IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

RONNIE MAURICE STEWART, et al., Plaintiffs, v. **ALEX M. AZAR II, et al.,** Defendants.	Civil Action No. 1:18-cv-152 (JEB)

NOTICE OF SUPPLEMENTAL AUTHORITIES

The federal defendants Alex M. Azar II, *et al.*, hereby submit the attached supplemental authorities, which bear on two topics discussed at the motion hearing on Friday, June 15, 2018.

First, the federal defendants attach two documents from the Centers for Medicaid and Medicare ("CMS"). One document is a December 2012 set of answers to frequently asked questions ("FAQ") about the Patient Protection and Affordable Care Act ("ACA"). Ex. A, U.S. Dep't of Health and Human Servs., Ctrs. for Medicare and Medicaid, Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid (Dec. 12, 2012), *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf. The other document is an August 2012 letter sent to the Governor of Arkansas. Ex. B, Letter from Cindy Mann, Director, Ctr. for Medicaid and CHIP Servs., to the Honorable Mike Beebe, Governor of Arkansas (Aug. 31, 2012). In both documents, CMS explains that if a state opts to cover the Medicaid expansion group, "it may later decide to drop the coverage." Ex. A at 11; *see also* Ex. B ("A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.").

Second, in response to the Court's question about the definition of "medically frail," the federal defendants attach a copy of 42 C.F.R. § 440.315. That provision permits states to adopt a definition of "medically frail," but sets a minimum federal standard for categories of persons who fall in this category. Ex. C. The regulation specifies that, for the purposes of determining exemptions from mandatory enrollment in an Alternative Benefit Plan under 42 U.S.C. § 1396u-7,

> the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in [42 C.F.R. § 438.50(d)(3), which describes certain categories of person under 19 years of age], individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

42 C.F.R. § 440.315(f). Medically frail individuals are exempt from Kentucky HEALTH's community engagement, premium, and lockout requirements, as well as Kentucky HEALTH's waiver of non-emergency medical transportation. *See* AR 24–26, 28–32, 84.

Dated: June 19, 2018

Respectfully submitted,

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EXHIBIT A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

Date: December 10, 2012

Subject: Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid

EXCHANGES & MARKET REFORMS

State-Based Exchanges and State Partnership Exchanges

1. Does HHS plan to further extend deadlines for states to decide on their level of involvement in implementing Exchanges?

A. No. As mentioned in the two letters that Secretary Sebelius sent to governors in November 2012, states have been and will continue to be partners in implementing the health care law and we are committed to providing states with the flexibility, resources and time they need to deliver the benefits of the health care law to the American people.

In response to various governors' requests for additional time, we extended the deadline for a Blueprint Application to operate a State-Based Exchange from November 16, 2012 to December 14, 2012. If a state is pursuing a State Partnership Exchange, we will accept Declaration Letters and Blueprint Applications and make approval determinations for State Partnership Exchanges on a rolling basis. A state that plans to operate the Exchange in its state in partnership with the federal government starting in 2014 will need to submit its Declaration Letter and Blueprint Application declaring what partnership role they would like to have by February 15, 2013.

A state may apply at any time to run an Exchange in future years.

2. What federal funding is available to assist a state in creating and maintaining a State-Based Exchange? Will a state have to return federal funding if it decides not to implement a State-Based Exchange?

A. By law, states operating Exchanges in 2014 must ensure that their Exchanges are financially self-sustaining by January 1, 2015. The costs to states for establishing a State-Based Exchange and testing Exchange operations during 2014 may be funded by grants under section 1311(a). Additionally, grants under section 1311 may be awarded until December 31, 2014, for approved establishment activities that fund first year start-up activities (i.e., activities in 2014). It is also permissible that under a State Partnership Exchange, a state may receive grants for activities to establish and test functions that the state performs in support of a Federally-Facilitated Exchange. This applies whether or not a state is a State Partnership Exchange. Generally, states will not be required to repay funds, provided funds are used for activities approved in the grant and cooperative agreement awards.

