" People helping people help themselves"

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Michael A. Gargano, Secretary

October 31, 2011

Center for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, MD 21244-8010

Attn: CMS-2349-P, CMS-9974-P, CMS-9989-P and REG-131491-10

Dear Secretary Sebelius:

On behalf of the State of Indiana, I appreciate the opportunity to comment on the Notices of Proposed Rule Making (NPRM) for Exchanges and Modified Adjusted Gross Income (MAGI) eligibility for premium tax credits and for Medicaid (45 CFR 155 and 156, 45 CFR 155 and 157, 42 CFR Parts 431, 433, 435, and 457, 42 and 26 CFR Part 1). Indiana has not yet committed to a state-based Exchange and the content of the final regulations will weigh heavily on Indiana's decision. Indiana has reviewed each NPRM and the State has significant concerns the proposed regulations create unnecessary federal oversight. The over-regulation and creation of new mandates not required by the Patient Protection and Affordable Care Act (PPACA) will collectively drive up the operating cost of the Medicaid program and state-based Exchanges. In general, requirements not contained within the PPACA should not be imposed upon states through regulations.

We have many significant concerns which are detailed on the attached pages. There are several issues that warrant specific attention. Regarding the proposed Exchange regulations, Indiana has strong reservations with the significant regulatory framework given there is no federal funding for Exchange beyond the first year of operations. In many respects, the breadth of the proposed regulations appears to be HHS' attempt to enforce an unfunded mandate. The extent of the regulation is unwarranted, unnecessary and potentially damaging to any effort to develop an efficient and cost-effective Exchange. We strongly urge maximum flexibility in Exchange design options be provided to states. We are also concerned that HHS proposes to utilize the State Plan Amendment (SPA) process for certification and long-term oversight of Exchanges. This process is both time consuming and bureaucratic and could limit the Exchange's ability to react swiftly to market changes. Modeling Exchange oversight on the current Medicaid program should not be considered and we strongly urge HHS to consider another option.

Premium tax credits and cost-sharing subsidies are federal programs. State-based Exchanges should have the option to cede responsibility for calculation and administration of these programs to the federal government. Indiana recommends another option for federal-state partnerships be created to include the federal government operating the premium tax subsidies program while leaving Medicaid eligibility to the states. In the event states that operate Exchanges are forced to operate the federal tax subsidy program, the regulations should provide the flexibility around who can make the eligibility determination for premium tax credits. The cost of conducting eligibility for federal premium tax credits will be considerable for states and is one of the largest operational costs for Exchanges. States and their Exchanges must have the flexibility to use a variety of staffing methods to address the influx of applications that will occur during open enrollment periods and the subsequent decline of applications through the remainder of the year.

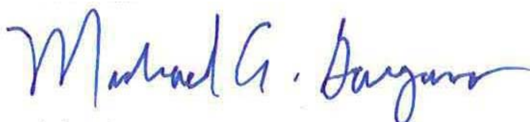
We are very concerned about the lack of information on the federal level. These proposed regulations still contain many critical gaps in information. The essential benefits, quality measures for health carriers, and the MAGI conversion methodologies are just a few examples of the glaring omissions in the regulations. Likewise, there is a complete lack of information on the details of the federal data hub and how it will interface with states' eligibility systems. These issues are pivotal as Indiana considers an Exchange and attempts preparation for the 2014 implementation in the event that the Supreme Court does not strike down the PPACA.

Regarding the MAGI determinations for Medicaid, we were very disappointed to see the lack of coordination between federal agencies. We have continually urged CMS to work with FNS and will do so again. Many states, including Indiana, operate a combined eligibility system. The proposed rules show no integration with SNAP and TANF. This will force beneficiaries to complete two eligibility processes and for states to maintain a system that conducts eligibility with two vastly different methodologies. We also urge HHS to reconsider its policies around retroactivity and presumptive eligibility as they are not likely to be needed if universal coverage is achieved.

Finally, we remain concerned with the condensed timeline for setting up the PPACA provisions, including an Exchange, by 2014. We strongly urge HHS to move expeditiously to release all remaining regulations, especially the regulations related to essential benefits, and to finalize all proposed regulations. The following pages contain specific comments regarding four of the regulations released; these comments are organized by the regulation section numbers. We offer them for your prompt consideration.

Thank you for the opportunity to submit these comments.

Sincerely,



Michael A. Gargano, Secretary

Indiana's response to specific provisions of Notice of Proposed Rule Making (NPRM) for 45 CFR 155 and 156 *Establishment of Exchanges and Qualified Health Plans*.

1) Undue Federal Oversight

The regulations require that state-based Exchanges seek federal approvals and permissions long after the federal government will cease funding the Exchanges. We are concerned that these requirements create undue government bureaucracy that is not warranted or needed and could certainly be avoided. Additionally, the citations below indicate the many examples where we believe that HHS is overly prescriptive, and this level of detail could have the effect of driving up operational costs for states.

§ 155.105

In the preamble to paragraph (d), comment is requested on implementing an approval process for the state-Exchange plans similar to Medicaid or CHIP in which HHS would have ninety (90) days to review the application and then an additional ninety (90) days to review any additional material requested. This section goes on to propose in paragraph (e) the State Plan Amendment (SPA) process as a model for how to deal with submissions of modifications to Exchange Plans. Indiana's experience with the Medicaid and CHIP process is that the SPA process places an undue burden and administrative cost on the State and prevents the State from responding to needed program changes in a timely manner. Indiana objects to any requirement of federal review for these state-based entities after the ACA mandated initial review and requests that these requirements be removed from the final regulation. Moreover, for the initial review by the federal government and any other review that cannot be removed, Indiana proposes that HHS have a maximum of thirty (30) days to review the application and an additional thirty (30) days to process additional requested materials. The timeline for the SPA process is too extensive, especially in light of the fact that states will be required to complete federal approval processes without federal funds after 2015.

Paragraph (e) proposes that a state must notify HHS before significant changes are made to the Exchange plan and that an Exchange must receive written approval of significant changes from HHS before they may be effective. Indiana questions what enforcement authority HHS maintains over state-based Exchanges after 2015 when there will be no continued federal funds to support Exchange operations. State Exchanges are state-based entities and changes to the Exchange program should be vetted at a state level and should not require approval from HHS to implement. If HHS intends to retain approval rights after 2015, then this legislative mandate must be funded.

§ 155.110

Paragraphs (c)(3) and (c)(4) propose standards on the membership of an Exchange board. While such expertise is required by the ACA, the regulations should contemplate that an individual's experience within the health care community may span several of the specialty areas that are detailed in the ACA and proposed regulations. Accordingly, the regulations should clarify that it is understood that an individual can represent many different areas of experience for purposes of representation in an Exchange. Failure to make such alterations to the regulations could inflate the number of members on an Exchange board in an attempt satisfy unclear regulations, which could be an obstacle to the efficient functioning of an Exchange.

In paragraph (f) of this section, HHS proposes that there may be periodic reviews of the accountability structure and governance principals of a state Exchange. The preamble to this section requests comment on the recommended frequency of these reviews. Once a state Exchange is established and completes a year of operations, there is no federal funding for the Exchange operations. Therefore, at such time, HHS should not have the authority to conduct reviews of Exchanges. State Exchanges are funded and administered by the states, and periodic reviews of accountability structure and governance principals are not necessary or appropriate. Such reviews would impede on the sovereignty of the states to carry out state operations. Furthermore, the reviews could lead to lack of the ability of state-based Exchanges to respond to changing local conditions and would create unnecessary and burdensome bureaucracy.

§ 155.205

In the preamble to this section addressing an Exchange's call center, the proposed regulations suggest that an Exchange consider operating the call center outside of normal business hours and that the Exchange should adjust staffing levels in anticipation of periods of higher call volume. These provisions are not currently in the regulation, and Indiana suggests that any decisions on the operating hours and staffing of state-run Exchange call centers be left to the direction of the respective state Exchange. These potential provisions have significant financial implications and should be solely under the direction of state Exchanges, which are better equipped to appreciate the impact and cost of such operations.

The preamble discusses paragraph (b) of this section with respect to the HHS Secretary establishing a standardized format for presenting coverage option information. Indiana recognizes that the ACA requires HHS to define this format, but requests that states have the flexibility to apply this format for coverage option information, to modify it, or to use an innovative, stated-created format for their Exchange, if they so choose, without having to request approval from HHS.

The preamble to this section also requests comment on a website requirement that would allow applicants and enrollees to store and access their personal account information and make changes. Indiana does not object to the idea that an Exchange web portal could store and retrieve application information for applicants and enrollees under a personal account. However, as Exchange continuing operations are to be funded entirely by states after the initial year of operations, the decision to implement additional web portal features should rest solely with the states and should not be required by federal rule. In Exchange design states should have the flexibility to implement this feature or not, based on their respective needs and resources.

