STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

B U L L E T I N NO.: 16-02FP
FROM: Sean Brown, Deputy Commissioner
Economic Services Division
DATE: June 7, 2016

SUBJECT: Health Benefits Eligibility and Enrollment (HBEE)

CHANGES ADOPTED EFFECTIVE:

INSTRUCTIONS

_____**Proposed Rule - Retain bulletin**

MANUAL REFERENCES: HBEE

The Agency of Human Services (AHS) filed a final proposed rule, referenced as Health Benefits Eligibility and Enrollment (HBEE) "B16-02FP" for purposes of this Bulletin, with the Office of the Secretary of State (SOS) and the Legislative Committee on Administrative Rules (LCAR). The rule being proposed is not in effect but if adopted following the full rulemaking process, will supersede HBEE as was amended by emergency rulemaking effective May 11, 2016. (See HBEE 16-09E) HBEE was last adopted, following the full rulemaking process, on July 15, 2015. (See HBEE 15-02F)

Eligibility criteria for Vermont's health benefit programs are set forth in HBEE. HBEE, including changes proposed in this rulemaking, implements health care reform reflected in federal and state law including the Patient Protection and Affordable Care Act. Specifically, this proposed rule is needed in order to align HBEE with federal and state law (including federal regulations published after AHS filed the proposed rule), align with federal guidance, provide clarification, correct information, improve clarity, make technical corrections, and to incorporate revisions effected on May 11, 2016 in emergency rulemaking.

View Final Proposed HBEE

HBEE (B16-02FP) can be viewed electronically at http://dcf.vermont.gov/esd/laws-rules/proposed-adopted.

Administrative Procedures Process

A public hearing was held on this rulemaking on April 29, 2016 at 10 a.m. at 289 Hurricane Lane, Williston, Vermont.

The public comment period on this rule closed on May 6, 2016. AHS received public comments from Vermont Legal Aid.

AHS filed the final proposed rule with the SOS and LCAR on June 3, 2016. A copy of the Responsiveness Summary and a Summary of Changes, both filed with the SOS and LCAR, are attached to this Bulletin. The clean and annotated versions of the rule are available at the hyperlink at the subheading, "View Final Proposed HBEE."

The final proposed rule will be heard by the Legislative Committee on Administrative Rules (LCAR) on June 30, 2016.

Information about the Rulemaking Process

To get more information about the rulemaking process, see the website of the SOS at https://www.sec.state.vt.us/ or call that office at 802-828-2863. For information about LCAR, see http://legislature.vermont.gov/committee/detail/2016/39 or call that office at (802) 828-5952.

Attachments:

1. Responsiveness Summary
2. Summary of Changes

Comments by Rule Sections

Part Three

23.06(a) Exemptions

Comment: AHS proposes to delete footnote 69, which sets a time limit on the delegation of Vermonters' individual shared responsibility payment exemption determinations to the federal Department of Health and Human Services (HHS). It now appears that HHS will permanently make the exemption determinations for Vermont Health Connect (VHC). We disagree with this decision. We believe that Vermonters are better off dealing with a smaller agency located in Vermont. A local agency with local personnel is generally better able to make informed and fair decisions about whether Vermonters have experienced a hardship.

Response: § 23.06(a) will be finalized as proposed with the addition of a footnote reference to the federal exemption application website. Vermont Health Connect is not able to process exemption determinations; therefore, it is important to clarify that customers can seek an exemption from HHS.

Part Five

29.08(d)(2) and 29.09(d)(5)(ii) Promissory Notes

Comment: These sections of the existing rule are confusing, and the revisions do not clarify how AHS handles nonexcluded promissory notes and other income-producing resources. Since 29.08(d) sets out the criteria for exclusion, it is not necessary to include (iii) on how nonexcluded resources are valued, since that criteria is set out under 29.09(d). It would reduce confusion to have the criteria in one place, 29.09, and to delete (iii) from 29.08.

Response: § 29.08(d)(2)(iii) has been deleted in response to this comment.

Comment: We also have concerns about the proposed changes to 29.09(d)(5). The first sentence of 29.09(d)(5)(i) suggests that AHS can simply impose a transfer penalty for the entire value of the asset, instead of considering it to be countable as a resource. What criteria would AHS use to make that determination? For a note or contract that has a discounted value, the revised language suggests that AHS intends to count the discounted value, and possibly impose a transfer for the amount of the discount. When would AHS decide not to impose a transfer penalty for the discounted value? This section should also clarify that any transfer occurred at the time of the creation of the contract or the note and that this section follows the standard rule on look backs.

