionally, we

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proposed to codify that if a BHP is operating in the service area of the Exchange, the Exchange will determine an applicant's eligibility for the BHP, using the statutory criteria for eligibility.

We also proposed that the Exchange determine eligibility for advance payments of the premium tax credit based on eligibility standards proposed in paragraph (f)(1) and (f)(2), and that the Exchange may provide advance payments of the premium tax credit only for an applicant who is enrolled in a QHP through the Exchange. Additionally, we clarified that the Exchange must determine a tax filer ineligible to receive advance payments of the premium tax credit if HHS notifies the Exchange that the tax filer or his or her spouse received advance payments for a prior year for which tax data would be utilized for income verification and did not comply with the requirement to file a tax return and reconcile the advance payments of the premium tax credit for such year. In the event the Exchange determines that a tax filer is eligible to receive advance payments of the premium tax credit, we proposed that the Exchange calculate advance payments of the premium tax credit in accordance with 26 CFR 1.36B-3 of the Treasury proposed rule (76 FR 50931).

We also proposed that the Exchange require an application filer to provide the social security number (SSN) of the tax filer if an application filer attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be utilized for verification of household income and family size. We solicited comments on how the Exchange can maximize the accuracy of the initial eligibility determination and establish a robust process for individuals to report changes in income to alleviate stakeholder concerns about income fluctuations during the year that may result in large reconciliation payments.

Finally, we proposed that the Exchange must determine applicants eligible for costsharing reductions based on eligibility standards described in paragraph (g), and we note that special eligibility standards for cost-sharing reductions based on Indian status are described in §155.350 of this subpart. Specifically, we clarified in the proposed rule that an individual with household income that exceeds 250 percent of the FPL who is not an Indian is not eligible for cost-sharing reductions. We codified the statute such that an applicant must be enrolled in a QHP in the silver level of coverage in order to receive cost-sharing reductions. Lastly, we proposed three eligibility categories for cost-sharing reductions, and proposed that the Exchange transmit information about an enrollee's category to his or her QHP issuer in order to enable the QHP issuer to provide the correct level of reductions.

Comments: We received comments regarding the provision in proposed §155.305(a)(1) which states that an individual must be "reasonably expected" to be a citizen, national, or a noncitizen who is lawfully present for the entire period for which enrollment is sought. One commenter recommended that the final rule remove the "reasonably expected" standard as it would limit non-citizens' eligibility to enroll in a QHP.

Response: The final rule maintains the "reasonably expected" standard in accordance with section 1312(f)(3) of the Affordable Care Act. We do not interpret this provision to mean that an applicant must be lawfully present for an entire coverage year; rather, we anticipate that the verification process will address whether an applicant's lawful presence is time-limited, and if so, the Exchange will determine his or her eligibility for the period of time for which his or her lawful presence has been verified. We anticipate providing future guidance on this topic, with a focus on minimizing administrative complexity and burden.

Comment: We received a number of comments related to and in support of the eligibility standard in proposed §155.305(a)(2) that in order to be eligible for enrollment in a QHP, an individual must not be incarcerated, with the exception of incarceration pending the disposition of charges. Several commenters expressed concerns and provided recommendations about how to coordinate and promote continuity of care for individuals who will be transitioning from incarceration, and some commenters expressed this concern in regard to specific populations of incarcerated individuals. One commenter recommended that prisoners should be able to apply for coverage through the Exchange in advance of their release so that coverage can be effective on their release date, while another commenter noted that we should provide that Exchanges must accept applications in the event they are submitted on behalf of an inmate of a correctional facility. Also, one commenter suggested that prisoners should

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not be held responsible for reporting changes if they become incarcerated, and prisoners should not be held liable for repayment of advance payments of the premium tax credit for which they would be liable if they are receiving them and then become incarcerated.

Response: In §155.305(a)(2) of the proposed rule, we codified section 1312(f)(1)(B) of the Affordable Care Act, which specifies that in order to be eligible for enrollment in a QHP, an individual must not be incarcerated, other than incarceration pending the disposition of charges. HHS will consider commenters' recommendations related to promoting continuity of care for individuals leaving incarceration in future guidance. Since the Exchange will accept applications and make eligibility determinations throughout the year, an inmate would not be precluded from applying for coverage through the Exchange in an effort to coordinate an effective date of coverage with his or her release date. We also note that §155.420(d)(7) provides a special enrollment period ("A qualified individual or enrollee who gains access to new QHPs as a result of a permanent move") which covers individuals who are released from incarceration.

The final rule maintains the provision specifying that an enrollee must report any change with respect to the eligibility standards in §155.305, which includes when an enrollee becomes incarcerated, other than incarceration pending the disposition of charges, as it is important for the Exchange to be able to discontinue the enrollment and recompute any advance payments or costsharing reductions to account for the change in eligibility. As with other changes that affect eligibility for enrollment in a QHP, not reporting such a change so that advance payments of the premium tax credit can be adjusted accordingly exposes a tax filer to the risk of repayment of advance payments of premium tax credits at tax filing.

In addition, we note that we clarify in §155.330(b)(4) of the final rule that an application filer may report a change on behalf of an enrollee, which, for example, allows a member of an enrollee's household to report the enrollee's incarceration. Also, in §155.330(d)(2) of this final rule, we allow for flexibility for Exchanges to periodically check trusted data sources, provided that the data matching program meets certain standards; this provision could allow an Exchange to engage in data matching on incarceration to provide an additional avenue to capture changes.

Comment: We received a number of comments related to the residency standards for enrollment in a QHP, described in proposed §155.320(a)(3). Several commenters recommended that the residency standards across the Exchange, Medicaid and CHIP be aligned and uniform so as to limit States' discretion in precluding certain transient populations from having continuous coverage throughout the year. Several commenters recommended that we align with the Medicaid "intent to reside" standard, and include the two provisions from the residency standard as proposed in the Medicaid proposed rule at 42 CFR 435.403(h)(1)(ii). One commenter suggested that we add the following alternative as a means of satisfying the residency standard: "Has entered the State with a job commitment (whether or not he or she is currently employed)."

A few commenters recommended that we should adopt a more stringent residency standard than included in the Medicaid proposed rule.

Response: We intend to align the residency standards with those of the Medicaid regulations; therefore, we are revising §155.305(a)(3) in this final rule in response to commenters' recommendations that we align residency standards with Medicaid and CHIP and in consideration of changes made from the Medicaid proposed rule to the Medicaid final rule.

For example, in §155.305(a)(3)(i)(B), this final rule provides that an applicant age 21 and over also meets the residency standard if he or she has entered the service area of the Exchange with a job commitment or seeking employment (whether or not the applicant is currently employed). This provision was included in the Medicaid proposed rule and is included in the Medicaid final rule; we include it here to provide consistency between these rules. We add language throughout §155.305(a)(3) to clarify that individuals must be "living" in the service area of the Exchange in addition to the prior standards, to clarify that an individual must be physically present in the service area of the Exchange in order to be eligible for enrollment in a QHP through that Exchange. We note,

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however, that this does not preclude an individual from submitting an application and receiving an eligibility determination in advance of relocating to a new State; in such a situation, his or her eligibility will not be effective until he or she is “living” in the new State. We have also restructured paragraph (a)(3)(i) and (ii) for clarity, and have added specific references to the Medicaid final rule.

Comment: We received a number of comments related to the proposal in §155.305(a)(3)(iv) related to residency standards for family members who meet the applicable residency standard for a different Exchange service area than of one or both of the tax filers. While several commenters supported the provision in the proposed rule that dependents and spouses may enroll in a QHP offered through the Exchange in the service area where they reside or through the Exchange serving the area where a tax filer meets the applicable residency standard (or in the case of a spouse who is married filing jointly, another tax filer meets the applicable residency standard), several commenters opposed this provision. If this policy is maintained, one commenter recommended that HHS develop a system for Exchanges to easily apportion premium tax credits among family members. Several commenters expressed concern that a person who purchases coverage from a QHP offered through the Exchange where he or she does not live would likely encounter difficulties in finding care as well as significant additional costs from the use of out-of-network providers. In addition, the QHP issuer would be limited in its ability to facilitate use of the highest quality and most efficient providers and coordinate care across providers and settings. Commenters encouraged HHS to consider limiting this option.

Several commenters recommended that HHS establish an electronic mechanism for Exchanges to communicate with each other, as well as sought clarification about how the Exchanges will coordinate tax credits for members of the same tax household purchasing coverage in QHPs through different Exchanges and other specific operational details around verification and the eligibility process. One commenter noted that this would be a simpler process if a tax filer could purchase coverage for a dependent or spouse in the other State’s Exchange through the tax filer’s Exchange via a link or web portal.