Additionally, the same section of the preamble indicates that HHS encourages Exchanges to develop a feature that allows for consumer assistance experts (Navigators, agents and brokers, enrollment and eligibility specialists) are able to maintain the records of individuals they have assisted with the application process. Indiana requests that no direct regulations be instituted around this requirement as the State has concerns around securing individual privacy information in situations where individuals are assisted by volunteer Navigators or enrollment brokers.

§ 155.230

The proposed regulation regarding the general standards for Exchange notices provides guidance with respect to the content that must be included in a notice generated by an Exchange. While Indiana does not have a specific objection to the required content for notices under this section, Indiana believes that states are in the best position to determine the content of such notices and that a one-size-fits-all approach could be damaging over the long-term. For a state-based Exchange, the required content for notices should lay within the purview of the state and under the direction of the Exchange. Indiana has experienced litigation due to federal notice requirements in the Medicaid sector, and Indiana is concerned that the extensive and prescriptive notice requirements will expose states and Exchanges to potential litigation.

In paragraph (c) of this section, it is proposed that the Exchange annually re-evaluate the appropriateness and usability of applications, forms, and notices, and consult with HHS when changes are made. Indiana objects to the federally-mandated annual evaluation period; state Exchanges should develop their own standards with respect to the evaluation of materials, and changes to materials should not require consultation with HHS. Requiring this annual evaluation period and consultation with HHS limits Exchanges flexibility, as well as increases administrative burden and, ultimately, cost.

§ 155.405

In paragraph (a), the rule describes the development of a single streamlined application by HHS. Paragraph (b) proposes that a state that seeks to use an alternative application must

have it approved by HHS. Indiana welcomes the development of a model application, but objects to having to seek HHS approval for alternative applications used in state-based Exchanges. States should be allowed the flexibility to modify Exchange applications as needed, without seeking HHS approval. Application approval should solely be conducted at the state level for state-based Exchanges.

Paragraph (c)(2) of this section requires that an individual must be able to file an application online, by telephone, by mail, or in person. Indiana has concerns with telephone filing requirements. There are data entry concerns with individuals completing applications over the phone. Indiana is also concerned with how to verify identity in phone transactions. Phone applications would be time consuming to complete, and, if handled by a live representative, would substantially increase the operational cost of the Exchange. Indiana understands that offering phone support is essential, however, requests that states be given the flexibility to implement phone applications as best suits their needs and resources.

The preamble to this section also requests comment on the requirement that an individual must be able to file an application in person. Indiana requests that HHS issue no additional requirements regarding in-person applications and allow specifics for fulfilling this ACA requirement to be determined by state-based Exchanges. States are diverse and issuing requirements around in-person application standards likely would create additional burdens and operational costs for an Exchange, especially in rural regions. Exchanges should be allowed to determine what level of in-person support best suits their circumstances.

§ 155.410

While we understand and support the notion of defined open enrollment periods to limit adverse risk selection, Indiana questions the proposed federal timeline requirements for initial and annual open enrollment periods for the Exchanges. These timelines should be left to the states to determine.

In paragraph (b) regarding the initial enrollment period, Indiana suggests that a state may desire to start the open enrollment period earlier than what is proposed, or alternatively, may need additional time (i.e., a few additional weeks) to start the initial enrollment period. Prescribing October 1, 2013 as the beginning of the Exchange initial enrollment period does not provide sufficient flexibility or recognition of state specific circumstances and needs.

In paragraph (e), the federally defined open enrollment period prevents states from designing their Exchange based upon the specific circumstances within the state. By requiring one annual open enrollment period, HHS would prevent states from implementing rolling enrollment periods and distributing the enrollment burden throughout the year. Theoretically, Indiana supports defined enrollment periods to avoid adverse selection; however, as a practical matter, all individuals that would use the Exchange would be utilizing the system and personnel resources at the same time. An annual open enrollment period requires an

Exchange to process the majority of the enrollment work during two months of the year. In Indiana, we expect that an Exchange may have to support eligibility determinations for 1.5 million individuals on public programs and 450,000 to 875,000 lives in the individual market. Processing eligibility and plan selection for all of these lives during a defined period of time when the process could be spread throughout the year may significantly increase system build and maintenance costs.

Additionally, Indiana's stakeholder outreach efforts have included meetings with brokers who indicate that federally defined enrollment periods are problematic, especially during the time period prescribed in the proposed regulations, which coincides with other open enrollment periods, such as Medicare Part D and for employers in the large group market. Indiana suggests that it may be possible to build a more efficient Exchange by allowing states the choice of rolling enrollment periods where the work load can be spread throughout the year. States should be given the flexibility to define their own enrollment periods and the option to design their Exchange with a rolling enrollment period should they choose.

Comment is requested on whether an Exchange should be required to automatically enroll individuals who receive advance payments of the premium tax credit and are disenrolled from a QHP because the QHP is no longer offered. Indiana believes that Exchanges should only automatically enroll these individuals as a last resort. There are concerns with automatic enrollment as Indiana has experienced significant administrative issues with its Medicaid auto-assignment process. Exchanges should make every effort to contact the disenrolled individual. Moreover, any requirements with respect to auto-assignment and contacting affected individuals in these cases should be issued by the individual state Exchanges and not by HHS.

Additionally, Indiana does not support the federal regulations providing the range of dates of any open enrollment period. As previously detailed, these specific dates could present administrative and operational challenges for state run entities, and also creates potential for litigation should an operational challenge require a state exchange to open the open enrollment period at a later date. Indiana requests that this overly prescriptive timeline be removed from the final federal rule and that defining the dates of the initial enrollment period for state-based Exchanges be left to individual states.

However, to the extent that HHS does mandate specific date ranges for enrollment periods, Indiana does not believe that the initial enrollment period should extend beyond January 1, 2014. Systems and policies for the Exchange will be built on 12-month periods of coverage. The initial year of Exchange operation should be no different. Allowing for initial enrollment beyond January 1, 2014, will cause the Exchange to create exceptions to processes and systems in the first year of the Exchange, just when Exchanges will be struggling to create an efficient and uniform system. If HHS is concerned about outreach and education, it should ensure that such outreach and education is conducted well in advance of

January 1, 2014, rather than *after* the go-live date of the Exchanges. Creating an immediate exception to the 12-month coverage rule will create an unnecessary one-time exception to a myriad of processes and policies.

§ 155.420

In paragraph (b)(1), it is proposed that the Exchange must ensure that a qualified enrollee's effective date is on the first day of the following month for all QHP selections made by the 22nd of the previous month. . As noted above, Indiana objects to the timelines contemplated in the proposed regulations. The exact dates of enrollment should be left to the discretion of the state-based Exchanges and states should be allowed maximum flexibility.

§155.700

In paragraph (b)(4) the proposed regulation allows employers to select a single QHP to offer employees. The decision to allow employers to select a single QHP should be a state level decision and should not be prescribed in federal rule.

§ 155.705

In paragraph (b)(6)(i), it is proposed that the SHOP require all QHPs to make any change to rates at a uniform time. Currently, in Indiana, rates can change at any time. With the medical loss ratio (MLR) requirements, it will be especially important over the first few years of the Exchange operation to allow plans significant flexibility in changing their rates.

Allowing carriers to change rates at any time becomes a solvency issue. If issuers are experiencing greater claims than expected and have to wait for a quarterly or annual period to change their rates, then paying out current claims could become a problem, especially for smaller issuers. In addition, limiting when rates can be changed will increase the volume of applications that the Indiana Department of Insurance receives at certain times, and will increase periodic workloads. Indiana requests that states retain the flexibility to allow issuers providing QHPs in the SHOP to submit rate changes at any time, or at periodic intervals other than monthly, quarterly, or annually, as defined by the Exchange operating the SHOP. Allowing this flexibility in rate changes will likely be beneficial to consumers as plans may need to decrease their rates to avoid MLR penalties, without this flexibility consumers will not be able to take advantage of decreased rates.

Paragraph (b)(7) indicates that if a state merges risk pools for the individual market and SHOP, employers and employees QHPs can only be offered if they satisfy the deductible requirements for small business plans. Indiana realizes that the deductible requirements are contained in the ACA, but wishes to register an objection to these requirements. They prevent small businesses from fully utilizing the potential of high deductible plans, will increase the price of coverage in the small group market, and discourage employers from

offering insurance. Indiana strongly feels that there should be no deductible limits imposed on the small group market. Additionally, requiring QHPs to be SHOP certified in a merged market will increase burdens on plans operating in such markets and decrease the likelihood that a merger of the individual and small group market will occur.

§ 155.710

In paragraph (d) of this section, HHS codifies the ACA requirement that employers that grow over 100 employees be allowed to continue to participate in the SHOP. Indiana recognizes that this is in statute, however, sees the potential for this to create challenges for issuers when designing plan pricing for small groups that could potentially be purchased by larger groups.