Response: This rule explains that the fair market value of a promissory note or other income-producing resource (contract) equals the amount of money used to establish the note or contract and any additional payments used to fund it, plus any earnings and minus any payments

received. This rule also states that a lower value will be considered if an individual makes a good faith effort to sell the note or contract and obtains valuations from reliable sources that the value is less.

For Long-Term Care Medicaid purposes, if a note or contract is determined to have no value on the open market, a transfer penalty will be applied for the fair market value (the full value that was used to establish the note or contract and any additional payments used to fund it, plus any earnings and minus any payments received). If the note or contract is determined to have a discounted value, that discounted value will be used as the value for the asset, and the difference between the discounted value and the fair market value will be evaluated by the agency for a potential transfer penalty. The agency will apply the transfer rules under § 25.00 of the Health Benefits Eligibility and Enrollment (HBEE) rule in its evaluation.

Since it is possible for a transfer to occur after the initial creation of a note or contract, this rule will not be revised as suggested by the commenter. The standard rule on look backs will apply based on when the transfer is considered to have occurred.

Part Six

32.00 Definition of Small Employer

Comment: We support the clarifying changes to this definition, which follow clarifications made by HHS. It is important to be clear when an LLC or Subchapter S corporation owner can enroll in a SHOP plan versus an individual market plan. This has been an area of some confusion in Vermont.

Response: As noted in the comment, this revision seeks to reduce customer confusion by aligning with the federal standards.

45.00 Employer Appeals of Employee APTC/CSR

45.00(a)

Comment: VHC should only send notice to employers when an employee actually enrolls in a plan with APTC. HHS recently amended the federal regulations to state that employer notice is not required after every determination of employee eligibility. See*, 81 Fed. Reg. 12,203, 12267 (Mar. 8, 2016). This makes sense, because the employee might never enroll in the plan, or might never make a payment to effectuate coverage. HHS noted that this change better reflects the statutory requirement and will reduce confusion.* See*, 80 Fed. Reg. 75,487, 75,529 (Dec. 2, 2015). This change should also be made to section 73.05(a)(3).*

45.00(b)

Comment: We would prefer for VHC to hear the appeals rather than HHS or HHS's contractor. We believe it would be easier for Vermont consumers and employers to navigate a local process. A local appeals process would allow VHC to use the data it already possesses, rather than having to transfer information to the federal appeals entity. We are concerned that cases could take longer to resolve in the national marketplace appeals system. A local appeals system

would also have more flexibility to adapt its practices to fit the needs of appellants and address any problems that arise as employer appeals are implemented.

Response: Subsection (a) has been simplified, and the substance of the employer notice provision has been moved to become new § 71.01(e) because it applies to the individual—not small group—eligibility and enrollment process. The suggested revisions have been made at § 71.01(e) in order to align with the recent federal regulation. At this time, Vermont Health Connect is not able to process employer appeals; therefore, no changes have been made to (b). The agency will consider hearing employer appeals in the future when resources permit.

Part Seven

Section 54.05 Citizenship and Immigration Status Inconsistencies

Comment: We support AHS's decision to maintain the existing 90-day opportunity period for citizenship and immigration status inconsistencies.

Response: This rule aligns with the revisions proposed by the Centers for Medicare and Medicaid Services (CMS) to the federal regulation at 42 CFR § 435.956. See, 78 Fed. Reg. 4594, 4695 (January 22, 2013).

57.00(c) Inconsistency Verification Opportunity Period

Comment: We expect a very high denial rate if the 10-day response period is enforced for renewal verifications. It can be difficult and time-consuming for consumers to gather the necessary documents to resolve an inconsistency issue. Sometimes statements or documents need to be obtained from third parties. The problem is compounded by the short time assumed between mailing and receipt of a notice. We do not believe allowing 2 days for mailing is sufficient. Consumers regularly report receiving Medicaid notices a week after the date printed on the notice. We suggest a 5-day mailing allowance.[2]

[2] *Medicaid notices are presumed to be received 5 days after the date of mailing for purposes of continuing benefits. 42 C.F.R. § 431.231(c)(2). The Medicare and SSI programs also use a 5 day mailing allowance.*

Procedural measures could reduce the number of erroneous denials and terminations. Ideally, the HBEE rule would say that notices must follow these criteria. First, notices should be dated on the day they are expected to be mailed. If a notice is generated on 4 p.m. on a Friday, the computer system (or worker) should date the notice the following Monday, when it's reasonable to expect that it will be mailed. We understand that this should be happening for VHC notices, but that it is not possible for ACCESS notices. We understand that ACCESS workers follow a manual process to extend due dates on ACCESS notices to account for expected delays in mailing. We are concerned that a non-automated process will have a higher error rate.