Response: We maintain the residency standard in §155.305(a)(3)(iv) of the final rule with limited modifications. All of the modifications result from a change in our terminology from “primary taxpayer” to “tax filer” in an effort to reduce confusion that could be associated with the term “primary taxpayer,” notably since primary taxpayer generally refers to the first name on the tax return of two individuals who are married, but both individuals are tax filers and there is no significance to which is the primary taxpayer for purposes of the premium tax credit (this change has been made throughout the final rule). The remaining changes are to clarify that any member of a tax household that has members in multiple Exchange service areas may enroll in a QHP through any of the Exchanges for which one of the household’s tax filers meets the applicable residency standard; the exception to this standard is that when both tax filers enroll in a QHP through the same Exchange, the tax filers’ dependents may choose either the Exchange through which the tax filers are enrolled or an Exchange for which the dependents meet the applicable residency standard in paragraphs (a)(3)(i)-(iii). Taken together, we expect that these residency standards will ensure that enrollees in QHPs through the Exchange have appropriate access to services.

Regarding comments suggesting that Exchanges should be able to apportion premium tax credits among family members, we will provide additional information in the future in coordination with the IRS. We note that the apportionment of advance payments will need to occur when a single tax household is covered by more than one QHP. Regarding comments we received related to network adequacy, a more detailed response is provided in §156.230 of this final rule. We also note that multi-State plans certified by and under contract with the Director of the Office of Personnel Management may provide another option in such scenarios. In response to comments recommending that we create an electronic mechanism by which Exchanges can communicate with each other and other operational details of the eligibility process, HHS is considering commenters’ recommendations regarding how best to coordinate cross-Exchange activities.

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Comment: A few commenters strongly supported limiting enrollment to a single open enrollment period per year.

Response: The language in §155.305(b) of the proposed rule specified that the Exchange determine an applicant eligible for an enrollment period in accordance with the provisions regarding enrollment periods in §155.410 and §155.420.

Comment: A number of commenters expressed overall support for the Exchange conducting Medicaid and CHIP eligibility determinations, and some suggested that the regulation be amended to include a standard that an Exchange determine eligibility for Medicaid on any basis of eligibility offered in that State (such as optional eligibility categories and categories that do not use the MAGI standard). Some commenters expressed support for uniformity and standardization around eligibility and enrollment in general. Several commenters recommended that HHS provide that the Exchange must collect information related to non MAGI eligibility to ensure that applicants can truly avail themselves of a “no wrong door” application process for Medicaid. A few commenters supported the clarification that eligibility for emergency Medicaid services does not count as Medicaid eligibility for purposes of eligibility for premium tax credit and cost-sharing reductions through the Exchange. Another recommended that there should be an emphasis on child-only plans through the Exchange for those children who are not eligible for Medicaid.

Response: Sections 155.345(b) and (d) of the final rule specify that the Exchange must assess information provided by an applicant who is not eligible for Medicaid based on standards specified in §155.305(c) to determine whether he or she is potentially eligible for Medicaid in a category that does not use the MAGI standard, and refer any potentially eligible individuals to the Medicaid agency for an eligibility determination. In addition, §155.345(c) of the final rule specifies that the Exchange must provide an opportunity for an applicant to request a full Medicaid eligibility determination based on factors not considered in §155.305(c). We believe that this proposal creates a streamlined eligibility process for the vast majority of applicants, while also allowing applicants who may be eligible for a category that does not use the MAGI standard to access a more streamlined process than is available today, without requiring the Exchange to accommodate all of the complexity associated with the categories of Medicaid that were not modified by the Affordable Care Act.

In order to maintain a single, streamlined application, and in accordance with section 1413(b)(2) of the Affordable Care Act, applicants will not be asked for more information than is needed for the Exchange to make an eligibility determination for insurance affordability programs based on MAGI, apart from collecting basic information to assess individuals for potential Medicaid eligibility on a non-MAGI basis, for example a single triggering question. Applicants will always have the opportunity to request a full determination of eligibility for Medicaid. We also note that we know that several States are considering leveraging a single Exchange/Medicaid/CHIP technology platform in future years to also accommodate non-MAGI Medicaid applicants, which is permitted under the statute and final rule. In response to commenters requesting clarification about whether eligibility for Medicaid coverage that is limited to emergency services counts as minimum essential coverage for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions, this determination is subject to other rulemaking. We note, however, that individuals who are not lawfully present, are not eligible for enrollment in a QHP, let alone for enrollment in a QHP that is supported by advance payments and cost-sharing reductions. We also note that immigration status is not a factor for emergency Medicaid eligibility. In this final rule, we also revise §155.305(c) to streamline references to Medicaid citizenship and immigration status and residency eligibility standards, and align with the Medicaid MAGI-based assessment described under 42 CFR 435.911(c)(1). Lastly, regarding child-only plans, we note that the Exchange will inform an applicant of all of the QHPs for which he or she is eligible, including any child-only plans.

Comment: We received a range of comments related to performance measurement and oversight tools related to eligibility and enrollment. One commenter recommended a modification of Federal audit tools to ensure that States are evaluated based on the number of eligible people they correctly enroll for coverage. Some commenters recommended that QHP issuers should not be held responsible for any errors that the Exchange may make in the

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eligibility determination process, while some commenters sought clarification of an Exchange's liability for inaccurate eligibility determinations. Other commenters requested State flexibility when operational challenges impede a seamless eligibility and enrollment process (including, for example, transitioning enrollees from one insurance affordability program to another).

Response: We plan to regulate in the future on oversight tools and performance measurements in future rulemaking and guidance. We will consider commenters' recommendations regarding oversight tools and performance measurement as we develop future guidance on this topic.

Comment: Several commenters strongly supported the Exchange sharing common eligibility standards with Medicaid, CHIP, and the BHP, and determining eligibility for the BHP. Several commenters suggested that the Exchange should conduct eligibility determinations for other programs that are not related to health insurance coverage, such as the Supplemental Nutrition Assistance Program and the National School Lunch Program. Other commenters stated that individuals who are served by those programs should also be enrolled in the appropriate health care program if they are not already enrolled. At least one commenter recommended that those applying for unemployment insurance also be directed towards health benefits for which they might be eligible.

Response: In the final rule, we do not require the level of integration between the Exchange and other human services programs that some commenters recommended. This would not preclude a State from leveraging the technology platform and supporting infrastructure for insurance affordability programs for other health and human services programs in the future, provided that privacy and security standards (and applicable cost allocation rules) are met, particularly regarding the use and disclosure of information provided to the Exchange by applicants and Federal agencies. To this end, on August 10, 2011 and January 23, 2012, CMS, the Administration for Children and Families (ACF), and the Food and Nutrition Service (FNS) issued joint letters providing guidance on the limited exception to cost allocation guidelines which allows Federally-funded human services programs to benefit from Medicaid, CHIP, and Exchange technology investments.

Comment: We received a number of comments related to eligibility standards for advance payments of the premium tax credit, in particular regarding compliance with the filing requirement described in proposed §155.305(f)(4). Some commenters recommended that the final rule clarify that if a tax filer is determined eligible for advance payments of the premium tax credit but opts not to take advance payments, his or her ability to file for the credit at the end of the tax year is not affected; commenters also asked whether such a scenario would adversely affect his or her eligibility for cost-sharing reductions. One commenter requested clarification regarding the length of time for which a taxpayer would be deemed ineligible for advance payment of premium tax credit following a failure to file a tax return. Some commenters suggested States should have the flexibility to discontinue eligibility for advance payments of the premium tax credit and Medicaid if Federal tax filings are not current.

Response: We clarify that when a tax filer is determined eligible for advance payments of the premium tax credit but opts to not have advance payments made on his or her behalf, the tax filer may still claim the premium tax credit on his or her tax return; further, such action does not adversely affect his or her eligibility for cost-sharing reductions. Regarding §155.305(f)(4), we note that the language of the proposed rule, which we maintain in the final rule, specifies that the Exchange may not determine a tax filer eligible for advance payments if advance payments of the premium tax credit were made on behalf of the tax filer, or either spouse if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household income and family size, and the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year as required by 26 USC 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit for that period.

We also note that a tax filer faced with this bar to eligibility may be able to regain eligibility by filing a tax return and reconciling the advance payments of the premium tax credit. Lastly, we do not have authority to discontinue

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Medicaid eligibility based on a failure to file a tax return. In the final rule, we also make a correction to the eligibility criteria for advance payments of the premium tax credit at §155.305(f)(1)(ii) to align with the statutory requirement in section 36B(c)(1)(A) of the Code; the Exchange must generally determine that the tax filer is expected to have a household income of greater than or equal to 100 percent of the FPL.