§ 155.720

In the preamble to this section, comment is requested on whether any target dates or guidelines should be set by HHS with respect to reconciliation of enrollment information to ensure multi-state employers are subject to consistent rules. Indiana is cognizant of the difficulties inherent for multi-state employers dealing with different timelines in different states. However, we request that HHS decline to establish target dates and guidelines, as such operations are dependent upon the capabilities and resources of the individual Exchanges. The establishment of target dates and guidelines should be a function of state Exchanges.

The preamble to this section also invites comment on whether Qualified Health Plans (QHPs) offered in the SHOP should be required to waive application of minimum participation rules or if a minimum participation rule at the SHOP level is desirable. Indiana believes that this decision should be left to the individual states operating Exchanges. States will need to work with insurers offering coverage on the specific state Exchange and employers seeking coverage to come to a decision on minimum participation requirements. Varying conditions from state to state could make minimum participation rates either desirable or prohibitive to participation in an Exchange.

Paragraph (a) of this section addresses the SHOP enrollment periods. As with the initial open enrollment period for the individual market, detailed above, Indiana objects to the prescription of exact dates in the federal rule. The rule should at most establish basic guidelines and leave the selection of exact dates to the individual state-based Exchanges.

§ 155.1000

Paragraph (b) requires a multi-state plan offered through OPM to be deemed as certified by an Exchange. The stated interpretation of the ACA is that state-based Exchanges must accept multi-state plans without applying additional certification processes to such plans. Indiana believes that all plans offered on a state Exchange should be required to meet the

state insurance department's certification and rate requirements. Indiana objects to being required to offer multi-state plans on the Exchange without these plans undergoing the same review process as all other offered plans. This would give these plans an unfair advantage over all other plans offered in Indiana that must complete the Indiana Department of Insurance certification. In addition, to the extent that a state's requirements are more protective of consumers than the standards that will be applied to multi-state plans, a state's efforts to protect its citizens through careful regulation of insurance products will be undermined. Given that the regulation of insurance companies authorized to offer products in a state has traditionally come under the jurisdiction of the several states, requiring an Exchange to automatically qualify a multi-state plan without applying additional certification processes is an unwarranted intrusion into the rights of the states to protect consumers and regulate companies in the insurance context.

Multi-state plans could give larger insurance companies regulatory advantages over smaller competitors because they would be automatically eligible to participate on a state Exchange, and larger insurers operating in numerous markets could spread their administrative costs over a large pool of individuals. This market advantage would not be enjoyed by Indiana's smaller insurers operating only within the state, and could pose serious repercussions to their survival. Moreover, it could disrupt state insurance markets, decrease consumer protections and threaten insurer solvency. Therefore, if this model is adopted, multi-state plans should have to meet all state laws and regulatory requirements as others offering products on an Exchange, so that these plans do not enjoy a regulatory advantage. Based on FSSA consultations with the Indiana Department of Insurance, Indiana sees the following list of disadvantages in the current structure of the multi-state plan rule:

- Potential exemption from external review and unreasonable rate review requirements, giving multi-state plans a regulatory advantage;
- Creates contractual confusion for insurers when establishing premium pricing for such plans;
- Diminishes market competition because larger insurers will gain increased market share;
- Generates federal certification or automatic attestation as a uniform plan offered for all state Exchanges;
- Negates the stated goal of HHS to allow an Exchange to implement selection criteria beyond the minimum federal certification requirements in determining whether a plan is in the interests of qualified individuals and employers in the state;
- Automatic certification will allow competitive advantage of covering large percentage of individuals and small groups, while spreading the administrative costs over a large number of lives;
- Potential exemption from state regulatory or filing review leading to an uneven playing field for consumers when comparing plans not subject to the same requirements;

- Potential exemption from state Exchanges' oversight and any additional requirements states may impose for QHPs;
- Mitigates state Exchange certification requirements causing a competitive disadvantage for other insurers which leads to market disruption, unless the proposed regulations are amended to require multi-state plans to play by the same rules;
- Potential exemption from fees and assessments hindering the ability to develop a self-sustaining state Exchange and putting other plans at a competitive disadvantage;
- Eliminates compliance of state network adequacy standards;
- Influences consumer perception as marketing a "Federal-Government Approved" health plan;
- Potentially enacts different solvency and reserve requirements than currently established at the state level, which could place enrollees at risk if insurance companies cannot pay their claims, particularly if OPM extends federal employee health benefit plan (FEHBP) solvency requirements to multi-state plans;
- Promotes rapid expansion for insurers in order to participate in Multi-State Plans causing increased levels of risk beyond their projected capitalization threshold;
- Generates possible manipulation of MLR by allowing national aggregation of insurer experience instead of state-by-state aggregation consistent with the intent of the statute;
- Promotes separate risk pooling or risk segmentation creating distinction between business sold inside and outside the Exchange, thus creating a potential monopoly for larger insurers;
- Creates consumer confusion by preempting states from exercising their authority to assist consumers because guidance is directed by OPM; and
- Prevents states from imposing consumer protections on multi-state plans that might otherwise apply to QHPs, thus diluting potentially important protections provided to the purchasers of coverage on an Exchange.

Indiana would not foresee requiring certification beyond the general state requirements of multi-state plans. HHS and OPM do not have rate review authority, and part of an adequate rate review is that this process is deferred to the states. Indiana is opposed to a regulation that requires a state Exchange to accept plans that have not been adequately reviewed by the state department of insurance (DOI).

§ 155.1050

The preamble to this section seeks comment on a potential additional requirement that HHS would provide additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether QHP provider networks provide sufficient access to care. HHS seeks comment on very specific standards under which QHP issuers would be required to maintain things such as sufficient numbers and types of providers, arrangements to ensure a

reasonable proximity of participating providers to enrollees, and other specific criteria. Indiana requests that these requirements be removed from the final federal regulations.

Exchanges should have the full ability to establish these standards as they deem necessary. Individual states, rather than the federal government, are in a much better position to create and evaluate the criteria necessary to ensure that QHPs adequately serve the state's population and to ensure that networks are adequate to provide the services needed by enrollees. States have a much better understanding of their own populations, demographic distributions, locations of providers, geography, and other factors that affect network adequacy. Federal requirements to establish these standards would be burdensome and unnecessary, and, potentially, harmful to a particular state's unique characteristics.

§ 155.1075

Paragraph (b) of this section proposes that the Exchange must complete the recertification process of health plans as QHPs on or before September 15th of the applicable calendar year, and solicits comment on the appropriateness of this deadline. Indiana does not support a federally imposed timeline, and instead proposes that states have the ability to determine their own recertification deadlines so long as those dates do not conflict with state established enrollment periods.

§ 156.265

In paragraph (b) HHS proposes that it will develop applications required to be used by issuers during the enrollment process of individuals. However, issuers currently have functional applications and the state requests that issuers be allowed to use the HHS application or an application modified to better suit their needs. Indiana does not support extensive HHS involvement in regulating and designing applications.

§ 156.285

Indiana questions the list of additional requirements contained in this section for an issuer to participate in the SHOP. The proposed rule specifies that QHP issuers provide enrollment packets, information on prices and policies, and notices of termination of coverage. These activities are already being conducted in the marketplace by the issuers, and therefore it is unnecessary to prescribe them in federal regulations. Additionally, issuing needed requirements should be a function of the individual SHOP Exchanges and not handled on a federal level.

2) Non-ACA Processes and Increased Burdens and Costs

The following proposed regulations contain additional processes that are not indicated in the ACA and yet are proposed through regulations by HHS. Every additional requirement imposed

on state-based Exchanges will increase costs to operate the Exchange and, ultimately, the costs for consumers and for publicly funded insurance affordability programs. These costs, if imposed by regulation, represent an unfunded mandate.

§ 155.110

Paragraph (c)(2) proposed that the Exchange board must hold regular public meetings for which the public is provided advance notice. Based upon the contemplated activities of the state Exchanges, it is understood that public transparency should be a key component of every Exchange. However, the requirement in the proposed regulations providing for public meetings of Exchange boards is both undefined and does not contemplate the differences among the states.

First, the regulations provide for public meetings and notice without defining what constitutes a "public meeting" and providing "advanced notice." Imposing such requirements without providing proper explanations creates even greater uncertainty. The purpose of regulations are to clarify and carry-out existing statutes, as opposed to creating additional, undefined requirements.

Moreover, the proposed regulations fail to contemplate the varying structures Exchanges throughout the country. Depending upon the structure of the Exchange, specific state open door laws and regulations may define the transparency requirements of the Exchange, including the requirements for public meetings. This broad public meeting requirement fails to contemplate the varying circumstances among the states, including the likelihood that confidential or privileged matters will be addressed at Exchange meetings.

Accordingly, if it is necessary to have regulations on this subject, which is questionable, it is more appropriate for the regulations to advocate transparency among the Exchanges. However, defining how an Exchange satisfies the transparency requirements should be left to the individual Exchanges that are better equipped to determine the appropriate standards based upon the structure of the Exchange as well as applicable state laws and regulations.