Second, the verification notice should tell the consumer the actual date on which the response is due. This should help consumers comply with the deadline. We understand that this is being done for most notices. Third, verification notices should tell consumers that they can request an extension of the deadline for good cause or to accommodate the recipient's disability. We understand that AHS was planning to include that language on all notices, where possible, or via an insert if modification of the notice was not possible.

We appreciate AHS's willingness to work with us to improve the clarity and substance of notices to consumers.

Response: To the extent that this comment is recommending that the agency increase the reasonable opportunity period at renewals, the agency addresses this in its response to the next comment.

The agency addresses the recommendation that it increase the operational mailing allowance for notices in its response to the comment regarding § 61.00(c)(2) on Vermont's timeliness standard for new applications.

The agency will not modify HBEE to require notice of the procedures outlined in the comment; however, the agency will continue discussions with stakeholders, outside of the rulemaking process, about its implementation of these procedures.

Comment: Verification Period for Medicaid Reviews
We understand that the Centers for Medicare and Medicaid Services (CMS) would not permit Vermont to maintain a 90-day opportunity period for Medicaid beneficiaries, because to complete the process by the beneficiary's renewal date would require starting five or more months in advance. However, as we explained above we believe 10 days is too short. A 10-day timeframe is not required by any federal regulation or formal administrative guidance. Setting the opportunity period at 20 days would be a more reasonable response to the issues raised by CMS.

The federal timeliness regulation for Medicaid, 42 C.F.R. § 435.912, applies to new applications and accounts transferred to Medicaid from "other insurance affordability programs" (such as APTC). That regulation does not set a timeliness standard for annual reviews. The federal regulation on Medicaid reviews (42 C.F.R. §435.916) does not reference § 435.912. Rather, it provides that the beneficiary has at least 30 days to respond to a pre-populated renewal form, and then verification is conducted in accordance with §§435.945 through 435.956. Those sections require a "reasonable period to furnish additional information" without giving a specific timeframe. Therefore, the State has significant flexibility in setting the inconsistency response period for Medicaid beneficiaries.

To some extent, the drastic reduction in the opportunity period was reportedly prompted by the fact that Vermont did not conduct regular Medicaid reviews in 2014 or 2015. This is an unreasonable response to the problem. Medicaid reviews need to occur annually as required by federal law, but the problem has been technology coupled with low staffing levels. Whether beneficiaries are given 10 days, 20 days, or 90 days to respond does not address the fundamental problem with Medicaid reviews. The State should not respond to its failure to conduct Medicaid reviews by shortening the verification period so drastically, when that was not the cause of the failure in the first place.

The State must take care not to terminate Medicaid for people who are actually eligible. This includes beneficiaries who do not respond to notices, for whom there is no indication that eligibility has changed. Also, the Department may only request verification after contacting the beneficiary or applicant and providing an opportunity to explain the discrepancy. HBEE § 57.00(c)(1). See, 42 U.S.C. § 1396a(a)(8), 42 CFR § 435.916 (passive redetermination process); 42 U.S.C. § 1396a(a)(8), 42 C.F.R. § 435.916(f) (pre-termination review process); Homewood v. McCarthy, S.D. Ohio, 2015 WL 3541290 (April 2, 2015) (enjoining the State of Ohio from, inter alia, terminating Medicaid benefits prior to implementing passive Medicaid eligibility redetermination and pre-termination review processes).

We appreciate AHS's efforts this spring to contact all "legacy" Medicaid beneficiaries before terminating their coverage for failure to submit a renewal form. We believe this was an appropriate response to the low response rate.

The procedures or instructions implementing the rule should remind state workers that SSI beneficiaries are automatically eligible for Medicaid and should not be sent unnecessary verification requests.

Response: The agency is finalizing § 57.00(c)(2)(ii)(B)(II) as proposed. The agency disagrees that it is unreasonable for an enrollee at renewal to resolve inconsistencies within ten days.