Comment: We received several comments requesting clarification as to how eligibility will be determined for specific household composition scenarios. One comment, for example, asked for clarification regarding situations in States that recognize same-sex marriages or civil unions.

Response: In §155.305(f) in this final rule, we use a number of cross-references to section 36B of the Code which governs the premium tax credit; these rules are the same rules that are used to determine eligibility for advance payments of the premium tax credit. Consequently, we refer commenters to those rules for details regarding family and family size. Similarly, in §155.305(c) and (d), we use a number of cross-references to 42 CFR parts 435 and 457, which contain the Medicaid and CHIP rules for household composition; we refer commenters to those rules for details regarding these provisions.

Comment: We received a comment asking that we address the issue of deeming a sponsor's income to non-citizen applicants for Federal means tested public benefits; specifically, the commenter asked whether that policy is applicable to calculation of annual household income for purposes of determining eligibility for advance payments of the premium tax credit and costsharing reductions. The same commenter suggested that for applicants who are determined ineligible for Medicaid as a result of accounting for sponsor income and whose annual household income is below 100 percent FPL, we should apply the special rule described in §155.305(f)(2) that would allow such applicants to be determined eligible for advance payments of the premium tax credits.

Response: We intend to work closely with Treasury to address the applicability of sponsor deeming in the calculation of annual household income for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions through future rulemaking or guidance. Such rulemaking or guidance will also address the relationship between sponsor deeming and the special rule described in §155.305(f)(2).

Comment: Several commenters expressed concern about the affordability of coverage for low-income individuals, notably lawfully present immigrants who are eligible for advance payments of the premium tax credit but ineligible for Medicaid. Some commenters requested clarification that lawfully present non-citizens with incomes below 100 percent FPL could be determined eligible for cost-sharing reductions in the 100 to 150 percent FPL eligibility category.

Response: In response to comments received regarding lawfully present non-citizens with incomes below 100 percent FPL and eligibility for cost-sharing reductions, we are clarifying in §155.305(g)(2)(i) of the final rule that an individual who is eligible for advance payments of the premium tax credit under §155.305(f)(2) (non-citizens who are lawfully present and are ineligible for Medicaid) fall within the 100 to 150 percent FPL eligibility category for purposes of determining eligibility for cost-sharing reductions. We also correct §155.305(f)(1)(i) to provide that an applicant who expects to have a household income of greater than or equal to 100 percent FPL may be determined eligible for advance payments of the premium tax credit; this is a technical correction to comply with section 36B(c)(1)(A) of the Code.

Comment: Several commenters suggested we clarify the relationship between advance payments of the premium tax credit and other forms of coverage, such as CHIP or Medicare, for determining eligibility as well as for the calculation of the premium tax credit.

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Response: We note that comments of this nature are outside the scope of this rule and are within the jurisdiction of the Secretary of the Treasury.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.305 of the proposed rule, with several modifications: we added language throughout §155.305(a)(3) of the final rule to clarify that individuals must be “living” in the service area of the Exchange in addition to the prior standards. In addition, in §155.305(a)(3)(i)(B), we include in the final rule that an applicant age 21 and over also meets the residency standard if he or she has entered the service area of the Exchange with a job commitment or seeking employment (whether or not currently employed).

We have also restructured paragraph (a)(3)(i) and (ii) for clarity, and have added specific references to the Medicaid final rule. In paragraph (c)(1), we also added a standard that the Exchange must determine an applicant eligible for Medicaid if he or she meets the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI (that is, citizenship or immigration status, residency, etc.), as certified by the Medicaid agency at 435.1200(b)(2), and added a cross-reference to 42 CFR 435.603(d) for household income, in addition to the other criteria described under this paragraph. In paragraph (d), we added a crossreference to 42 CFR 435.603(d) for household income.

In paragraph (f)(1)(i), we have changed “at least 100 percent” to “greater than or equal to 100 percent” to align with statutory language. In paragraph (f)(1)(ii)(B), we codified the exception for coverage in the individual market. In paragraph (f)(4), we have added, “or either spouse if the tax filer is a married couple,” and clarified that applicable Treasury provisions requires a tax filer on whose behalf advance payments are made to both file an income tax return, and as a part of that return, to reconcile the advance payments made.

We have combined and restructured paragraphs (g) and (h) of the proposed rule into paragraphs (g)(1) and (g)(2) of the final rule. In paragraph (g)(2)(i) we have added a provision to implement section 1402(b) of the Affordable Care Act, which provides a special rule for noncitizens who are lawfully present; this revision clarifies that individuals who are expected to have a household income of less than 100 percent of the FPL for the benefit year for which coverage is requested and who are also eligible for advance payments of the premium tax credit under paragraph (f)(2) are eligible for cost-sharing reductions.

In paragraph (g)(3), we have added language implementing section 1402 of the Affordable Care Act, which provides cost-sharing reductions at a policy level, in situations where multiple tax households are covered by a single policy. In this paragraph, we specify a hierarchy of available cost-sharing provisions, and explain that when multiple tax households are covered on a single policy, the Exchange will apply only the first category of cost-sharing reductions listed in this paragraph. The categories are listed such that the lowest level of costsharing reductions will be provided to the combined households. We note that the tax households are always free to purchase separate policies, and in doing so, receive the benefit of all costsharing provisions for which they are eligible.

Lastly, in paragraph (g)(4) we added language to clarify that household income for the purposes of eligibility for cost-sharing reductions is defined in accordance with section 36B(d)(2) of the Code, which is the same definition used for advance payments of the premium tax credit. We also clarified that the time period for measuring income for cost-sharing reductions is the same as for advance payments of the premium tax credit. We also made technical changes to the final rule. In §155.305(c), we changed the reference to 42 CFR 435.1200(c)(1) to 42 CFR 435.1200(b)(2), and throughout the section, as in the rest of the subpart, we replaced language regarding application filers providing attestations with references to applicants providing attestations, since the language in §155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

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d. Eligibility determination process (§155.310)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (e) of this section as an interim final provision, and we are seeking comments on it. In §155.310, we proposed the process by which the Exchange will determine an individual's eligibility for enrollment in a QHP through the Exchange and for insurance affordability programs. Specifically, we proposed that the Exchange must accept applications from individuals in the form and manner described in §155.405, and included standards around the collection of information from non-applicants. We also proposed that the Exchange permit an individual to decline an eligibility determination for insurance affordability programs. In addition, we proposed that the Exchange accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during a benefit year. After the Exchange has collected and verified all necessary data, we proposed that the Exchange conduct an eligibility determination in accordance with the standards described in §155.305 of this part.

We also proposed that the Exchange allow an applicant who is determined eligible for advance payments of the premium tax credit to accept less than the expected annual amount of advance payments authorized. We clarified that the Exchange may provide advance payments on behalf of a tax filer only if the tax filer first attests that he or she will meet the tax-related provisions discussed in the definition of tax filer, including that he or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her tax family.

We also proposed that if the Exchange determines an applicant is eligible for Medicaid or CHIP, the Exchange will notify the State Medicaid or CHIP agency and transmit relevant information, including information from the application and the results of verifications, to the relevant agency promptly and without undue delay. We also proposed that effective dates for enrollment in a QHP through the Exchange, advance payments of the premium tax credit and cost-sharing reductions be implemented in accordance with the dates specified in §155.410(c) and (f) and §155.420(b).

We proposed that the Exchange provide an applicant with a timely, written notice of his or her eligibility determination, including the applicant's eligibility for insurance affordability programs, as appropriate. We also proposed that when the Exchange determines an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions based, in part, on a finding that the applicant's employer does not provide minimum essential coverage, provides coverage that is not affordable, or provides coverage that does not meet the minimum value standard, the Exchange must notify the employer and identify the employee.

Finally, we proposed rules regarding the duration of an eligibility determination for an applicant who is determined eligible for enrollment in a QHP but does not select a QHP within his or her enrollment period in accordance with subpart E of this part. We solicited comments on whether a new determination should be conducted after a specific period of time has passed and whether the application process should begin anew in some or all situations.

Comment: We received a few comments recommending the adoption of a timeliness standard within which the Exchange would need to complete an eligibility determination. Most of these commenters recommended requiring that the Exchange adhere to the Medicaid timeliness standard as outlined in 42 CFR 435.911(a)(2), which provides that the Medicaid agency must establish a standard for determining an individual's eligibility and informing the individuals of his or her eligibility determination that does not exceed 45 days.