3. Will HHS charge fees to a state that utilizes federal data in connection with its State-Based Exchange?

A. No. HHS is establishing a federally-managed data services hub to support information exchanges between states (Exchanges, Medicaid and CHIP agencies) and relevant federal agencies. In many cases, federal agencies other than HHS will be providing information through the hub. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there.

4. What is the approval process for a state that would like to participate in a State Partnership Exchange?

A. To operate a State Partnership Exchange in 2014, a state must submit a declaration letter, complete the relevant portions of the Exchange Blueprint and be approved or conditionally approved by HHS for participation in a State Partnership Exchange. State Partnership Exchange approval standards mirror State-Based Exchange approval standards for plan management and the relevant consumer activities, where applicable, and include standards related to sharing data and coordinating processes between the state and a Federally-Facilitated Exchange. States have until February 15, 2013 to submit a declaration and Blueprint Application for approval as a State Partnership Exchange.

Federally-Facilitated Exchange

5. How will HHS work with state policymakers to make sure that the Federally-Facilitated Exchange accounts for the needs of a particular state? How will the Federally-Facilitated Exchange for each state ensure that it accurately incorporates state-specific laws and procedures into its business processes?

A. To the greatest extent possible, HHS intends to work with states to preserve the traditional responsibilities of state insurance departments when establishing a Federally-Facilitated Exchange for a particular state. Additionally, HHS will seek to harmonize Exchange policy with existing state programs and laws wherever possible.

For example, qualified health plans that will be offered in a Federally-Facilitated Exchange must be offered by issuers that meet state licensure and solvency requirements and are in good standing in the state (section 1301(a)(1)(C) of the Affordable Care Act; 45 C.F.R. section 156.200(b)(4)). In addition, qualified health plans will be subject to requirements that apply to all individual and small group market products such as the proposed market rules. Accordingly, states continue to maintain an important responsibility with respect to qualified health plans licensed and offered in their states, regardless of whether the Exchange is Federally-Facilitated or State-Based.

HHS is currently working to determine the extent to which activities conducted by state insurance departments such as the review of rates and policy forms could be recognized as part of the certification of qualified health plans by a Federally-Facilitated Exchange. For example, most states currently have an effective rate review program in place and HHS will rely on such processes in connection with qualified health plan certification decisions and oversight by a Federally-Facilitated Exchange. HHS will work with regulators in each state with a Federally-Facilitated Exchange to identity these efficiencies.

HHS is working with the National Association of Insurance Commissioners to enable states to use the System for Electronic Rate and Form Filing as part of the qualified health plan submission and certification process in a State Partnership Exchange. This will help ensure that state and federal regulators are using the same data for their reviews and simplify issuer compliance responsibilities.

HHS also will collect state-specific Medicaid and CHIP policy data so that the Federally-Facilitated Exchange is able to evaluate Medicaid and CHIP eligibility.

6. ***Will Federally-Facilitated Exchange customer support personnel be familiar with state rules so that they can advise consumers adequately?***

A. Yes. HHS will operate the Federally-Facilitated and State Partnership Exchange call center and website, and personnel will be trained on relevant state insurance laws and Medicaid and CHIP eligibility standards so that they can advise consumers. In a state operating in a State Partnership Exchange, a state will be responsible for the day-to-day management of the Exchange Navigators and the development and management of another separate in-person assistance program, and may elect to conduct additional outreach and educational activities. The Affordable Care Act directs Navigators to conduct public education to target Exchange-eligible populations, assist qualified consumers in a fair and impartial manner with the selection of qualified health plans and distribute information on tax credits and cost-sharing reductions, and refer consumers to any consumer assistance or ombudsman programs that may exist in the state. Navigators must provide this information in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities.

7. ***What restrictions will there be on a state regulator's authority to enforce state laws when consumers purchase coverage through a Federally-Facilitated Exchange? Will states retain their ability to protect consumers?***

A. States have significant experience and the lead role in insurance regulation, oversight, and enforcement. We will seek to capitalize on existing state policies, capabilities, and infrastructure that can also assist in implementing some of the components of a Federally-Facilitated Exchange. We also encourage states interested in improving this alignment to apply to conduct plan management through a State Partnership Exchange.