§ 155.200

Paragraph (c) proposes that an Exchange must perform eligibility determinations. The requirement that Medicaid eligibility be performed by state employees increases state cost tremendously. In a projected cost model, Indiana would save between $1.3 and $1.6 million in 2014 by using non-state merit employees for Medicaid Expansion eligibility determinations. The proposed regulations do not include requirements around tax credit eligibility determinations, but if Indiana is required to use state merit employees in place of contracted employees for tax credit determinations, the additional cost to the state will be $12.2 million in 2014.

Due to the extraordinary cost of performing eligibility, especially in light of the unprecedented expansion in coverage, Indiana requests that HHS reconsider and allow states to use non-state merit employees for completing eligibility determinations for Medicaid expansion populations. For tax credits, HHS should clarify that eligibility does not have to be performed by state merit employees, especially in light of the fact that the federal government will not provide any funding to state-based Exchanges after 2015. Additionally, requiring state-merit employees to make tax credit eligibility determinations challenges the viability of the nonprofit Exchange model.

§ 155.210

This section proposes that Exchanges must provide grants to Navigators. The ACA indicates that an Exchange shall provide grants to navigators; however, this provision creates a financial burden to an Exchange both in finding the funds for grants and in administration of the grants. The grants have to be provided before an Exchange is operational, and, as they cannot be provided with federal funds, this could create a significant startup cost burden. Indiana suggests that states should be able to direct the scope and makeup of any Navigator programs, and determine whether Navigators should be paid or operate on a volunteer basis.

HHS should consider that some states may choose to develop a volunteer-based Navigator program. This program could be similar to the SHIP program, with Navigators acting as volunteers through community-based organizations that already focus on helping vulnerable populations seek public assistance. Indiana requests that HHS consider that volunteer Navigator programs are a viable alternative and that requirements to provide funding to these types of organizations should be at the discretion of the Exchange.

§ 155.410

Paragraph (d) proposes that the Exchange must send written notification to enrollees about the annual open enrollment period. The preamble indicates that HHS is considering codifying the requirement that such notice be sent no later than thirty (30) days before the start of the annual open enrollment period and requests comment on this provision. Indiana is opposed to codifying specific timing in the final federal rule. Federal timelines limit the flexibility of state design of Exchanges. Indiana suggests that no additional timeframes be defined. Additionally, written notification about open enrollment periods is a function currently performed by health plans. Requiring the Exchange to perform this function is duplicative, and increases the administrative burden and operational costs for an Exchange. Alternatively, while Indiana objects to this requirement, the State also requests clarification of whether "written notification" encompasses electronic communications as well as paper based media.

§ 155.420

Paragraph (c) proposes a sixty (60) day length for each special enrollment period. Indiana comments that HHS should consider shortening this to a thirty (30) day enrollment period. Thirty (30) days is the standard length of time for special enrollment periods in the current market and extending the special enrollment period to sixty (60) days opens up greater potential for individuals to experience periods without coverage and could creates selection issues. Indiana does not perceive added value in this deviation from current practice.

Paragraph (d)(2) indicates that individuals who gain a dependent are eligible to change from one QHP to another. Indiana objects to the ability to change plans in the event of gaining a dependent. Adding a new dependent to a plan is a simple procedure and should not trigger a special enrollment period, except in the case where an individual's QHP does not provide dependent coverage. Allowing individuals who add a dependent to change plans will increase administrative burden for the Exchange and potentially increase adverse selection issues.

Paragraph (d)(7) proposes that special enrollment periods related to individuals who move. These enrollment periods are proposed to begin either on the date of the permanent move or on the date the individual provides notification of such a move. Comments are requested on alternatives. Indiana would like to comment that allowing special enrollment periods to begin on the date an individual provides notice of their move is problematic. The enrollment periods should begin on the date which the individual experiences the event that triggers the special enrollment period. Allowing special enrollment periods to begin when individuals report a change could cause selection issues as well as issues surrounding the verification of the event triggering the special enrollment period.

§ 155.705

Paragraph (b)(4) requires that the SHOP perform premium collection and premium aggregation functionality. Indiana objects to this requirement on the SHOP. Indiana's online Exchange questionnaire which received over 2,000 responses and targeted individual consumers, businesses, insurers and providers, found little support for premium collection as a function of the Exchange. In the aggregate, only 28% of respondents supported the Exchange having premium collection functionality in the individual market, and only 33% of respondents supported the Exchange having premium collection functionality in the small group market. Indiana's one-on-one stakeholder outreach efforts have also found little support for this provision. Hoosier insurers are comfortable maintaining their billing and collection responsibilities, and overall employer response to having the possibility of a state-based Exchange involved in premium collection has been unenthusiastic.

Furthermore, Indiana does not believe that the requirement for the SHOP to collect premiums is contemplated by the ACA or a function that will increase the successfulness of an

Exchange. This requirement significantly increases the level of complexity of SHOP operations and will increase SHOP build and ongoing operational costs. Additionally, this puts Exchanges in the middle of financial transactions between employers and insurers and increases the potential liability exposure for the Exchange.

Indiana recognizes that the HHS vision is for the SHOP to decrease the administrative burden on employers who are offering their employees coverage in the SHOP. However, requiring a SHOP Exchange to bill and remit premiums may be duplicative and declines to leverage the current expertise of carriers and employers in billing and remitting payment. State-based SHOP Exchanges should have the option to perform premium collection functionality, or not, as best suits their unique environments and resources. SHOP premium billing rules should allow for State flexibility.

§ 155.710

Indiana objects to the requirement contained in paragraph (b)(2), which provides that the SHOP shall ensure that a qualified employer provides an offer of coverage through the SHOP to all full-time employees. This places an administrative burden on the SHOP and would be difficult to enforce.

§ 155.715

This section proposes that a SHOP must verify additionally that an employer offers all full time employees access to health coverage through the SHOP. Verifying employer offerings could be burdensome to the SHOP especially in the case of an employer with employees in multiple states. Indiana is aware of no data sources that provide this information and requests clarification on where and how a state is expected to verify this information. If verification beyond a self-attestation is required, this responsibility seems to fit more within the purview of the Department of Labor and should not be required under state-based Exchanges.

§ 155.720

Paragraph (e) of this section requires the SHOP to ensure that qualified employees enrolled in a QHP are notified of the effective date of coverage. If the SHOP is required to notify individuals of their effective date of coverage, this would duplicate a service already performed by health plans and increase administrative costs in the SHOP. A requirement that the SHOP notify individuals of their effective date of coverage would be burdensome and unnecessary. Indiana sees notification of effective coverage as a core competency of the QHPs and requests validation of the assumption that a state-based Exchange can make this a requirement for QHPs.

Paragraph (h) of this section places additional burden on the SHOP Exchange. It requires the SHOP to notify the individual's employer if the employee voluntarily terminates coverage from a QHP. Indiana sees notification of coverage termination as a responsibility of the QHP, and does not believe there is a valid reason for it to be a SHOP requirement. Every additional required function on the SHOP will increase administrative burden and cost. In this case, Indiana feels this function can be efficiently and effectively performed by the QHPs.

§ 155.725

Paragraph (d) contains the requirement that the SHOP notify employers that their annual election period is approaching. The request for comment indicates that HHS is considering whether to require thirty (30) days advance notice. Indiana objects to the requirement that the SHOP notify employers as this is a function currently carried out by health plans and, thus, is a duplicative requirement on the SHOP. Additionally, the timing of notice requirements should be left to the individual Exchanges. These notice requirements are burdensome to the Exchange.

Additionally, paragraph (d) of this section requires the SHOP to establish effective dates of coverage for qualified employees. Currently, this function is performed by employers and carriers, and Indiana questions why this should be a function of the SHOP. If employers and carriers can effectively perform a function, then the requirement for the SHOP to perform the function(s) creates unnecessary work, adds to administrative cost, and is duplicative.

§ 155.730

Paragraph (d) of this section proposes that a SHOP may use the HHS model single employer and single employee applications, or as detailed in paragraph (e), the SHOP may use an alternative employer application with HHS approval. Indiana supports Exchanges' ability to use the HHS model applications; however, applications developed on a state level should not have to require HHS approval. Exchanges are state entities and should not be burdened by HHS and potentially untimely approval processes when improving and customizing applications to best suit the state's needs.

§ 155.1040

In paragraph (b) of this section, the Exchange is required to monitor the use of plain language by QHP issuers. Indiana's experience with monitoring plain language in its Medicaid plans demonstrates that this is an administratively burdensome and costly process. Exchanges should not be required to monitor QHP issuers use of plain language. These issuers should instead be allowed to attest that they have met applicable plain language usage guidelines. Not allowing self attestation will increase administrative burden and costs for the Exchange.