The commenter's conclusion that the proposed reasonable opportunity period for enrollees is the agency's response to not promptly conducting annual renewals is not accurate. With the implementation of the Affordable Care Act (ACA), the agency adopted a 90-day opportunity period, at application and renewal, in order to align with a federal rule on qualified health plans (QHPs). Due to subsequent guidance from CMS, the agency, by emergency rule effective January 11, 2016 (and a second emergency rule effective May 11), replaced the 90-day periods with the ones that had been in effect prior to the ACA. The proposed rule, like the emergency rules, simply restores the opportunity period that was in place for Medicaid enrollees prior to the ACA.

It is reasonable to allow enrollees a shorter period of time than new applicants to provide necessary verification. An enrollee must report, within ten days, any changes that may impact eligibility. Accordingly, an enrollee at renewal only has to provide documentation of any changes s/he has not previously reported. In addition, if an enrollee does not timely resolve an inconsistency, the agency sends a notice that Medicaid will close in not less than eleven days based upon the agency being unable to determine ongoing eligibility. The notice tells the enrollee that if s/he provides the missing documentation on or before the Medicaid closure date that there will be no gap in coverage. Accordingly, the enrollee is afforded a second opportunity to resolve the inconsistency.

As discussed in the agency's response to the next comment, § 57.00(c)(3) provides that the agency will extend the opportunity period if the enrollee has demonstrated a good faith effort to obtain documentation during the period.

The agency agrees with the commenter that the timeliness standard does not apply to renewals; however, increasing the opportunity period to 20 days would require the agency to start the renewal process 90 days before the renewal due date instead of the current 60 days. The change would require extensive IT changes in the agency's legacy system (ACCESS) and Vermont Health Connect.

The recommendation to remind eligibility staff not to send verification requests to people who receive Supplemental Security Income (SSI) is outside the scope of this rule; however, the agency welcomes an explanation of the commenter's concern. Because Vermont is a 1634 state, persons on SSI are automatically entitled to Medicaid and do not have to apply for, renew or verify Medicaid eligibility with the agency (see HBEE at § 51.00).

57.00(c)(3) Extending the Opportunity Period

Comment: Given the major shortening of the opportunity period, it is critically important for AHS to provide individuals with the right to request a good cause extension of the opportunity period. AHS should include this right on all verification notices and on all verification denial or termination notices. We appreciate that notice of this right is currently included on VHC verification notices.

AHS should process all requests for additional time under this section no matter what form the request is presented in, oral or written. This section should also be revised to clarify that a good cause extension can properly be requested after the period ends, including after the termination or denial notice has been sent. We have seen examples in which the Department's requests for verification were sent to individuals that clearly lacked capacity and needed assistance with their application and who were then denied or terminated without consideration of their potential need for an extension. The Department clearly has the implied authority to reopen improper denials and terminations, including under Vermont's Fair Hearing Rules 1001.3(G) and under Medicaid regulations governing fair hearings, 42 C.F.R. § 231.246(b).

We propose the following revision:

> *(3) Extend the opportunity period described in paragraph (c)(2)(ii) of this section if the individual demonstrates that a good-faith effort ~~h~~was ~~been~~ made to obtain the required documentation during the period. If the request is made during the 90-day appeal period after a termination or denial, AHS will reopen the denial or termination if good cause is demonstrated.*

Response: This rule section will not be revised as proposed by the commenter. The agency believes that this rule is complete and accurate for the purpose it serves as it is currently written.

This rule is specific to extending the periods of time within which individuals must present satisfactory documentary evidence or otherwise resolve inconsistencies. It gives the agency discretion to extend those periods beyond what is stated in the rule at § 57.00(c)(2)(ii) if an individual can demonstrate that they have made a good-faith effort to obtain the required documentation during the applicable period.

From the agency's perspective, what is actually being asked by the commenter is for this rule to be expanded beyond its intended purpose of extending the opportunity periods, and be used to allow the agency to "un-do" a decision to deny or terminate an individual's eligibility. That is outside the scope of this rule section. If an individual seeks relief from a decision made by the agency, the individual should file an appeal of the decision. Vermont's Fair Hearing rule at 1000.3(G), as noted by the commenter, requires the agency to review an individual's grievance, prior to a hearing, and make a determination of whether or not an individual is entitled to the relief being sought. It would be through this process that the agency could consider whether or not to re-open a denial or termination.