Response: We recognize that there is a need for a timeliness standard for Exchange eligibility determinations. We add paragraph (e) which states that the Exchange must conduct an eligibility determination promptly and without undue delay. We also include that the Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an insurance affordability program, when applicable. We intend to

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further interpret this timeliness standard in future guidance in coordination with standards established for the Medicaid and CHIP programs.

We note that we think it is reasonable that the majority of eligibility determinations will be completed in a very short period of time and encourage the Exchange to continuously monitor and identify ways to shorten the time it takes to process an application and notify an applicant of his or her eligibility determination. We plan to work closely with States to establish a more detailed understanding of the timing needed for an eligibility determination as well as how the length of time needed can be reduced, and will provide future guidance on timeliness standards.

Comment: We received a substantial number of comments in support of our proposed policy, as described in §155.310(a)(2), that the Exchange may not require an individual who is not seeking coverage for himself or herself to provide a SSN except as provided in proposed §155.305(f)(6) (when he or she is the tax filer and the application filer attests that the tax filer has a SSN and has filed a tax return for the year for which the tax data would be utilized for verification of household and family size). While the majority of commenters supported the policy on the collection of SSNs, as proposed in §155.310(a)(2) and §155.305(f)(6), a few commenters suggested adding language to reinforce the applicability of guidance on the collection of SSNs issued on September 21, 2000 by CMS (then HCFA), the Administration of Children and Families, and the Food and Nutrition Service (the 'Tri-Agency guidance'); others asked that we cross-reference the companion provision in the Medicaid proposed regulation (42 CFR 435.907(e)(1)).

Response: First, in new §155.310(a)(3)(i), we have clarified that the Exchange must collect a SSN from an applicant who has a SSN. We have also moved the proposed provision in §155.310(a)(2) to §155.310(a)(3)(ii). We clarify that this provision only provides that the Exchange must collect SSNs from a non-applicant if he or she is the tax filer, has a SSN, and has filed a tax return for the year for which tax data would be utilized. We believe this provision is necessary given the standards for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, as described in sections 1402(f)(3), 1411(b)(3) and 1412(b) of the Affordable Care Act, which provide that the most recent tax data available be the basis for determining eligibility for these benefits to the extent such tax data is available.

In addition, we note that section 36B(d)(2)(A)(ii)(II) of the Code specifies that household income for purposes of premium tax credits includes the MAGI of any individuals who have a filing requirement. As previously noted, a SSN must be used to obtain tax data from the IRS, and the IRS will not provide the tax data of a dependent who had a filing requirement without the dependent's SSN. As noted above, while the Exchange will require an individual who is seeking coverage for himself or herself who has a SSN to provide it, the Exchange will only require an individual who is not seeking coverage for himself or herself to provide a SSN if he or she is a tax filer who meets the standard described in paragraph (f)(6). That is, in the limited number of cases in which a dependent is not seeking coverage for himself or herself, the Exchange will not require such a dependent to provide his or her SSN, although the dependent may provide it on a voluntary basis. However, we believe that §155.305(f)(6), as proposed, is permissible under section 1412, given that a) whether a dependent has a filing requirement may change frequently, resulting in a change in circumstances that allows the Exchange to use an alternate verification process; and b) we believe that it will be challenging for an applicant to determine whether a dependent was or will be required to file (versus a voluntary filing). Further, we do not believe that it is appropriate to add a provision to require the Exchange to collect the SSN for every dependent who is not seeking coverage for himself or herself, regardless of whether he or she had a filing requirement, because this would go beyond what is needed to obtain tax data for those who had a requirement to file. As such, we maintain this provision in the final rule. To the extent that a dependent who is not seeking coverage for himself or herself has income that needs to be considered for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, the Exchange will verify it through an alternate verification process.

We believe that these provisions also comply with the statutory standards contained in section 1411(g)(1) of the Affordable Care Act, which specifies that the Exchange must not require an applicant to provide information

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beyond what is necessary to support the eligibility and enrollment process. Given the statutory standards, we believe these are the appropriate application of the Tri-Agency guidance. We intend to continue to review these issues in the context of all insurance affordability programs and to develop a single, streamlined application that accommodates these policy and eligibility differences.

In addition, we have added §155.315(b), which clarifies that in accordance with section 1411 of the Affordable Care Act, the Exchange will transmit SSNs to HHS for validation with SSA. This is separate from the provision regarding citizenship verification, and only serves to ensure that SSNs provided to the Exchange can be used for subsequent transactions, including for verification of family size and household income with IRS. We clarify that in accordance with section 1411(e)(3) of the Affordable Care Act, which governs inconsistencies regarding SSNs, to the extent that the Exchange is unable to validate a SSN, the Exchange will follow the inconsistency procedures specified in §155.315(f).

Comment: We received a number of comments in support of our proposed policy to allow applicants to opt out of an eligibility determination for insurance affordability programs but to not allow applicants to choose among a subset of insurance affordability programs in proposed §155.310(b). Only one commenter did not support the provision to allow individuals to opt out of screening for insurance affordability programs, citing that it is more important to provide a uniform eligibility determination for all applicants to increase the likelihood that individuals have access to affordable coverage options. One commenter also suggested that the final rule provide certain exceptions to the provision barring individuals from selecting among insurance affordability programs.

Response: We believe it is important to preserve the option for an applicant to bypass the examination of his or her household income and other information that may result in a lengthier eligibility process, and allow him or her to enroll directly in a QHP without financial assistance if he or she so chooses. Therefore, in the final rule, we are maintaining the provision in §155.310(b) with some clarification; the Exchange must permit an applicant to request only an eligibility determination for enrollment in a QHP through the Exchange, but that the Exchange may not permit an applicant to request an eligibility determination for less than all insurance affordability programs. We expect that an Exchange could implement this provision by allowing an applicant to opt-out of an eligibility determination for all insurance affordability programs.

We also maintain that an applicant may not choose between insurance affordability programs since section 36B(c)(2)(B) of the Code specifies that a tax filer is ineligible for advance payments of the premium tax credit for any applicant who is eligible for other minimum essential coverage.

Comment: A number of commenters, particularly consumer groups, noted support for the provision in proposed §155.310(d)(2), which would allow an enrollee to accept less than the full amount of advance payments of the premium tax credit for which he or she is determined eligible; however, the majority of these commenters recommended that HHS complement this provision with a standard that the Exchange must provide detailed consumer education and tools regarding the premium tax credit and reconciliation. We also received a number of comments which raised concerns that individuals may not fully understand the responsibilities associated with receiving advance payments of the premium tax credit; such commenters recommended that HHS provide more detail concerning what information will be provided to consumers about reconciliation.

Response: We amended the final rule in §155.310(d)(2)(ii) to state that the Exchange may authorize advance payments of the premium tax credit on behalf of a tax filer only if the Exchange obtains certain attestations regarding advance payments of the premium tax credit from a tax filer. We intend to provide further guidance regarding the additional attestations that may be asked of individuals, which may include an attestation from a tax filer acknowledging that he or she understands the potential impact of reconciliation.

Comment: We received a number of comments regarding the standards for Exchanges to notify the State Medicaid or CHIP agency upon determining an applicant eligible for Medicaid or CHIP and transmit relevant information

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promptly and without undue delay described in proposed §155.310(d)(3). Commenters recommended that HHS provide a timeliness standard that is more specific than “promptly and without undue delay,” and suggested adding language to provide the Exchange must transmit the relevant information “within no more than 24 hours.” A few commenters also recommended aligning with Medicaid language to clarify that “relevant information” transmitted to Medicaid or CHIP agencies include “the electronic account containing the finding of Medicaid or CHIP eligibility, all information provided on the application, and any information obtained or verified by the Exchange in making such a finding.”

Response: We considered the recommendation to adopt a specific time standard for the transmittal of information between the Exchange and State Medicaid or CHIP agencies; however, we believe that the timeliness standard in the regulation text at paragraph (e) provides the necessary flexibility to accommodate technological advances. We anticipate that we will interpret and clarify this standard in guidance. Furthermore, this standard is aligned with the Medicaid standard described in 42 CFR 435.911(c)(1); CMS also plans to issue guidance to clarify this standard.

We also considered comments asking HHS to specify the meaning of “relevant information.” We recognize that clarification is necessary, and in the final rule, replace the phrase “relevant information” in §155.310(d)(3), with “all information necessary to effectuate coverage in Medicaid or CHIP.” Although this is not the identical language used in Medicaid regulations, we believe it is the appropriate standard to adequately address the concern raised by the commenter.

Comment: We received a variety of comments related to the notification of eligibility determination, described in proposed §155.310(g). Several commenters asked that we amend the language in this provision to provide that such a notice must be “written,” as we specified in the proposed rule governing general notice standards in §155.230(a). One commenter suggested adding language to allow applicants or enrollees to choose to have notices sent to other parties, such as application assisters or authorized representatives; another recommended adding a notice to individuals when an application is incomplete.