§ 155.1080

This section requires Exchanges to implement procedures for decertification of health plans as QHPs. In Indiana, decertification is a function currently performed by the Indiana DOI. As with other uniquely insurance department functions, Indiana envisions any potential state-based Exchange contracting with the Indiana DOI to fulfill decertification functions. Indiana requests that the ability for state-based Exchanges to contract this activity to their DOI be made clear in the final rule.

§ 156.210

In paragraph (a) it is proposed that a QHP's rates must be applicable for an entire benefit year, or in the SHOP, for the plan year. Indiana requests that this decision on rates applicability for an entire plan or benefit year be left to a state's discretion. It is possible that it may be necessary to adjust a rate during the year due to birthdays (age changes), changes in behaviors (such as beginning or ceasing smoking), or changes in geography. A member could move from one county to another and be covered by the same plan, but the new county could have higher or lower geographic rates. Additionally, in the short term, plans will be grappling with the MLR requirements and may need to adjust rates based upon claims experience. Not allowing changes in rates throughout the year could be detrimental both to plans and to members as it prevents rates from going up or down. The complexities of this issue likely varies state to state, and thus the ability of QHPs to vary rates should be left to the state Exchanges.

§ 156.220

The preamble to this section states "[w]e recognize that there are web-based entities and other entities with experience in health plan enrollment that are seeking to assist in QHP enrollment in several ways, including: by contracting with an Exchange to carry out outreach and enrollment functions, or by acting independently of an Exchange to perform similar outreach and enrollment functions to the Exchange." The preamble further states that, "[w]e understand that such entities may provide an additional avenue for the public to become aware of and access QHPs, but we also note that advance payments of the premium tax credit and cost-sharing reductions may only be accessed through an Exchange. We seek comment on the functions that such entities could perform, the potential scope of how these entities would interact with the Exchanges and what standards should apply to an entity performing functions in place of, or on behalf of, an Exchange."

Indiana proposes that these entities could serve as private partners to state-based Exchanges, or be developed as private Exchanges. As long as a strong private partnership is in place, entities serving as private Exchanges should be able to provide individuals access to premium tax-credits as a designated "private Exchange."

§ 156.230

In paragraph (b) this section proposes that a QHP issuer must make its health plan provider directory available to the Exchange electronically and to potential and current enrollees in hard copy upon request. Theoretically, Indiana supports the ability of Exchange users to access QHP provider directories; however, detailing this requirement in federal regulations increases both the burden on QHPs and on the Exchange. Indiana requests flexibility for this regulation. It is possible that Exchange users could access provider directories without QHPs being required to submit them electronically to the Exchange. Indiana should have the flexibility to determine how to give users access to provider directories. The preamble requests comment on standards that might be set to ensure the QHP issuers maintain up-to-date provider directories. Indiana suggests that setting these standards be left to the individual state Exchanges and not prescribed in federal regulations.

§ 156.235

In the preamble, comment is solicited on how to define a sufficient number of community providers. Indiana suggests that defining "a sufficient number" should be left to the discretion of state Exchanges. State Exchanges will better understand the local situation of their essential community providers, and the diversity among states will require this definition to differ. Indiana does not support any specific health plan contracting requirement with essential community providers. As acknowledged in the preamble to the proposed rule, Indiana feels that this would be a disincentive to innovative network design, and furthermore, it could hurt quality initiatives if all essential community providers receive contracts regardless of quality.

Indiana is investigating how its ‘any willing provider’ standard will interact with the essential community provider standard. Indiana believes that each state's approach to the any willing provider law should apply to this issue. However, Indiana wants health plans to have the ability to contract selectively for quality and value and not be required to provide coverage at locations with inferior quality. Allowing selective contracting based on quality could spur provider side innovation and quality and value improvements.

This section proposes an approach requiring QHP issuers to pay at least the Medicaid PPS rates when contracting with a Federally Qualified Health Center (FQHC). To meet this requirement QHPs would need to know the Medicaid PPS rate for each FQHC. Additionally, this rate is updated annually based on inflation. This would require that the state Medicaid agency provide the rates for FQHCs to the QHPs. As the Medicaid agency likely has no direct contact with the QHPs, this transaction would likely have to go through the Exchange. Submitting this information creates an administrative burden for the Medicaid agency, and if the information travels through the Exchange to reach the QHPs, also increases the administrative costs to the Exchange. Additionally, FQHC rates are all inclusive and this

conflicts with how traditional commercial contracts are reimbursed. To contract with FQHCs, QHPs will have to learn to contract differently than they would with a traditional doctor's office, and will have to sort out how to pay an all inclusive rate at one location compared to a line item rate at another location. Due to these complexities Indiana suggests that HHS leave it to the FQHCs and the QHPs to address rates and contracting procedures on an individual basis, and not add this as an additional burden onto the State Medicaid agency or state Exchanges.

§ 156.285

The preamble to this section requests comments on the requirement for QHPs in SHOPs to offer dependent coverage. Indiana feels that the market will drive QHPs to offer dependent coverage options. Accordingly, requiring QHPs to offer dependent coverage is unnecessary and does not need to be included in the final regulations.

§ 156.290

The preamble to paragraph (c) of this section requests comment on the extent to which enrollees should continue to seek coverage from a decertified plan. Indiana supports allowing enrollees to remain with the decertified plan and not be forced from its coverage. Enrollees should be notified that a QHP has been decertified, and made aware of other coverage options. Moreover, the enrollee should be required to acknowledge receiving notice that their QHP has been decertified. However, enrollees should not be forced to change coverage and should be allowed to continue to receive coverage from the plan through their redetermination period.

3) Questions and Requested Clarifications

Indiana's review of the proposed rule generated the below questions and requests for clarification.

§ 155.105

1) This section indicates that states must seek federal approval for changes to Exchange plans and forms. Indiana requests clarification on what penalties exist should an Exchange make changes deemed significant without HHS approval.

2) What funding options are available for states that decide to establish an Exchange after 2013?

§ 155.110

3) Paragraph (a)(3) identifies the State Medicaid agency as an eligible entity for which the Exchange can contract. Indiana requests clarification that any state agency is an eligible entity with which the Exchange can contract, including a DOI. The Indiana DOI currently performs many functions related to certification, decertification, rate review and enforcement that the Exchange will have to perform or delegate to an "eligible entity." Indiana requests that the final rule state that the Exchange can contract with the DOI to perform these functions. Excluding state agencies as eligible contracting entities would create duplicative processes, workloads, and costs, and create possible conflicts between Exchanges and the existing state agencies that currently perform many of the functions contemplated within the ACA.

4) Paragraph (c)(1) proposes that the Exchange be administered under a formal, publicly-adopted operating charter or by-laws. Indiana seeks clarification as to what is meant by a publicly-adopted operating charter or by-laws. The ACA and the proposed regulations contemplate that the Exchange can take the form of a nonprofit entity. Each state has laws and regulations as to how a nonprofit entity is formed and governed. Indiana would like to confirm that following this type of state law will satisfy the governance standards contained in the proposed regulations. Creating additional governance requirements in addition to the state laws and regulations that govern a nonprofit entity will inhibit the ability of states to establish an Exchange.

§ 155.160

5) Paragraph (b)(4) provides that state Exchanges arrange the assessment of user fees on health insurance issuers in advance of the plan year. What if an Exchange determines during a "plan" year that it needs to increase its user fees to have sufficient funds to operate?

§ 155.165

6) Indiana requests clarification on paragraph (b) of this section, which indicates that a state Exchange can generate funding by charging user fees or assessments on participating issuers. Indiana requests clarification on whether assessments may be charged on all insurers and self insurers in the market place regardless of whether they participate in the Exchange .

§ 155.200

7) Indiana requests clarification regarding whether eligibility for tax credits can be performed by non-state merit employees.

8) Additionally, the state requests clarification on whether a nonprofit Exchange can perform Medicaid eligibility.

§ 155.205

9) Paragraph (b)(4) of this section requires that the Exchange portal provide applications with information about Navigators and other consumer assistance services. We seek clarification on whether insurance agents can be included with consumer assistance services.

§ 155.210

10) Indiana requests clarification regarding whether Navigators are prevented from receiving compensation outside of the Exchange.

11) Indiana requests clarification regarding whether all organizations serving as Navigators must receive grants.

12) If a grant must be provided, is it to an entity or can it be provided to an individual?

13) Additionally, does HHS foresee creating any minimum or maximum limits on the size of the grants?

§ 155.230

14) Indiana has a general question around notice requirements for individuals over 400% FPL. Are individuals over 400% FPL determined ineligible for MAGI based Medicaid or premium tax credits subject to the same notice requirements as individuals under 400% FPL? Current process is that whenever an individual is determined ineligible for Medicaid they are sent a notice indicating that they were denied coverage for Medicaid. Especially as relates to high income individuals, will these notice requirements still apply in the world of MAGI Medicaid and Premium tax credits? If an individual is screened through the Exchange and found ineligible for Medicaid or a premium tax credit but eligible will there be a requirement to send a denial notice?