A Federally-Facilitated Exchange's role and authority are limited to the certification and management of participating qualified health plans. Its role and authority do not extend beyond the Exchange or affect otherwise applicable state law governing which health insurance products may be sold in the individual and small group markets. Several qualified health plans certification standards rely on reviews that some state departments of insurance may not currently conduct. Therefore, HHS will evaluate each potential qualified health plan against applicable certification standards either by deferring to the outcome of a state's review (e.g., in the case of licensure) or by performing a review necessary to verify compliance with qualified health plan certification standards. Federally-Facilitated Exchanges will consider completed state work to support this evaluation to the extent possible.

8. How will the Federally-Facilitated Exchange be funded?

A. To fund the operation of the Federally-Facilitated Exchange, we proposed for comment in the draft Payment Notice that participating issuers pay a monthly user fee to support the operation of the Federally-Facilitated Exchange. For the 2014 benefit year, we proposed a monthly user fee rate that is aligned with rates charged by State-Based Exchanges. While we proposed that this rate be 3.5 percent of premium, it may be adjusted in the final Payment Notice to take into account State-Based Exchange rates. Exchange user fees will support activities such as the consumer outreach, information and assistance activities that health plans currently pay themselves. This policy does not affect the ability of a state to use grants described in section 1311 of the Affordable Care Act to develop functions that a state elects to operate under a State Partnership Exchange and to support state activities to build interfaces with a Federally-Facilitated Exchange.

9. If a state chooses to provide some services to a Federally-Facilitated Exchange, will the state be reimbursed for its costs?

A. Yes in certain circumstances. HHS expects that states supporting the development of a Federally-Facilitated Exchange may choose to seek section 1311(a) Exchange Establishment cooperative agreement funding for activities including, but not limited to:

- Developing data system interfaces with the Federally-Facilitated Exchange;
- Coordinating the transfer of plan information (e.g., licensure and solvency) from the state insurance department to the Federally-Facilitated Exchange; and
- Other activities necessary to support (and related to the establishment of) the effective operations of a Federally-Facilitated Exchange.

After section 1311(a) funds are no longer available, HHS anticipates continued funding, under a different funding vehicle, for state activities performed on behalf of the Federally-Facilitated Exchange. To the extent permissible under applicable law, HHS intends to make tools and other resources used by the Federally-Facilitated Exchange available to state partners in State Partnership Exchanges, as well as to State-Based Exchanges.

Market Issues

10. How are Exchanges going to increase insurance market competition based on quality and cost? Some markets may be starting off from a position of having few local issuers.

A. The introduction of Exchanges and the insurance market rules in 2014 will help promote competition based on quality and cost since consumers will have an unprecedented ability to compare similar products from different issuers and will be assured the right to purchase these products, regardless of their health condition. Further, consumers in many states will have new options such as the ability to purchase coverage from the Consumer Operated and Oriented Plans and Multi-State Plans created under the Affordable Care Act. Additionally, Exchanges can leverage market forces to drive further transformation in health care delivery.

We anticipate that the number of individuals who will be eligible for advance payments of premium tax credits and cost-sharing reductions – which are only available in connection with qualified health plan coverage purchased through an Exchange – will attract issuers to Exchanges where the certification process will encourage and reward high quality affordable insurance offerings. In addition, HHS is developing a Star Ratings system for qualified health plans purchased in an Exchange pursuant to section 1311(c)(3) of the Affordable Care Act.

11. When will we have final rules on essential health benefits, actuarial value, and rating?

A. The proposed rules on essential health benefits and actuarial value and the market reforms, including rating, were published on November 20, 2012. Public comments are due by December 26, 2012. On November 20, 2012, we also issued a state Medicaid directors letter on how we will propose essential health benefits be implemented in Medicaid. HHS will analyze the comments, adjust any policies accordingly, and publish final rules early next year.

12. What level of benefit is required in a specific benchmark to satisfy the ten essential health benefit categories? What process will be undertaken by HHS to select backfilling benefit options if a state defaults to the largest small group product?