Response: Because paragraph §155.230(a) of the proposed rule specifies that notices issued by the Exchange must be “written,” this general notice standard would apply to the notification of eligibility determination, which we clarify in §155.310(g) in this final rule. We will further address notices and the roles of application assisters and authorized representatives in future rulemaking and guidance.

Comment: We received a large number of comments on proposed §155.310(g) regarding the content and scope of employer notices of an employee’s eligibility for advance payments of the premium tax credit and cost-sharing reductions. These commenters suggested that HHS limit employer notices to a subset of employers to provide greater privacy protections for consumers. Most commenters stated that the employer should be notified of an employee’s receipt of advanced payment of the premium tax credit or cost-sharing reductions only if this determination might trigger an employer responsibility payment. Some commenters asserted that the appropriate trigger for an employer to receive notification is if the employer has 50 or more full time equivalent employees and the employer has full-time employees that receive advanced payment of the premium tax credit or cost-sharing reductions through the Exchange. One commenter said that only employers that offer unaffordable coverage should receive a notification and employers that offer no coverage should not receive any employee information.

Response: While we recognize that the employer responsibility provisions of section 4980H of the Code apply only to employers with 50 or more full-time equivalent employees, section 1411(e)(4)(B)(iii) of the Affordable Care Act imposes the obligation to provide the notice regardless of the size of the employer. Therefore, we are not limiting the scope of the notice standard in this final rule to a subset of employers. We anticipate that HHS may provide additional guidance regarding how the content of the notice can be structured so as to minimize potential employer confusion associated with whether a determination will have implications under section 4980H of the Code.

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Further, we are aware that employer contact information may not always be available, because a person fails to provide it, or provides incorrect information, or that person changed employers, or a host of other reasons. We will work with Exchanges and employers on this to develop a solution for situations in which the Exchange does not have a seamless way to reach the correct employer for the purposes of delivering the notice.

Comment: Other commenters raised additional privacy concerns regarding the content of notices sent to employers under proposed §155.310(g). Several commenters suggested that the Exchange provide the employer with the minimum amount information necessary to evaluate liability for the employer responsibility payment. One commenter suggested that the Exchange should only transmit information necessary under law—the employee name and taxpayer identification number. This commenter stressed that the regulation should specify that the taxpayer identification number (TIN) should be used, and not the SSN, in accordance with section 1311(d)(4)(I) of the Affordable Care Act. One commenter suggested that even the employee name should not be disclosed. Finally, a few commenters noted that HHS should be sensitive to the fact that some employees do not want their employers to know their household income.

Response: For the purposes of the employer notice under section 1411(e)(4)(B)(iii) of the Affordable Care Act, we believe that only the minimum necessary personally identifiable information should be released to an employer. The Affordable Care Act provides that the Exchange must notify an employer that his or her employee has been determined eligible for advance payments of the premium tax credit and that the employer may appeal such eligibility determination. The proposed rule provided only that the notice identify the employee. However, based on sections 1411(e)(4)(B)(iii), 1411(e)(4)(C), and 1411(f)(2)(B) of the Affordable Care Act, our final regulation provides that if an enrollee is eligible for a premium tax credit or costsharing reductions because that enrollee's employer does not provide minimum essential coverage through an eligible employer-sponsored plan, or that the employer provides coverage but it is not affordable or does not meet minimum value, the Exchange must notify the employer, identifying the employee, relating the opportunity to appeal, indicating that the employee has been determined eligible for advance payments of the premium tax credit, and indicating that the employer may be liable for a shared responsibility payment under section 4980H of the Code if the employer has 50 or more full-time workers. We note that we do not expect the Exchange to relay to the employer the exact reason for which the applicant was determined eligible, or to provide any tax return information to the employer. Rather, the notice should indicate the list (above) of potential reasons for the determination. We have amended the final rule, redesignating proposed section (g) as section (h) and adding sections (h)(2) and (h)(3) to §155.310 to clarify these standards. The notice will not disclose an enrollee's household income or any other taxpayer information, except the enrollee's name or other personal identifier. We anticipate that additional guidance regarding the content of the notification will be released in the future.

Comment: One commenter expressed concern about potential HIPAA violations that may occur if an applicant provides the wrong employer contact information, and an incorrect employer receives the notification, with respect to the notices sent in accordance with proposed §155.310(g).

Response: To the extent the Exchange is not a HIPAA covered entity or business associate, the Exchange would be subject only to the privacy and security standards of 155.260. If a State has determined that its Exchange is a HIPAA covered entity or business associate, to the extent the Exchange was merely acting on incorrect information provided to the Exchange by an applicant, there would be no HIPAA violation. In addition, we do not expect that the notice will result in a violation of applicable privacy and security standards in this section. We acknowledge that the notices outlined under this section will contain personally identifiable information, such as the name of enrollees. However, we think any inadvertent disclosure would be mitigated by the fact that only minimal information about the individual will be included in the employer notice; thus, we do not believe that this standard poses a substantial threat to individual privacy. In addition, we plan to disseminate guidance to Exchanges on practices designed to minimize the instances of individuals or entities other than the enrollee's actual employer receiving the notice.

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Comment: A number of commenters asked that Exchanges inform employers that retaliation based on the notices sent in accordance with §155.310(g) is prohibited and that evidence of retaliation could subject the employer to a penalty.

Response: We note that section 1558 of the Affordable Care Act, which amends the Fair Labor Standards Act and is within the jurisdiction of the Department of Labor, includes a prohibition on an employer discharging or discriminating against an employee because the employee has received a premium tax credit or cost-sharing reductions. Because of this statutory provision, we do not believe additional standards are necessary in this final rule.

Comment: One commenter suggested that IRS, and not HHS, effectuate the notice described in §155.310(h) because (1) IRS has information about employers subject to free rider assessments, and (2) IRS maintains a database of employer contacts for the transmission of sensitive personal information. Another commenter suggested that reporting to employers should be consolidated and centralized into a Federal process, with information provided on a monthly or quarterly basis.

Response: Section 1411(e)(4)(B)(iii) provides that this notice must be provided to employers by Exchanges in connection with certain eligibility determinations. It is not within the discretion of the Secretary to shift responsibility for provision of this notice to the IRS. We do support reducing reporting burden by consolidating and streamlining reporting, if feasible. In addition, we plan to issue guidance to help Exchanges develop an operational strategy for reporting.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.310 of the proposed rule, with a few modifications. In paragraph (b), we clarified that the choice of an applicant is whether to allow the Exchange to determine his or her eligibility for insurance affordability programs. In paragraph (d)(2)(ii), we added language specifying that attestations from the tax filer will be attestations regarding advance payments of the premium tax credits. In paragraph (d)(3), we removed the reference to “relevant” information and further clarified that the Exchange must transmit all information from the records of the Exchange promptly and without undue delay to such agency that is necessary for the State Medicaid or CHIP agency to provide the applicant with coverage. In paragraph (e), we adopted a provision which provides that the Exchange must conduct eligibility determinations promptly and without undue delay.

In paragraph (f), we clarified in the header that the effective dates outlined are effective dates for eligibility, and not for coverage. Consistent with changes we discuss in §155.420, we also added language in paragraphs (f)(1) and (f)(2) to differentiate between effective dates for initial eligibility determinations, which will be implemented in accordance with §155.410(c) and (f) and §155.420(b), as applicable, and effective dates for redeterminations, which will be implemented in accordance with the dates specified in §155.330(f) and 155.335(i), as applicable.

In paragraph (g), we added language to specify that the notice of eligibility determination must be written, consistent with other notice standards. We redesignated proposed paragraph (g) as new paragraph (h). In new paragraph (h), we added three additional standards, in accordance with section 1411(e)(4) of the Affordable Care Act, for the content of the notice to employers. In addition to identifying the employee, the notice must indicate that the employee has been determined eligible for advance payments of the premium tax credit; that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under section 4980H of the Code; and that the employer has the right to appeal the determination. Also included in this final rule are several technical corrections from the proposed text. In paragraph (a)(1), we removed the reference to 45 CFR and changed the phrase to “specified in §155.405 of this chapter.” In paragraph (b), we added the words “insurance affordability” before “programs” as a clarification.

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e. Verification process related to eligibility for enrollment in a QHP (§155.315)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (g) of this section as an interim final provision, and we are seeking comments on it. In §155.315, we proposed the general standard that the Exchange must verify or obtain information to determine that an applicant is eligible for enrollment in a QHP, unless a request for modification is granted in accordance with proposed paragraph (f) of this section.