§ 155.410

15) Relating to the open enrollment periods, Indiana requests clarification on the close of the period. When accepting paper applications does the application need to be post marked by the last day of the open enrollment period or received by the last day of the open enrollment period? If an application must be postmarked by the last day of the open enrollment period but received after the close of the period, does this impact the date by which an individual has to make a plan selection in order to be enrolled in the next month? What is the

expectation on state-based Exchanges relating to the processing time of paper applications received in the last few days of a special enrollment period?

§ 155.420

16) With regard to the special enrollment periods, Indiana requests guidance on how to deal with the issue of Medicaid retroactivity for individuals leaving Exchange products and entering into Medicaid. In this case, are members provided with a period of duplicate coverage?

17) Indiana requests clarification on how the special and open enrollment periods for Exchange determined MAGI Medicaid interact with Medicaid requirements for continuous eligibility?

§ 155.710

18) The preamble to paragraph (b)(1) of this mentions full time employees, Indiana is unaware of any national definition of "full time employee" and requests clarification on this terminology.

§ 155.725

19) Paragraph (h) of this section indicates that an individual remains enrolled in SHOP coverage unless they choose to disenroll, enroll in another QHP, or the QHP they are enrolled in ceases to exist. Indiana requests that clarification be provided on the auto-enrollment process for the SHOP Exchange in cases where a QHP ceases to exist and an individual does not respond and select another QHP. In these cases is the SHOP responsible to auto enroll these individuals in another QHP?

§ 155.1000

20) If a state mandates benefits outside of the essential benefits, will multi-state plans include the mandated benefits?

21) Paragraph (c) references Exchanges certifying health plans. In Indiana, the Indiana DOI handles plan certifications. Requiring the Exchange to also perform this function is duplicative and will increase costs. An Exchange not housed in a DOI should be able to contract with the department to complete plan certification requirements. Indiana requests clarification on whether Exchanges may contract all functions that are currently performed by DOIs to the DOI.

22) Indiana requests clarification that the state DOI will have the responsibility and oversight of plans sold on any Exchange in the state, irrespective of whether it is a state-based or federal Exchange.

23) Indiana requests clarification that multi-state plans will be subject to state certification by the state DOI.

§ 155.1020

24) This section requires the Exchanges to consider certain factors related to health plan rates when determining whether to certify QHPs. Having both Exchanges and DOIs with responsibility for reviewing rate justifications creates a situation where one entity may find a rate increase justified, and another entity may find it not justified. This could undermine DOI authority and create the risk of having different rates existing in the market for the same or similar health plans. Indiana envisions the State DOI certifying QHPs, and requests conformation that an Exchange has the ability to contract QHP certification, including review of rates, to the Indiana DOI.

§ 155.1065

25) This regulation codifies the requirements in the ACA to allow limited scope dental plans to be offered on the Exchange. Indiana recognizes that the ACA did not mention limited scope vision plans or other stand alone coverage, but requests clarification that offering stand alone plans for other benefits is allowed and is left to the discretion of individual state Exchanges.

§ 156.200

26) Indiana requests clarification on paragraph (a) of this section requiring certification of health plans, and if the State is responsible for health plan certification for QHPs in the event the State elects the federal Exchange option. QHPs offered on the Exchange should be required to be licensed in the State and that the State should have jurisdiction over any plan offering on the Exchange, regardless of whether the Exchange is state-based or federally-facilitated.

§ 156.260

27) Paragraph (a)(1) indicates that a QHP must enroll a qualified individual. Indiana requests clarification on if a QHP can reject an application from an employer or individual due to previous proven fraud? Is an individual or employer proven to have previously engaged in fraud still considered qualified for enrollment in a QHP through the Exchange?

§ 156.270

28) Indiana requests clarification regarding whether, after the three month grace period, health plans can initiate collection proceedings if individuals fail to pay.

29) Indiana also requests clarification on how reconciliation described in 26 CFR part 1 will be conducted for members operating under the grace period.

4) Support:

Indiana supports the below proposed regulatory provisions.

§155.420

Indiana supports HHS interpretation that failure to pay premiums does not trigger a special enrollment period. Indiana believes individuals should be held responsible for premium payments and supports excluding those that fail to pay premiums from coverage until the next open enrollment period.

§155.715

In the preamble to this section HHS offers the option for Exchanges to allow employers to self-report workforce size and to attest to the reports accuracy. The option is also provided for SHOPs to conduct a more stringent determination of employer size. Indiana supports this approach and appreciates the flexibility offered here to SHOP Exchanges to develop policies on determining employer size.

§155.725

Indiana supports the policy in paragraph (b) of this section allowing employers rolling enrollment and requests that state-based Exchanges be allowed to apply rolling enrollment periods to the individual market as well as to the SHOP.

§155.1000

The preamble to this section allows Exchanges the ability to decide how they will select the plans to offer on the Exchange and mentions options of competitive bidding process and 'any qualified plan' strategies. Indiana supports the flexibility offered to state-based Exchanges to determine plan selection procedures.

§155.1075

This section permits the Exchange to determine the frequency for recertifying QHPs. Indiana supports allowing states this flexibility. The State does not support any additional more specific federal requirements associated with the term length for recertification.

Indiana's response to 42 CFR Parts 431, 433, 435, and 457 *Medicaid Program: Eligibility Changes under the Affordable Care Act of 2010*

§431.10 & 431.111

The proposed rules on who may make eligibility determinations for (1) Medicaid and (2) premium tax credits are not clear. While several sections of the proposed rules state that the Exchange will conduct eligibility, another section specifically states that Medicaid workers must make the eligibility determinations for the Medicaid program. Indiana requests clarification on who may make an eligibility determination, both for (1) Medicaid and for (2) premium tax credits. While the federal Medicaid program has longstanding rules on who may conduct eligibility determinations, Indiana specifically requests that the federal government give states complete flexibility with regards to the staffing for the new premium tax credit program. Any employee of the Exchange, whether full-time or contracted, should be permitted to make eligibility determinations for premium tax credits. The cost of hiring and maintaining a full staff of classified State employees is significant, and it does not allow for staffing flexibility, especially with high volume workload anticipated at open enrollment. Deloitte Consulting was hired by the State of Indiana to develop detailed processes, business requirements and a cost model. Deloitte has estimated the annual cost of operating the Exchange with classified State employees performing premium tax credit eligibility determinations to be $57.7M, whereas the annual cost with contracted eligibility workers would be approximately $45.2M. Given that the Exchanges must be self-sustaining in 2015 and no further federal dollars will be available, this cost savings is significant to the State. Indiana again asks the federal government to give states flexibility in area of Exchange staffing.

§433.10

The proposed regulation does not include the full definition of states eligible for the enhanced match that is located in the Affordable Care Act. The ACA designates expansion states as those offering a benchmark plan or benchmark-equivalent plan to the expanded population, among the other criteria. The full language in the ACA should be explicitly stated in the final rule.

§433.206-210

With regards to the FMAP methodologies, states should be given options of methodologies, and Indiana requests that CMS not implement a "one size-fits all" approach. Medicaid programs are remarkably different from state to state, and flexibility should be given to the states. Additionally, if states will be required to notify CMS of their chosen methodology by December 31, 2012, CMS must promptly issue final regulations and provide the necessary technical assistance to implement the methodologies. Indiana is concerned that this timeline may be too aggressive. The commitment of three years to an FMAP methodology may also be too aggressive in the new environment, and flexibility is requested on the three year time

commitment as well. There are many unknowns, and small percentage swings in FMAP rate will have a significant financial impact on states.

Specifically, Indiana requests that final guidance include how to address FMAP for 209(b) states that transition to 1634 states. Because states must use the eligibility guidelines in place on December 1, 2009 for claiming FMAP, may 209(b) states claim the enhanced FMAP for individuals currently on SSI but not eligible for Medicaid with transition to 1634 status?

With regards to the threshold methodology, Indiana requests clarification on how to account for the current asset tests in Medicaid eligibility determinations. States will need to adjust this methodology for the relative asset values, and Indiana recommends freezing levels at the 2009 threshold.

Next, regarding the statistically valid methodology, Indiana requests guidance on how states are supposed to implement this method since it would require individuals to complete the full application process under the 2009 Medicaid program. This is of particular concerns for 209(b) states, like Indiana, that require a full medical disability review of applicants applying for the Medicaid disability program.

Finally, how are states to consider other populations that are not subject to the ACA provisions, specifically: children, dual eligible individuals, individuals over 65, the disabled and pregnant women? Will states be expected to convert to a MAGI equivalent basis for all of these populations as well, and will the states need to maintain the current eligibility system for these individuals but use the MAGI eligibility system for parents and adults?