61.00(c)(2) Timely Determination of Eligibility

Comment: AHS should amend this section to change Vermont's 30-day application processing time for applications not based on disability to 45 days. This would allow an inconsistency period of 20 days rather than 10. A longer timeliness standard is preferable if the alternative is giving consumers an inadequate time to respond to verification requests.

Response: The 30-day timeliness standard set forth in this rule applies to new applications, and individuals newly applying for Medicaid already have an opportunity period of 20 days within which to resolve inconsistencies (see proposed revision to HBEE rule at § 57.00(c)(2)(ii)(B)(I)). Accordingly, increasing the reasonable opportunity period is not a basis for extending the application timeliness standard.

The agency assumes that this recommendation is based upon the earlier comment that the agency should increase the operational allowance for mail time from two to five days. In the case of new applicants to whom the agency must send two separate ten-day notices, a five-day mail time would make it impossible for the agency to process the application within the 30-day timeliness standard. (The applicant's two ten-day periods, along with the five-day mailing time for each notice, would account for the entire 30-day processing time.)

The agency disagrees that a longer application processing time is necessary to give the applicant adequate time to resolve inconsistencies. As explained previously, the change being proposed in this rule simply restores the opportunity period to what it was before the ACA went into effect. The operational procedure that allows a two-day mailing allowance remains unchanged. The agency does not have evidence that mailing times in Vermont have increased since those prior to the ACA to justify increasing the mailing allowance from two to five days. The agency will monitor new applicants that are required to resolve inconsistencies to assess whether the current mailing allowance is adequate. It is the agency's view that extending the application timeliness standard to 45 days is a significant change in policy, one that potentially can delay access to care for some applicants, and accordingly, that monitoring the system to determine if the mailing allowance is inadequate is a preferable approach. If needed, the timeliness standard can be addressed in future rulemaking.

Finally, as stated in the prior response, the rule at § 57.00(c)(3) provides a process for an applicant to request an extension of time. If an applicant is unable to provide documentation during the opportunity period, including due to mail time, the agency will extend the period if the applicant demonstrates that they have made a good-faith effort to obtain the documentation during the period. In this circumstance, the 30-day timeliness standard will be extended to provide the applicant with more time.

Billing and Premium Payment, 64.01 - 64.08 & 70.02

64.02(c)

Comment: The proposed change to this section eliminates the need for advance notice and public comment on a substantial change in Dr. Dynasaur premiums or in the consequences for non-payment. What is the justification for this change? We believe advance notice and opportunity for public comment should be retained.

Response: This rule section was taken directly from the federal Medicaid regulation at 42 CFR § 447.57(c) and has no application in the State of Vermont. There is nothing in Vermont's Medicaid State Plan on Dr. Dynasaur premiums. Thus, any modifications to the existing premiums for Dr. Dynasaur would not be through a State Plan amendment. All premium information in regard to Dr. Dynasaur is contained in Vermont's Global Commitment waiver, and there is no need to modify this rule section to state the amendment process for the Global Commitment waiver as that process is sufficiently addressed in the waiver instrument.

64.05(b)(2)

Comment: We support the change clarifying that a person can specify different payment allocations. We note, however, that so far VHC has not been technologically able to allocate payments in this manner.

Response: The revisions being proposed in this rule section are to eliminate references to payment of past-due Medicaid premiums (payment of past-due Medicaid premiums will no longer be a condition of re-enrollment in Medicaid; see proposed revision to the HBEE rule at § 64.08). The opportunity for an individual to specify a different payment allocation for other premiums due was not changed by these proposed revisions.

64.06(a)(1) Grace Periods

Comment: The HHS Notice of Benefit and Payment Parameters for 2017 clarifies three issues around grace periods and binder payments. The HBEE rule does not currently mention binder payments, and VHC practices are in line with the clarified HHS rules. However, we think it would be good to include the three issues in AHS rules to increase their transparency and clarity. A new section on binder payments should be added to the HBEE rule, perhaps at section 64.03 which is currently reserved.

> *First, HHS clarified that a binder payment for a new year's plan is not required if the consumer is re-enrolling into the same product. 81 Fed Reg. at 12,311 (Mar. 8, 2016).*
>
> *Second, HHS clarified that a 3-month grace period is required if a consumer has APTC in December, re-enrolls in coverage not requiring a binder payment, and then misses their January premium payment.* Id.
>
> *Third, flexibility on due dates for binder payments should be added to HBEE, or else to the forthcoming QHP rule.* See, *81 Feg. Reg. at 12271 (Mar. 8, 2016).*

Response: The agency will consider addressing these premium processing rules in a future rulemaking with public comment.