To verify whether an applicant for coverage through the Exchange is a citizen, national, or otherwise lawfully present individual in accordance with section 1312(f)(3) of the Affordable Care Act, we proposed to codify the role of the Secretary (through HHS) as an intermediary between the Exchange and other Federal officials, specifically the Social Security Administration and the Department of Homeland Security. In the case of an inconsistency related to citizenship, status as a national, or lawful presence, we proposed that the time period for the resolution is 90 days from the date on which the notice of inconsistency is received. We also clarified that the date on which the notice is received means 5 days after the date on the notice, unless the applicant shows that he or she did not receive the notice within the 5 day period.

We also proposed that the Exchange verify an applicant's residency by accepting an applicant's attestation without further verification or following the procedures of the State Medicaid or CHIP agency, if such agency examines electronic data sources for all applicants. We also proposed that the Exchange may examine data sources regarding residency to the extent that information provided by an applicant regarding residency is not reasonably compatible with other information provided by the applicant or in the records of the Exchange. In addition, we proposed that a document that provides evidence of immigration status may not be used alone to determine State residency. We also proposed that the Exchange verify an applicant's attestation that he or she is not incarcerated. We solicited comment as to what electronic data sources are available and should be authorized by HHS for Exchange purposes, including whether access to such data sources should be provided as a Federally-managed service like citizenship and immigration status information from SSA and DHS. Further, we proposed that when an individual attests to information and such attestation is inconsistent with other data in the records of the Exchange, the Exchange must make a reasonable effort to identify and resolve the issues. If the Exchange is unable to resolve the inconsistencies, we proposed that the Exchange notify the applicant of the inconsistency. After providing this notice, we proposed that the Exchange provide 90 days from the date on which the notice is sent for the applicant to resolve the issues, either with the Exchange or with the agency or office that maintains the data source that is inconsistent with the attestation. We also proposed that the period during which an applicant may resolve the inconsistency may be extended by the Exchange if the applicant can provide evidence that a good faith effort has been made to obtain additional documentation.

We further proposed that the Exchange allow an individual who is otherwise eligible for enrollment in a QHP, advance payments of the premium tax credit or cost-sharing reductions to receive such coverage and financial assistance during the resolution period, provided that the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit received during the resolution period are subject to reconciliation. We also proposed that if after the conclusion of the resolution period, the Exchange is unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information available from the data sources specified in this subpart and notify the applicant of such determination. We clarified that the Exchange must make effective this eligibility determination no earlier than 10 days after and no later than 30 days after the date on which such notice is sent.

Finally, we also proposed that HHS may approve an Exchange Blueprint to change the methods used to collect and verify information, within certain standards. We also proposed that the Exchange must not require an applicant to provide information beyond the minimum necessary to support eligibility and enrollment processes.

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Comment: We received a few comments asking that we establish standards for the collection, use and safeguarding of data used to verify applicant information, as described throughout proposed §155.315. We received a few comments suggesting that we incorporate specific safeguards and protections for information used in the verification of citizenship and immigration status, proposed in §155.315(b). Commenters suggested including language stating that information related to the verification of citizenship and immigration status be used only for purpose of verifying eligibility for enrollment in a QHP and that pending such verification, coverage should not be delayed, denied, reduced or terminated.

Response: We address the privacy and security of information and the specific standards and protocols for the transmission of data in §155.260 and §155.270 of this final rule and note that these provisions apply to the transactions described throughout subpart D, including §155.315. Language in §155.260 provides that information must be provided to or obtained by the Exchange for the purposes of determining eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, under sections 1411(b) through(e) of the Affordable Care Act, or exemptions from the individual responsibility provisions in section 5000A of the Code, may only be used to carry out those minimum functions of the Exchange described in §155.200; we believe this language addresses these concerns and establishes appropriate safeguards.

Regarding comments asking that coverage not be delayed, denied, reduced or terminated, pending verification of citizenship and immigration status, we addressed these concerns in §155.315(f), which allows an applicant to enroll in coverage with financial assistance pending such verification. We also amend §155.315(c) in order to be consistent throughout this subpart and clarify that an applicant and not an application filer receives the notice of inconsistency.

Comment: A number of comments addressed the process for resolving inconsistencies between applicant information and data obtained by the Exchange, as proposed in §155.315(e). Commenters requested that we provide details on the types of documentation that the Exchange may use to verify applicant information; specifically, commenters asked for details on documents that the Exchange will be permitted to use in verifying citizenship and immigration status. Others commenters asked that we clarify the ways in which individuals will be able to submit documentation to the Exchange when attempting to resolve such inconsistencies. Furthermore, in response to the Medicaid eligibility proposed rule, HHS received a number of comments requesting adoption of an exception for agencies administering insurance affordability programs to accept attestations alone from certain applicants, who are part of at-risk populations and who may not have access to necessary documentation to resolve inconsistencies.

Response: While we acknowledge commenters' requests for details regarding documentation used during the inconsistency process, we believe that this level of specificity is most appropriate for guidance. Therefore, we maintain that the applicant may "present satisfactory evidence" in §155.315(f)(2)(ii) of the final rule. We intend to issue future guidance with details on documents which may be used to support verification, in coordination with Medicaid and CHIP and in accordance with the statutory standard for the Exchange to follow the procedures specified in section 1902(ee) of the Act.

We accept commenters' suggestions that we specify the ways in which an applicant will be able to submit documentation to the Exchange; accordingly, we adopt language in the final rule at §155.315(f)(2)(ii) that the Exchange must provide the applicant with the opportunity to present satisfactory documentary evidence via the channels available for the submission of an application, as described in §155.405, except for by telephone.

We also proposed a provision in §155.315(g) to provide a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available. We proposed this language to account for situations which documentation cannot be obtained, and to achieve consistency with the Medicaid program; examples of individuals for whom this provision may apply include homeless individuals, victims of domestic violence or natural disasters, and sporadic earners. We believe that adding this provision is permissible within the Secretary's

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statutory authority to change verification methods as provided under sections 1411(c)(4) and 1321(a)(1) of the Affordable Care Act. We note also that if at the conclusion of the 90 day period, the Exchange is unable to verify the applicant's attestation and the data from the data sources specified in §155.315 are unavailable, the Exchange must notify that applicant that the Exchange finds the applicant ineligible for the eligibility standard in question. In §155.320(c)(3)(vi)(F), we also describe the procedures for the Exchange to discontinue advance payments and cost-sharing reductions in the event that the applicant's attestation is not verified by the conclusion of the 90 day period.

We also make several changes throughout verification provisions of the final rule at §155.315 and §155.320 where information is found by the Exchange to be not reasonably compatible with an applicant's attestation and where the inconsistency process is triggered; we change the language in a number of places to state that the Exchange "must," rather than "may," examine electronic data sources or supporting documentation, when applicable. The proposed rule did not consistently require that the Exchange examine other data sources or documentary evidence for all verification processes.

Comment: We received several comments regarding our use throughout §155.315 of the term "reasonably compatible." Many commenters asked that we define the term and provided a number of suggested definitions; one common approach to clarifying the term was to provide the Exchange must only consider material differences between an attestation and available electronic data as not reasonably compatible.

Response: We believe that the common approach suggested by commenters is a sensible one, and in §155.300(d) of this final rule, provide that the Exchange must consider information to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not have an impact on the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions. This provision would provide, for example, that if an individual attested to one address within an Exchange service area, but Exchange-obtained data demonstrated a different address within the same Exchange service area, he or she must be considered to meet the residency eligibility standard. We note that while we provide this clarification in the final rule, Exchanges may still exercise flexibility in defining what is considered reasonably compatible. We expect that definitions will vary depending on the types of information subject to verification, and that States will use this flexibility to enhance the eligibility process. We intend to provide future guidance on this issue. We also clarify that to the extent that income information provided by an application filer and income information obtained through electronic data sources both indicate that the applicant is eligible for Medicaid or CHIP, such information must be considered reasonably compatible; this provision aligns with the provision of the Medicaid eligibility final rule at 42 CFR 435.952(c)(1). We also clarify that this rule does not mean that an applicant's attestation regarding annual household income must be identical to that of the tax return information in order to be considered reasonably compatible. The standard for household income is discussed in more detail in §155.320.

Comment: We received a few comments which asked that we explicitly state that an applicant has the ability to access and amend the data used to determine his or her eligibility.