§435.116

Guidance on the collapsed Medicaid category for pregnant women and this category's interaction with the other Medicaid categories remains unclear. If a woman is receiving Medicaid coverage in 2014 and becomes pregnant, why should she be moved to the pregnancy category, if the benchmark benefit package requires maternity coverage? If CMS envisions that the woman should be transferred from one category of Medicaid to another, what process does CMS propose and how will this be tracked for FMAP purposes? Indiana further requests clarification on the State's responsibility if the woman does not notify the Medicaid agency that she is pregnant. Lastly, in the 2014 Affordable Care Act environment, presumptive eligibility for pregnant women is not needed as all individuals are responsible for having insurance coverage.

§435.118

Medicaid categories for children are collapsed in this section of the proposed regulation. However, the Affordable Care Act requires that foster children remain eligible for Medicaid until age 26. Is it CMS' assumption that age 19 foster children would be transitioned from the "infants and children under age 19 category" to the coverage for "individuals age 19 or and under age 65 at or below 133% FPL (435.119) category," or do foster children remain in their own Medicaid category that bypasses the MAGI screening?

Additionally, in Indiana, children are continuously eligible from ages 0-3. Are states permitted to operate continuous eligibility for children ages 0-3, and if so, how? Please provide additional guidance on the issue of continuous eligibility in the post-Affordable Care Act implementation environment. Lastly, does the maintenance of effort on CHIP apply to newborns?

§435.603

The income counting rules proposed for 36B definition of MAGI does not include Social Security Benefits, even though these benefits are counted as income in today's Medicaid program. A recent, publically released Milliman study estimates that an additional 2.3M individuals nationwide will be eligible for Medicaid if the SSI provision on the proposed rules does not change. These individuals would otherwise be able to purchase private insurance on the Exchange with the aid of premium tax subsidies. **Indiana strongly encourages CMS** to write rules such that SSI is still counted as income for determining Medicaid eligibility.

The proposed regulation states that the family size of a pregnant woman is two. The family size of others in the household can include or not include the unborn child as this has been given as a state option. How are states to handle a woman who is carrying twins, triplets, etc.? One of the CMS eligibility calls indicated the pregnant woman would be counted as two individuals regardless of how many babies she was carrying; however, this is contradictory to current policy. Please address this contradiction.

Lastly, regarding the MAGI eligibility determination for Medicaid, FNS coordination should be considered to avoid chaos. Many states operate a combined eligibility system, and while CMS has attempted to simplify the eligibility rules for Medicaid, the current lack of coordination with FNS will require individuals to understand two remarkably different sets of rules and processes. Indiana urges CMS to coordinate efforts with FNS.

§435.905

Indiana supports the proposal to modify 435.905 to eliminate the specific requirements regarding the quantity and availability of written and electronic pamphlets. Rather than have a universal requirement for all states, the modification of this regulation to broaden the language, allows states to readily adapt the needs of their specific clients without the worry of an over-burdensome regulation.

§155.410

The proposed regulation states that CMS is considering adding a regulation that would require Medicaid coverage for an additional month when an individual is found ineligible for Medicaid and eligible for a tax subsidy after the twenty-second day of the month. In response to the request for comment, Indiana asks that the federal government provide states flexibility on providing the individual an extra month of Medicaid coverage or enrolling them in an Exchange product, when the eligibility determination takes place after the twenty-second day of the month. The cost of providing the extra month of Medicaid, over time, could be significant to the State. Furthermore, as noted elsewhere in this comment, the State requests that flexibility be given on the effective date currently defined as the twenty-second day of the month. The details of how to provide

seamless and continuous coverage to individuals via insurance affordability programs should be left to the states.

Additionally, at no place in the regulation has the issue of retroactivity been addressed. In the post-Affordable Care Act environment, there is no longer a need for retroactivity as individuals are expected to participate in health coverage at all times. Indiana strongly encourages CMS to issue rules that remove the requirement for retroactivity in 2014 and beyond.

§435.948 and §435.949

The narrative accompanying the proposed regulation states that information gathered from the federal hub will not need to be reevaluated or re-verified for another insurance affordability program. Because there is no need for reevaluation or re-verification, the narrative states that pulling the information by another program will not be permitted. Does this mean that states must store the information once it is retrieved or can states retrieve again if necessary? Does CMS intend to include a rule in the final regulation stipulating when and how often a state may access the federal government? Indiana does not recommend limiting states' access to the information in the federal hub as it is vital to the eligibility for the new and revised insurance affordability programs.

§435.1200

Medicaid for the blind and disabled is addressed in this section of the regulation. Individuals not found eligible for Medicaid based on MAGI but desiring to be screened for Medicaid for the blind and disabled, may enroll in an insurance affordability program. The regulation states that if an individual is determined eligible for Medicaid disability, he/she is not liable for premium tax credit payments received during the retroactive approval of Medicaid during the period for which advanced payments were received. Please provide clarification on who is responsible for the claims incurred during this time period, whether it is the qualified health plan or the Medicaid agency. If the Medicaid agency, would an individual receive reimbursement for the amounts they paid to the qualified health plan during that period?

§457.380

The proposed regulation requires a child eligible for CHIP to be enrolled in CHIP, even if the parent is eligible for a Qualified Health Plan and could add their child or their children as dependent(s). CMS should not force families into the Medicaid program, if they prefer to have their child enrolled through a QHP. The policy, as proposed, is disruptive to the market, increases crowd-out and drives up cost as a young, potentially healthier population is moved out of the risk pools.

Indiana's response to specific provisions of Notice of Proposed Rule Making (NPRM) for 26 CFR Part 1 *Health Insurance Premium Tax Credit*.

§ 1.36B-2

Paragraph (a)(2) of this section indicates that an individual is not eligible for premium tax credits if they are eligible for other minimum essential coverage. Indiana requests clarification on if an individual remains eligible for premium tax credits if they are eligible for coverage that does not qualify as minimum essential coverage. For example, if a state chooses to provide an option of a wrap around benefit package, covering only specific services not available in the commercial market, for disabled individuals or waiver demonstration populations above the new 138% FPL Medicaid eligibility threshold would receiving these specific benefits disqualify an individual from receiving a premium tax credit? In this case, the coverage option would qualify as a government sponsored coverage program but would not provide comprehensive benefits or minimum value as applied to employer sponsored plans. Indiana requests that states be allowed the flexibility to develop wrap-around coverage Medicaid options for specific populations. The option of wrap around coverage for specific non-commercially available services or benefits should not disqualify an individual from receiving a premium tax credit.

Paragraph (c)(3)(v) describes the process for calculating the affordability of employer sponsored insurance for the determination of eligibility for other minimum essential coverage. Indiana is not aware of any current data sources that provide information on the cost of employer sponsored insurance. What are the details on where and how Exchanges are to get accurate information on the cost of employer sponsored insurance? Will this information be available through the federal hub or other data bases? The State has significant concerns around the collection of information on the affordability of employer sponsored insurance and its potential to increase Exchange operational costs. Indiana urges consideration around the complexity of this process and requests that this information be provided through electronic sources such as the federal hub. Additionally, the process described for calculating affordability of employer sponsored insurance is based on the affordability of the individual premium. In cases where an individual premium is affordable and a family premium is not affordable the current regulation would disqualify family members from eligibility for a premium tax credit. If the goal is to ensure that all individuals have access to affordable minimum essential coverage Indiana suggests that the affordability test for employer sponsored insurance be based both on the individual and family premiums. Unaffordable family coverage options through employers should not disqualify low-income families from receiving premium tax credits.

§ 1.36B-3

Paragraph (f) proposes that the amount of the premium tax credit is indexed to the second lowest cost silver plan at the time of the individual or family enrollment. In markets with extreme price volatility, which is possible during the first years of Exchange operation, consideration may want to be taken of reevaluating the premium tax-credit and the second lowest cost silver plan throughout the year. Additionally, Indiana requests clarification on if an individual or family leaves a plan due to the plans decertification or a special enrollment event that their premium tax credit will be recalculated based upon the second lowest silver plan at the time of the special enrollment.

§ 1.36B-5

Paragraph (a) details information required to be reported to the Exchange. At § 1.36B-4 (b) the proposed rule indicates that if filing status changes then the premium tax credit is computed using the applicable benchmark plan on the first day of every coverage month. To facilitate these calculations Indiana suggests that reporting the cost of the second lowest cost sliver plan on the first day of every month be included in the Exchange reporting requirements.

Appeals of premium tax credit eligibility are not addressed under this rule. However, as premium tax credits are a federal program and eligibility criteria for premium tax credits are federal, Indiana objects to requirements on the state-based Exchanges to handle appeals' of premium tax credit eligibility or premium tax credit amount. These appeals should be handled on the federal level and should not be a responsibility of state-based Exchanges.

Indiana's response to specific provisions of Notice of Proposed Rule Making (NPRM) for 45 CFR 155 and 157 *Exchange Functions in the Individual Market: Eligibility Determinations: Exchange Standards for Employers*.