64.06(a)(1)(iii)

Comment: We support the expansion of the Dr. Dynasaur grace period to 60 days.

Response: This proposed rule revision aligns with the federal Medicaid regulation at 42 CFR § 447.55(b)(2).

64.06(b)(2)(iv)

Comment: The changes here make sense, but we are concerned that consumers will have problems if the billing system does not function correctly, as has been the case. Currently many consumers are not receiving Dr. Dynasaur invoices at all. It is extremely important for consumers to receive timely and accurate bills and for payments be applied to the correct month.

Response: This new rule section is being proposed so that the law is clear on the proper allocation of monthly Dr. Dynasaur premium payments since more than one monthly premium could be owed at the same time. It is important that payment be applied to the oldest premium first to avoid termination for non-payment. The agency is working closely with the billing contractor to ensure that the billing system functions correctly.

64.08

Comment: 64.08 is being reserved. We infer from this change and from the changes made to section 70.02 that payment of outstanding Dr. Dynasaur premiums will no longer be a condition of Medicaid enrollment in any circumstances. Is this inference correct?

Response: The deletion of this rule section, and the revisions proposed at § 70.02, will mean that an individual re-applying for Dr. Dynasaur who has an outstanding Dr. Dynasaur premium from a prior grace period will not have to pay that outstanding premium as a condition of their Medicaid re-enrollment. That individual will, though, have to pay their initial premium in order to re-enroll if they are approved for Medicaid with a premium obligation (see HBEE at § 70.02(a)).

70.02(a) and (b)

Comment: We support the proposed changes to this section. Many people may have past due balances for Dr. Dynasaur because of all the billing problems that VHC has experienced. It is good that consumers will be able to re-enroll in Medicaid without paying those outstanding balances.

Response: The revisions proposed in these rules are to align with the agency's proposed deletion of the rule at § 64.08. The purpose of the deletion of § 64.08 is explained in the prior response.

Retroactive Medicaid, 70.01

Comment: We support this change. It is good to make it explicit that one can apply for retroactive coverage even if the applicant is dead.

Response: This proposed revision carries forward text from the agency's repealed Medicaid rule at 4112, and aligns the HBEE rule with the federal Medicaid regulation at 42 CFR § 435.915(a)(2).

71.03 Special Enrollment Periods

Comment: We support the addition of special enrollment periods for resolution of a citizenship or immigration inconsistency and for victims of domestic violence or spousal abandonment.

We believe AHS should have a guidance system that could be used for announcing limited-scope SEPs in response to specific circumstances. HHS uses a guidance system in this manner.

Response: The agency is seeking to implement a standardized guidance system for QHP related items.

73.05 Redetermination and notification of eligibility

Comment: Please see our comment above on section 45.00(a).

VHC procedures following a successful employer appeal: HHS recently provided states with additional guidance and flexibility regarding state exchange options when an employer prevails in an appeal of an employee's APTC eligibility. 81 Fed. Reg. 12,203, 12,279 (Mar. 8, 2016). HHS gives two options for state exchanges. The first option is to

conduct a redetermination of the employee's APTC eligibility based on the appeal decision and any other information available to the exchange. The employee would have received a copy of the appeal decision, but no request for updated information. The second option is to notify the employee of the requirement to report changes.

We think combining the two options would make the most sense. VHC should give enrollees 30 days to update their information, and then it should redetermine eligibility based on the appeal decision and any other information available. We understand that HHS rejected this combination as overly burdensome on the exchanges, but Vermont could adopt procedures that are more protective of consumers than required by HHS.

If Vermont moves forward with its plans to have HHS hear employer appeals, and the HHS notice of appeal decision will not be sufficient to warn employees that they need to update their application information by a certain date, we think VHC should adopt option 2 and send consumers a letter advising them to update their application information. We think this option will be best for most consumers, even though people who do not update their information may receive too much APTC.

As explained above, we believe that Vermont should not delegate employer appeals to HHS. The implementation context provides an example of the flexibility that is lost by delegation. We understand HHS notices of appeal decisions will not be tailored to each state; they will be generic and will not give employees specific information about the steps their exchange will be taking next. If Vermont handled employer appeals, it could use the notice of appeal decision to tell employees that they should contact the marketplace to update their information.