Response: Section 155.330 of the proposed rule allowed an enrollee to report changes affecting his or her eligibility to the Exchange, which must then be verified by the Exchange. We maintain this provision in this final rule. We anticipate that the Exchange will make the information used in an eligibility determination available to the applicant and enrollee, including through a web-based self-service tool with appropriate safeguards. In addition, we direct the commenter to the final rule at §155.260(b)(3)(i), which provides the Exchange must incorporate a principle of individual access to personally identifiable information as part of the Exchange's privacy and security policies and procedures.

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Comment: We received comments asking that we specify the content of the eligibility determination notice provided to applicants, which is described in proposed §155.315(e)(2)(i). Commenters also suggested certain content standards for such a notice, including clear procedures for the inconsistency process.

Response: As noted in the notice of proposed rulemaking, we intend to provide content and timing standards for notices in future rulemaking and guidance. We have made a minor edit to the final rule at §155.315(f)(2)(i) to clarify that this notice is sent to the applicant by the Exchange.

Comment: We received a number of comments regarding the process to resolve inconsistencies, as described in proposed §155.315(b)(3) and (e). A few comments asked that the inconsistency periods described in proposed §155.315(b)(3) and (e) begin when the application is submitted, not when the notice of inconsistency is sent or received by the applicant. Other commenters asked that we align inconsistency periods for the Exchange with the inconsistency period described in section 1902(ee) of the Act.

Response: Section 1411(e)(3) of the Affordable Care Act states that for inconsistencies related to citizenship and immigration status, the Exchange must follow procedures described in section 1902(ee) of the Act. Section 1902(ee) provides that the applicant must be given a period of 90 days from the date of the receipt of the notice to present satisfactory documentation. Because such a receipt date is difficult to pinpoint, we have adopted language specifying that the date on which the notice is received is 5 days from the date the notice is sent, unless the applicant demonstrates that he or she did not receive the notice within the 5 day period. This standard is also utilized by the SSA. Alternatively, for inconsistencies not related to citizenship and immigration status, section 1411(e)(4)(A)(ii)(II) of the Affordable Care Act provides that the 90 day period must begin on the date on which the notice is sent to the applicant. Due to these statutory standards, we are unable to change the point at which the inconsistency period is triggered, and unable to further align the provision in proposed §155.315(e) with the process described in section 1902(ee) of the Act. Therefore, we maintain the provisions in §155.315(c)(3) and (f) in the final rule.

We neglected to include the statutory language found in section 1411(e)(4)(A)(i) of the Affordable Care Act which provides that the Exchange must address “typographical or clerical errors” in order to address causes of inconsistencies, prior to accepting documentation or other evidence from the applicant; we adopt this language in the final rule at §155.315(f)(1).

Comment: We received a number of comments which expressed concern over the potential for increased liability for QHP issuers as applicants are provided coverage during the inconsistency period described in proposed §155.315(e). We also received comments suggesting that issuers should not be required to enroll, nor continue enrollment of, individuals for whom the Exchange is still verifying eligibility during the resolution period.

Response: The standard to determine eligibility based on the information on the application (that is, an individual’s attestation) during the inconsistency period is specified in section 1411(e)(3) and (e)(4) of the Affordable Care Act. We note that this final rule does not prohibit QHPs from requiring premium payment prior to providing coverage. We also expect that the Exchange and an applicant’s selected QHP issuer will provide notice to an applicant to ensure that the enrollee is aware of liability for premium payment.

Comment: One commenter suggested that the Exchange be given more flexibility to decrease the length of the inconsistency period.

Response: The period of time during which an applicant is permitted to provide documentation in order to resolve an inconsistency is specified in sections 1411(e)(3) and 1411(e)(4)(A)(ii)(II) of the Affordable Care Act; therefore, we maintain provisions §155.315(c)(3) and (f)(2)(ii) the final rule.

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Comment: A few commenters asked that we explicitly allow certain application assisters, Navigators, and application filers to help applicants navigate the inconsistency process, described in proposed §155.315(e).

Response: As described in §155.210, part of the duties of a Navigator will be to educate the consumer, facilitate enrollment, and assist with any part of the application process. We also anticipate that agents and brokers will provide such assistance. In addition, we expect that application assisters who are not Navigators, agents, or brokers will provide support for consumers during the application process, and we anticipate providing additional guidance regarding this role, including on appropriate privacy and security protections.

Comment: We received a number of comments on proposed §155.315(e)(3), in which we proposed that the Exchange may extend the inconsistency period if the applicant demonstrates a good faith effort to obtain the documentation. Commenters asked that the Exchange must provide such an extension.

Response: We adopted the provision regarding the extension of the inconsistency period in order to align with Medicaid guidance, which provides States the flexibility to allow a good faith extension. Therefore, we are maintaining the proposed text in the final rule.

Comment: We received a comment asking that we include timeliness standards for processing inconsistencies.

Response: We adopt a timeliness standard of “promptly and without undue delay” for eligibility determinations made by the Exchange in the final rule at §155.310(e), but intend to provide future guidance about best practices for an Exchange to make the best use of the 90 day inconsistency period.

Comment: We received a number of comments on proposed §155.315(g), in which we proposed that the Exchange may not require the applicant to provide information beyond the minimum necessary to support the eligibility and enrollment process. Commenters asked us to define “minimum necessary”; others suggested that we include language describing how HHS will conduct oversight to ensure compliance with this provision.

Response: We acknowledge the importance of oversight to ensure compliance with the provision described in §155.315(g) of the proposed rule, which is finalized in §155.315(i), and intend to provide additional detail regarding oversight in future rulemaking and guidance. HHS will also consider this in the context of evaluating alternate applications developed by States, as described in §155.405(b), and will continue to work with States on the issue of information collection.

Comment: We received a number of comments related to the proposed process for verification of citizenship and immigration status, described in proposed §155.315(b). A few commenters found the process unclear, and asked for more information regarding the verification process for other individuals listed on the application, such as spouses and tax dependents. We also received a number of comments related to the services that will be provided by a Federally–managed data services hub to support verification of citizenship and immigration status. Several comments recommended that we utilize the DHS Systematic Alien Verification for Entitlements (SAVE) system to verify immigration status. Comments on the proposed rule asked for information on the impact of services available through the Federally-managed data services hub on existing State agency connections with Federal data sources used for verification of citizenship and immigration status. Commenters recommended that Exchanges not use “Everify” to verify immigration status and others asked that we provide details on the format of data provided to the State agency or Exchange. We also received comments asking whether it would be legally permissible for the Exchange to transmit information to DHS, via HHS, when an individual has attested to being a citizen. Another commenter asked how the Exchange will know whether an individual has documentation at the point of application that can be verified through DHS, as described in the provision proposed at §155.315(b)(2).

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Response: Section 1312(f)(3) of the Affordable Care Act, as codified in §155.305(a)(1) in this final rule, states that an individual may only enroll in a QHP through the Exchange if he or she is a citizen, national, or a non-citizen who is lawfully present, and is reasonably expected to be so for the entire period for which enrollment is sought. Because citizenship, status as a national, or lawful presence is an eligibility standard for any applicant seeking coverage through the Exchange for him or herself, the verification process described in §155.315(c) applies to each applicant, regardless of whether he or she is a tax filer or dependent.

While we do not specify a level of operational detail in the final rule that includes the specific services or data formats which will be used in supporting verification, we are working closely with our Federal partners to develop and provide details on the verification services provided by the Federally-managed data services hub; we expect to provide such details in guidance. However, we believe that the final rule supports the use of SAVE. We also note that we do not intend to use the E-verify service, as it is designed for employers to check the work authorization of employees, rather than to verify eligibility for benefits. Regarding existing State connections used in verification, we anticipate that Medicaid agencies, CHIP agencies, and Exchanges will leverage the Federally-managed data services hub for connections to SSA and DHS to support verification of citizenship and immigration status.

With regard to the Exchange transmitting information to DHS via HHS, when an individual has attested to being a citizen, section 1411(c)(2) of the Affordable Care Act specifies that in such cases when an individual who attests that he or she is a citizen but for whom citizenship cannot be verified through SSA, the Secretary of HHS shall submit to DHS the applicant's information and other identifying information for verification of immigration status. Based on this statutory standard, we maintain §155.315(b)(2) in the final rule as §155.315(c)(2).

Lastly, we intend to work with DHS to provide Exchanges with the information needed to identify whether an applicant can likely be matched through DHS. DHS has existing verification relationships with many State Medicaid and CHIP agencies, as well as other Federal, State, and Local government entities, which means that many States will already be familiar with this information.