Comments:

§ 155.305

Paragraph (f) describes the eligibility process for the premium tax credit. Premium tax credits are a federal program and Indiana suggests that state-based Exchanges should be allowed to choose federal calculation and administration of premium tax credits as an option. These processes will be under development for the federally-facilitated Exchanges. States should have the flexibility in their state-based Exchanges to design their own premium tax credit eligibility process or to pass responsibility for premium tax credit calculation, administration to the federal government. Premium tax credit calculation and administration should be an area of flexibility in Exchange design. State-based Exchanges should have the option but be relieved of the requirement of calculating and administering premium tax credits.

§ 155.310

At paragraph (g) this section proposes that the Exchange notify an individual's employer that an employee has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions and that such notice must identify the employee. In the case of individuals working part time or for employers who do not offer coverage Indiana sees potential conflicts with sending notices to employers that their employees are eligible for tax-credits. Indiana requests that this regulation be clarified to indicate that a notice to employers that their employee has been found eligible for a premium tax credit only applies in situations where the employer may face a penalty for not providing affordable minimum essential coverage for that employee.

§ 155.315

This section attempts to describe the process for verification of social security number (SSN). In the preamble to paragraph (b)(2) the Department of Homeland Security (DHS) is mentioned as a verifying agency. The preamble indicates that an Exchange would submit a request to HHS for SSN verification and then HHS would submit the request to DHS. The State's interpretation of this section of the proposed rule is that the transaction will go through the data hub without additional burdens placed on the Exchange. Indiana comments that all data verification transactions should be provided through the central federal data hub. States should have flexibility in design to interface with other data sources, however, state-based Exchanges should not be required to support interface with other federal agencies.

Additionally, Indiana has significant concern surrounding the ninety (90) day periods for individuals to provide or verify information that was not obtained through electronic data matching or was not found to be reasonably compatible. The State believes that this ninety (90) day period is excessive. Current state processes should be considered and states should be allowed flexibility in determining the time frame individuals have to verify missing information. In Indiana, the current process works well; individuals have ten (10) days to correct or provide a social security numbers for Medicaid eligibility. Indiana has specific concern at paragraph (b)(3) where it is proposed that individuals who attest to citizenship or lawful presence but who cannot be verified as such through electronic data sources receive ninety (90) days of coverage in insurance affordability programs during the extended verification process. Individuals who are not or may not be eligible for coverage should not be provided interim coverage, especially in cases where the state may expect fraud or has a reasonable expectation that the individual is not a citizen, national, or lawfully present due to previous encounters.

§ 155.320

At places in this section there are requirements for state-based Exchanges to accept self-attestation, provided that the self-attestation is reasonably compatible. Indiana objects to requirements on state-based Exchanges to accept self-attestation. In all cases, states should be provided the flexibility in Exchange design to accept self-attestation or to require more rigorous verification based on unique state factors and resources.

At paragraph (d) it is proposed that the Exchange accept an individual's attestation around enrollment in an employer sponsored health plan without further data verification unless that attestation is found to be not reasonably compatible with other data. The State has significant concerns around the definition of reasonably compatible and in the case of employer sponsored insurance, the existence of the other data sources. The definition of reasonably compatible should be defined by individual state-based Exchanges. Indiana strongly objects to any additional federal requirements to develop state data sources for the purposes of verifying if attestations are reasonably compatible. Decisions surrounding the development of data sources, specifically sources relating to employer sponsored insurance should be left to the State.

§ 155.330

The preamble to this section describes how throughout the year individuals will be expected to provide the Exchange with updates relating to changes in living circumstances, household size, and income. The preamble solicits comment on if there should be an ongoing role for Exchange-initiated data matching beyond what is required. Indiana feels strongly that any decisions around ongoing Exchange-initiated data matching should be left to the individual state-based Exchanges and should not be dictated in federal rule.

This section discusses the process for redetermination and suggests that an Exchange may use electronic data sources to determine what may have changed for an individual during the year. Indiana requests that states be given the flexibility to determine what data sources to use for additional verification. Each state-based Exchange may have access to different state specific data sources and states need the flexibility to determine what data sources are most appropriate for use in verification purposes by state-based Exchanges.

Paragraph (e)(1) of this section proposes that the Exchange may establish a "cut-off-date" for redeterminations. Indiana supports the ability for an Exchange to establish a "cut-off-date" by which a redetermination must be completed in order for an individual to receive coverage beginning of the first of the next month. The ability to establish this date will help to guarantee that state-based Exchanges can implement smooth application processing.

§ 155.335

Paragraph (f)(1) of this section indicates that the Exchange must require an enrollee to sign and return the redetermination notice. Indiana comments that this is inconsistent with the application process that allows for electronic signatures. Indiana requests that the final rule specify the electronic acknowledgement of the notice is an acceptable form of communication.

§ 155.345

Paragraph (e)(2) of this section proposes that state-based Exchanges use model agreements established by HHS for the purpose of sharing data with the Medicaid and CHIP agency. The state requests clarification on if there are similar requirements surrounding the use of HHS model agreements for data transfers between the Exchange and state-based agencies. Indiana feels strongly that related to HHS model agreements, state-based Exchanges should have the flexibility to develop their own agreements for transfer of information between the Exchange and other state-based entities. In these cases states should have maximum flexibility and there should be no requirement for state-based Exchanges to utilize HHS model agreements.

Questions:

§ 155.305

One eligibility factor for premium tax credits at (f)(1)(ii)(B) is that an individual must not have access to other minimum essential coverage. Minimum essential coverage can refer to employer-based coverage that meets minimum value and affordability requirements. Indiana requests clarification on how a state-based Exchange is expected to verify: (1) if an individual is enrolled in employer sponsored insurance; (2) if an individual has access to employer sponsored insurance; (3) if that insurance meets minimum value requirements; and

(4) if that insurance meets affordability requirements. How and where are states expected to access the employer data necessary to verify that an individual is eligible for a premium tax credit?

§ 155.310

Paragraph (d) (3) of this section specifies that when an individual is determined eligible for Medicaid that their information must be transferred to the Medicaid Agency. Can an individual determined eligible for Medicaid decline Medicaid coverage? Can this individual choose to purchase a QHP at full price on the Exchange?

§ 155.315

This section describes the process for verification of SSN. Indiana has concerns surrounding the processes in the event an SSN does not match the individual who SSA indicates it is associated with. Indiana requests clarification on the processes that will address discrepancies between the SSA records and other data sources.

In terms of verification for citizenship, incarceration, residency, income and household size, Indiana requests detail of what the policies of the federally facilitated Exchange will be related to self-attestation. How does the federally facilitated Exchange plan to use self-attestation? What will the federally facilitated Exchange consider reasonably compatible? What are the processes by which verification of self-attestations will be carried out?

Paragraph (b) discusses the process for verifying if an individual is a citizen, national, or lawfully present. Indiana requests clarification on if the current process used in Medicaid will still be applicable as pertains to declaring citizenship. Currently, an individual applying for Medicaid must declare citizenship, national, or lawfully present on their application. Under the new eligibility process will individuals be expected to declare their status and have it validated by the federal hub? Or alternatively, will the federal hub return the individuals status without a requirement that the individual declare citizenship?

Paragraph (b)(3) addresses inconsistencies in submitted information and inability to verify information. Indiana has a question relating to individuals who self-attest that they are a citizen, national, or lawfully present but cannot be verified and receive 90 days of coverage under the verification process during which no verification is attained. If this individual reapplies at the next open enrollment period and again self-attests that they are a citizen, national or lawfully present but this information can still not be verified by electronic data sources is the individual again eligible to receive 90 days of coverage during the extended verification process? Additionally, if status of citizen, national, or lawfully present could not be verified during the open enrollment period is the individual eligible to report an event eligible for a special enrollment period, self- attest to citizenship and be eligible for an additional 90 days of coverage during an extended verification process? Could a state-based

Exchange consider self-attestations where the individual is known to have not been verified as a citizen, national, or lawfully present previously as not reasonably compatible?

Paragraph (d) discusses verification of incarceration status. Indiana requests that incarceration be more clearly defined. At § 155.305 (a)(2) it indicates that an individual is not eligible if incarcerated, other than incarceration pending the disposition of charges; however, this does not address individuals incarcerated for short periods of time and does not account for the data matching lags between correction departments and other state agencies. Will data relating to federal incarceration be made available to state Exchanges? For cases where incarcerated individuals are admitted to a hospital are these individuals still considered incarcerated? If not, will Medicaid be required to pay for individuals still serving sentences who happen to be hospitalized?

§ 155.355

This section of the proposed rule addresses and individuals right to appeal. Indiana has significant concerns related to the costs of the appeals process. As premium tax credits and cost sharing subsidies are federal programs Indiana strongly feels that appeals process for these programs should reside with the federal government.