Response: As noted previously, the agency has delegated employer appeals to HHS. The agency appreciates the feedback regarding the method for implementing successful employer appeals. Because discussions with HHS are ongoing, it is premature to codify such a methodology in rule. The agency will continue to address this with stakeholders outside the rulemaking process.

73.06 Effective Dates

Comment: FFM policy and regulations are now more flexible in situations where consumers are permitted to choose either a retroactive or a prospective effective date. See, 81 Feg. Reg. at 12,271 (Mar. 8, 2016). The new HHS rule provides that, if a consumer pays only one month's premium, the consumer will automatically receive prospective coverage. If the consumer pays all retroactive premiums dueu, they will receive retroactive coverage. There is a certain automatic aspect to the new FFM policy, which would avoid confusion over what VHC's current default is, and when consumers must call in to request a different outcome for their case. However, it only works if a consumer is notified of their payment options and of the consequences attending each option.

Response: The agency notes that this comment is outside the scope of this rulemaking; however, it will consider including related rules in a future rulemaking with public comment. The agency is addressing premium processing issues on an operational basis at this time.

75.03 Renewal Procedures for Medicaid

Comment: With the reduction in the opportunity period to respond to inconsistencies, we believe it is important to clarify beneficiaries' rights when inconsistencies are resolved late. Section 75.03(b)(3) requires AHS to reconsider an individual's eligibility if necessary information is submitted within 90 days after the date of termination. The Centers for Medicare and Medicaid Services (CMS) has stated that, "with a 90 day reconsideration period, we would expect that in most cases, retroactive coverage will extend back to the date of the termination." 77 Fed. Reg. 17,143, 17,182

(March 23, 2012). The HBEE rule should explicitly include the availability of retroactive coverage to a renewal granted within the 90-day reconsideration period.

Response: The HBEE rule at § 75.03(b)(3) will not be revised as suggested by the commenter. The agency believes that this rule is clear for the purpose it serves as it is currently written.

§ 75.03(b)(3) is derived from the federal Medicaid regulation at 42 CFR § 435.916(a)(3)(iii). As stated by CMS, the purpose of this 90-day reconsideration period is to avoid unnecessary application processing for an individual, as well as the agency, when an individual has been terminated for not timely returning their pre-populated renewal form or required documentation. If a completed pre-populated renewal form is returned by the individual during this 90-day reconsideration period, this rule allows for that completed renewal form to serve as the individual's application; the individual will not be required to submit a full new application. See, 77 Fed. Reg. at 17,182 (March 23, 2012). The individual is still applying for new coverage, though. It is just being done through their pre-populated renewal form rather than through a new application. Accordingly, the HBEE rule on Medicaid enrollment at § 70.00, including eligibility for retroactive coverage at § 70.01(b), will apply to the same extent and in the same way as if the individual had filed a new application.

77.00(e) Allocation of APTC and the Vermont Premium Reduction Among Policies

Comment: Currently it is difficult for VHC to enroll members of the same tax household in multiple QHPs, while correctly calculating each family member's subsidy. HCA has advised consumers flummoxed by this situation. We believe clarifying the applicable rules would help consumers and assisters assess and understand VHC eligibility determinations in these situations.

Specifically, we suggest that AHS incorporate a specific allocation method into section 77.00(e). Currently the rule is vague; it only states that AHS will establish a reasonable and consistent allocation method. We believe a simple method proportional to the number of enrollees in each QHP would make the most sense. If VHC does not put its allocation policy in the HBEE rule, it should at least be published in VHC guidance and online.

Response: The agency notes that this comment is outside the scope of this rulemaking; however, the agency agrees with the proposed allocation methodology and will consider codifying it in future guidance or rule. The agency is currently prioritizing the functional remediation of this issue.

HBEE Rule 16-02FP
Summary of Changes

In addition to the changes being made in HBEE rule 16-02FP in response to public comments (see responsiveness summary being filed contemporaneously herewith), additional changes are being made to (1) bring the rule into alignment with recently issued federal regulations and guidance, (2) bring the rule into alignment with recently enacted state legislation, (3) provide clarification, (4) add clarity and improve consistency, and (5) correct technical and typographical errors.

The following is a list of these additional changes and the reasons for them. All changes being made in HBEE rule 16-02FP are identified in gray highlight in the annotated version of the final proposed rule being filed contemporaneously herewith.