Comment: We received several comments recommending the inclusion of language in proposed §155.315(b) describing the verification process as to whether an applicant is "reasonably expected" to be lawfully present for the entire period for which enrollment is sought. The "reasonably expected" standard is part of the standard for determining whether an applicant is a citizen, national or non-citizen who is lawfully present, which is described in §155.305(a)(1). Commenters' specific recommendations for such a verification process varied. One requested that as long as an applicant's residency is verified, that he or she be considered reasonably expected to be lawfully present for the entire period for which enrollment is sought. Others suggested that self-attestation alone be used in verification.

Response: In the final rule, we address our interpretation of the term "reasonably expected" in §155.305. We intend to provide additional interpretation of this standard, including how it applies in specific scenarios, in future guidance.

Comment: We received a few comments asking that we specify in regulation that an applicant is permitted to provide his or her A-number for verification of immigration status through the records of DHS.

Response: In §155.315(b), we proposed that for purposes of verifying citizenship and immigration status through the records of DHS, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS. We intend the phrase "information from the applicant's documentation and other identifying information" to encompass information such as A-numbers; therefore, we maintain the provision in the final rule. This approach incorporates other types of identifying information (for example, I-94 numbers) that are used by DHS, as well as preserves the intent and applicability of this regulation if DHS changes its process in the future.

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Comment: We received a number of comments regarding the connections between the Exchange and Federal data sources needed to support verification of applicant information. Comments expressed concern that each Exchange would need to develop separate data sharing arrangements and interfaces with Federal agencies maintaining information for use in verification. Comments responding to the proposed rule, which identified HHS as a conduit for information transmitted between the Exchange and Federal agencies, asked that we specifically refer to the Federally-managed data services hub, or electronic service, throughout §155.315, rather than refer to HHS as the entity through which data will be transmitted.

Response: Acknowledging comments to the RFC and specific direction from section 1411(c) of the Affordable Care Act, we proposed that HHS would be the entity through which information would be transmitted to and from Exchanges and Federal data sources to support the verification process. In the final rule, we maintain HHS' role in supporting verification. However, in order to remain flexible to the technology used to transmit such data, we do not specifically mention in the final rule the "electronic service" or "data services hub". Instead, the final rule focuses on HHS' role as the entity which will facilitate the transfer of information, rather than how such information will be transferred. We anticipate that as technological advances are made, there may be changes in the procedures used by HHS to receive information from the Exchange and to communicate with other Federal agencies involved in the verification process.

Comment: We received a number of comments on the process for verification of residency, proposed in §155.315(c). A significant number of commenters asked that selfattestation of residency be accepted without further verification. A smaller number of commenters recommended always allowing the Exchange to verify residency through electronic data sources, not only when the State Medicaid or CHIP agency operating in the State of the Exchange opts to examine such data sources.

Response: We are redesignating proposed §155.315(c) as §155.315(d), and amending it to state that an Exchange may accept an attestation of residency from an applicant or examine electronic data sources which have been approved by HHS. This flexibility would allow an Exchange, should it choose, to align with the verification procedures of the State Medicaid or CHIP agency. Such alignment may facilitate integration across insurance affordability programs and result in a more streamlined process. We amend §155.315(d)(3), as well as equivalent provisions throughout this subpart, to specify that if the Exchange finds that information provided by an applicant is not reasonably compatible, it must examine any information available through other electronic data sources. The proposed rule was inconsistent, and used, "may," instead of, "must," in this paragraph and in several other areas. This change was made to create consistency throughout the subpart, and because the rationale for the reasonably compatible concept, as described in the proposed rule, is that it is a threshold for when additional verification (for example, examining other electronic data sources) is necessary to complete the verification process. For example, in the event the Exchange accepts self-attestation without further verification, in accordance with paragraph (d)(1), and such attestation is found to be not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange would continue the verification process by examining available electronic data sources in order to verify the attestation. If the Exchange is still unable to complete the verification after examining information in electronic data sources, the Exchange would then follow procedures to resolve the inconsistency, in accordance with §155.315(f). As discussed in the proposed rule, examining data sources, when available, prior to moving through the inconsistency process will help minimize the need to request paper documentation from applicants, and the burden for Exchanges to process such documentation.

Comment: We received a few comments regarding the provision in proposed §155.315(c)(4) in which we propose that a document that provides evidence of immigration status may not be used alone to determine State residency. A commenter requested that we remove the word "alone" from this phrase. Another asked that we allow the Exchange to use documentation of immigration status to positively verify residency.

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Response: We are removing the word “alone” from §155.315(d)(4) in the final rule because we do not intend for documents that provide evidence of immigration status to be used to determine State residency either alone or together with other documentation. We have also amended the phrase to allow the Exchange to positively verify residency using immigration documentation, which aligns with Medicaid regulations.

Comment: We received a number of comments regarding the verification of incarceration status, as proposed in §155.315(d). Several commenters recommended that selfattestation of incarceration be accepted without further verification. Others believed that information or an attestation regarding incarceration should never be requested of an applicant, since such a request may be a deterrent to consumers applying for coverage through the Exchange. A smaller number of commenters questioned the availability of recent, accurate data with which Exchanges may verify incarceration status. One commenter stated that by not defining “release date,” incarceration status will be difficult to verify.

Response: We acknowledge that there are challenges regarding the availability of electronic data on incarceration. However, we believe it is important for the Exchange to utilize any such data sources that are available and have been approved by HHS for this purpose, and, at the very least, accept self-attestations of incarceration status since such status is a statutory standard for eligibility to enroll in a QHP. In addition, we believe that this attestation can be collected with minimal burden on an applicant, and we expect that it will be paired with a clear explanation as to why the information is being requested. We believe that allowing for verification of incarceration status through paper documentation would increase administrative burden on the Exchange and applicants, and for these reasons, allow for the examination of paper documentation only in the event that the applicant’s self-attestation is not reasonably compatible with other information provided by the individual or information in the records of the Exchange. For greater detail about the definition of incarceration, please see comment response for §155.300.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.315 of the proposed rule, with the following modifications. We added paragraph (b), which clarifies that the Exchange will validate SSNs that are provided by individuals. In paragraph (c)(3), we changed the word “shows” to “demonstrates” in referring to what the applicant must do if he or she did not receive the notice within the 5 day period; this change was made to more accurately describe the obligation of the applicant. In paragraph (d)(1) and (2), we allowed the Exchange may choose whether it accepts an attestation from applicants regarding residency without further verification or examines electronic data sources for all applicants, and we clarify that the standard for approval of electronic data sources for verification of residency will be based on whether such sources are sufficiently current and accurate, and minimize administrative costs and burdens.

In paragraph (d)(3), we clarify that by referring to data sources, we mean those data sources that are available to the Exchange and that have been approved by HHS for this purpose. In paragraph (d)(3), we remove the reference to “a document that provides” before “evidence” so as not to limit the acceptable types of such evidence. We also remove the word “alone” in order to clarify that the Exchange may not use evidence of immigration status alone or together with other evidence to determine State residency. In paragraph (d)(3), we also change the term “may” to “must” to specify that if the applicant’s attestation is not reasonably compatible with information in the records of the Exchange, the Exchange must examine available, approved data sources in order to verify the attestation. We also change the phrase in paragraph (d)(4) to state that evidence of immigration status may not be used to determine that an applicant is not resident of the Exchange service area.

We clarified in paragraph (f) that an inconsistency may result when electronic data is necessary for verification but is not available. We also included in paragraph (f)(1), “including through typographical or other clerical errors” to describe the causes of inconsistency. In paragraph (f)(2)(i), we changed “notify” to “provide notice to the applicant regarding” in order to clarify the Exchange’s notice standard. Also, we added language to paragraph (f)(2)(ii) to specify that all channels described in §155.405(c) of this part are acceptable for the submission of documentation

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to resolve inconsistencies, except for by telephone. In paragraph (f)(5)(i), we specify that the Exchange must determine the applicant's eligibility based on the information available unless such applicant qualifies for the exception provided under paragraph (g). We also add, on an interim final basis, paragraph (g), which provides a case-by-case approach to resolving inconsistencies for applicants for whom documentation does not exist or is not reasonably available.

We also made technical corrections. We redesignated paragraphs (b) through (g) as paragraphs (c) through (i). In paragraph (a), we changed the reference to paragraph (e) to paragraph (g). In paragraph (d), we changed "by" to "as follows," and changed verb tenses in (d)(1) and (d)(2). In paragraph (f)(3), we corrected the reference to paragraph (f)(3) and changed it to (f)(2)(ii). In paragraph (f)(5)(ii), we changed the word "implement" to "effectuate." We also add, on an interim final basis, paragraph (g) to provide a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available.

In paragraph (h), we changed the word "plan" to "Blueprint." Throughout the section, as in the rest of the subpart, we replaced language regarding application filers providing attestations with references to applicants providing attestations, since the language in §155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.