The changes, in order by section number, are as follows:

PART ONE

Section 5.01(b)(2)(ii) – To align with federal regulation, add text that explains that standardized comparative information may include differential display of options on consumer-facing plan comparison and shopping tools

Section 5.03(d)(6) – To align with federal regulation, revise text describing the gifting to applicants and potential enrollees prohibited by Navigators

Section 5.03(f)(10)(i) – To align with federal regulation, revise text to clarify that the role of a Navigator is not to provide tax or legal advice

Section 5.05(e)(1) – To align with federal regulation, revise text to clarify that the role of a certified application counselor is not to provide tax or legal advice

Section 5.05(f)(3) – To align with federal regulation, revise text describing the gifting to applicants and potential enrollees prohibited by certified application counselors

PART SIX

Section 31.00 – To align with state legislation passed during the 2016 session, revise definition of "qualified employer" at (b), removing future expansion to employers with more than 100 employees

Section 39.00 – To align with federal regulation and § 71.03, remove a cross reference at (a)(1)(i)

Section 43.01 – To align with federal regulation, make technical revision to the language in (b)(1)

Section 44.00 – To align with federal regulation, revise language at (a)(2) and (b)(2) clarifying eligibility appeals bases, and at (j) clarifying effective dates for appeal decisions

Section 45.00 – For clarity, simplify the language at (a) and move the former language to new § 71.01(e) because it applies to the individual—not small group—eligibility and enrollment process; revise the language moved to §71.01(e) to align with federal regulation

PART SEVEN

Section 55.02(a)(3) – For clarity, add "eligibility" after "QHP" on fourth line of text

Section 55.02(d)(3)(iii) – To align with federal regulation, insert text describing what sufficient verification data means

Section 55.02(d)(3)(iv) – To align with federal regulation, revise text to allow for establishing an alternative process for the 2016 and 2017 benefit years

Section 65.01(a) – To correct typographical error, replace "of" with "or" on fifth line of text

Section 71.01(e) (NEW) – (See explanation at Section 45.00 above)

Section 71.02(f)(2) – To provide clarification to align with federal regulation, revise text since, according to federal regulation, annual open enrollment periods are only expected to be through December 15th beginning in January 2019

Section 71.03(b)(2)(vii) – To align with federal regulation, revise text to explain effective date for special enrollment period (SEP) for a qualified individual who is no longer incarcerated

Section 71.03(c)(2) – To align with federal regulation, revise text to describe the SEPs which have advanced availability

Section 71.03(d)(3) – To align with federal regulation, revise text to clarify that this SEP is available to a qualified individual who is no longer incarcerated

Section 71.03(d)(7) – To align with federal regulation, revise text to include eligibility criteria for permanent move SEP

Sections 71.03(d)(9)(ii) and (iii) – For clarity, combine and simplify paragraphs (ii) and (iii) to state that an expired hardship exemption is a qualifying event for an SEP

Section 71.03(d)(9)(iv) – For clarity, revise cross-reference to exemption rule at 23.06

Section 73.05(a)(3) – To align with federal regulation, revise text to reference new section 71.01(e)

Section 75.02(h)(1)(iii) – To align with federal regulation, revise text to reference new section 71.01(e)

Section 76.00(b)(1)(iv) (NEW)– To align with federal regulation, revise text to add examples of permissible retroactive termination of enrollment

Section 76.00(b)(2)(ii)(A) – To align with federal regulation, revise text to clarify that individuals are entitled to 3-month grace period if they received APTC when first failing to timely pay premiums even if they are no longer receiving APTC

Section 76.00(b)(2)(vi) (NEW) – To align with federal regulation, revise text to include another example of permissible AHS or issuer-initiated termination

Section 76.00(d)(9) through (12) (NEW) – To align with federal regulation, revise text to include effective dates for enrollment terminations under new sections 76.00(b)(1)(iv) and 76.00(b)(2)(vi)

PART EIGHT

Section 80.03(a)(7) (NEW) – To align with federal regulation, add a new provision, at "(7)," to include a determination of eligibility for a special enrollment period as a basis for requesting a hearing

Section 80.05(a)(1)(i) – To align with state legislation passed during the 2016 session, delete text limiting Secretary reversals or modifications to decisions or orders of the Human Services Board concerning Medicaid

Section 80.06(a)(1)(ii) – To align with federal regulation, revise text to clarify the effective date of a retroactive implementation of a QHP decision