A. In section 156.100 of the proposed rule on Essential Health Benefits/Actuarial Value/Accreditation, we propose criteria for the selection process for a state that chooses to select a benchmark plan. The essential health benefits benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state. This approach and benchmark selection, which would apply for at least the 2014 and 2015 benefit years, would allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products. Since some base-benchmark plan options may not cover all ten of the statutorily required essential health benefits categories, we propose standards for supplementing a base-benchmark plan that does not provide coverage of one or more of the categories.

We also propose that if a base-benchmark plan option does not cover any items and services within an essential health benefits category, the base-benchmark plan must be supplemented by adding that particular category in its entirety from another base-benchmark plan option. The resulting plan, which would reflect a base-benchmark that covers all ten essential health benefits categories, must meet standards for non-discrimination and balance. After meeting these standards, it would be considered the essential health benefits-benchmark plan.

The proposed rule also outlines the process by which HHS would supplement a default base-benchmark plan, if necessary. We clarify that to the extent that the default base-benchmark plan option does not cover any items and services within an essential health benefits category, the category must be added by supplementing the base-benchmark plan with that particular category in its entirety from another base-benchmark plan option. Specifically, we propose that HHS would supplement the category of benefits in the default base benchmark plan with the first of the following options that offer benefits in that particular essential health benefits category: (1) the largest plan by enrollment in the second largest product in the state's small group market; (2) the largest plan by enrollment in the third largest product in the state's small group market; (3) the largest national

Federal Employees Health Benefit Program plan by enrollment across states that is offered to federal employees; (4) the largest dental plan under the Federal Employees Dental and Vision Insurance Program, for pediatric oral care benefits; (5) the largest vision plan under the Federal Employees Dental and Vision Insurance Program, for pediatric vision care benefits; and (6) habilitative services as described in section 156.110(f) or 156.115(a)(4).

Multi-State Plans

13. The Office of Personnel Management is required to certify Multi-State Plans that must be included in every Exchange. How will you ensure that Multi-State Plans compete on a level playing field and are compliant with state laws?

A. The U.S. Office of Personnel Management released a proposed rule implementing the Multi-State Plan Program on November 30, 2012. To ensure that the Multi-State Plans are competing on a level playing field with other plans in the marketplace, the proposed regulation largely defers to state insurance law and the standards promulgated by HHS and states related to qualified health plans. Under the proposal, Multi-State Plans will be evaluated based largely on the same criteria as other qualified health plans operating in Exchanges. The few areas in which the Office of Personnel Management proposes different regulatory standards from those applicable to qualified health plans are areas where the Office of Personnel Management has extensive experience through its administration of the Federal Employees Health Benefits Program. However, in order to ensure that these few differences will not create any unfair advantages, the Office of Personnel Management seeks comment from states and other stakeholders on these proposals. The regulation appeared in the Federal Register on December 5, 2012, and the comment period runs through January 4, 2013.

Bridge Plan

14. Can a state-based Exchange certify a Medicaid bridge plan as a qualified health plan?

A. Yes. HHS has received questions about whether a state could allow an issuer that contracts with a state Medicaid agency as a Medicaid managed care organization to offer qualified health plans in the Exchange on a limited-enrollment basis to certain populations. This type of limited offering would permit the qualified health plan to serve as a "bridge" plan between Medicaid/CHIP coverage and private insurance. This would allow individuals transitioning from Medicaid or CHIP coverage to the Exchange to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network. This approach is intended to promote continuity of coverage between Medicaid or CHIP and the Exchange.

In general, an Exchange may allow an issuer with a state Medicaid managed care organization contract to offer a qualified health plan as a Medicaid bridge plan under the following terms:

- *The state must ensure that the health insurance issuer complies with applicable laws, and in particular with section 2702 of the Public Health Service Act.* Consistent with section 2702(c) of the Public Health Service Act, a health plan whose provider network reaches capacity may deny new enrollment generally while continuing to permit limited enrollment of certain individuals in order to fulfill obligations to existing group contract

holders and enrollees. Therefore, if the issuer demonstrates that the provider network serving the Medicaid managed care organization and bridge plan has sufficient capacity only to provide adequate services to bridge plan eligible individuals and existing Medicaid and/or CHIP eligible enrollees, the bridge plan could generally be closed to other new enrollment. However, in order to permit additional enrollment to be limited to bridge plan eligible individuals, the state must ensure there is a legally binding contractual obligation in place requiring the Medicaid managed care organization issuer to provide such coverage to these individuals. We note that any such contract would need to have provisions to prevent cost-shifting from the non-Medicaid/CHIP population to the Medicaid/CHIP population. We also note that the guaranteed availability provision of section 2702 of the Public Health Service Act is an important protection that provides consumer access to the individual and small group markets. Accordingly, we plan to construe narrowly the network capacity exception to the general guaranteed issue requirement.

- *The Exchange must ensure that a bridge plan offered by a Medicaid managed care organization meets the qualified health plan certification requirements, and that having the Medicaid managed care organization offer the bridge plan is in the interest of consumers*.

- *As part of considering whether to certify a bridge plan as a qualified health plan, the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits.*

- *The Exchange must accurately identify bridge plan eligible consumers, and convey to the consumer his or her qualified health plan coverage options.*

- *The Exchange must provide information on bridge plan eligible individuals to the federal government, as it will for any other individuals who are eligible for qualified health plans on the Exchange, to support the administration of advance payments of premium tax credits.* This will be done using the same mechanism that will be in place for the larger Exchange population.

Successful implementation of a Medicaid bridge plan will involve a high degree of coordination between the state Medicaid agency, department of insurance and the Exchange. States operating State-Based Exchanges will be best positioned to achieve the level of coordination needed to implement and support the offering of a Medicaid bridge plan on an Exchange. Additional guidance will be issued soon.

Pre-Existing Condition Insurance Plan and Other High-Risk Pools

15. Does the federal government intend to maintain the Pre-Existing Condition Insurance Plan program beyond 2014? How will state high risk pools be affected by the affordability and insurance market reforms in 2014?

A. Under the Affordable Care Act, coverage for persons under the Pre-Existing Condition Insurance Plan program (whether federally-run or state-run in a state) will generally not extend beyond January 1, 2014, which is when all individuals will be able to access coverage without any pre-existing condition exclusions in the individual market. The transitional

reinsurance program is expected to help stabilize premiums in the individual market by reimbursing issuers who enroll high cost individuals, such as those currently enrolled in the Pre-Existing Condition Insurance Plan, as they enter that market.

In the notice of proposed rulemaking on the health insurance market rules (77 Fed. Reg. 70584; November 26, 2012), we noted that we are exploring ways in which states could continue to run their existing high risk pools (i.e., separate from the Pre-Existing Condition Insurance Pool program) beyond 2014.

Basic Health Plan

16. Will HHS issue federal guidance and regulation regarding implementation of the Basic Health Plan?

A. Yes. HHS plans to issue guidance on the Basic Health Plan in the future. States interested in this option should continue to talk to HHS about their specific questions related to the implementation of the Basic Health Plan.

CONSUMERS

Consumer Outreach

17. How does HHS plan to conduct outreach about the Exchanges and new coverage options? Will outreach materials be tailored to each state? Will states be able to provide HHS with input in developing materials?

A. Education and outreach are high priorities for implementing the changes coming in 2014. HHS plans to conduct outreach to consumers in a variety of ways, including the Navigator program, in-person assistance, the internet, and call centers. States and other stakeholders definitely will be able to provide input in developing its outreach approach to consumers.

18. How does HHS plan to operate the Navigator program for the Federally-Facilitated Exchanges? How many and what types of Navigators will there be in a particular state? What will their roles be? Can states require Navigators to hold a producer license? If not, what type of training or certification will they receive?

A. Section 1311(i) of the Affordable Care Act directs an Exchange – whether a State-Based Exchange or a Federally-Facilitated Exchange – to establish a program under which it awards grants to Navigators. Section 1311(i) and 45 C.F.R. section 155.210 articulate the required duties of a Navigator. In addition, section 155.210(c)(2) directs that the Exchange select two different types of entities as Navigators, one of which must be a community and consumer-focused non-profit group. This program is further described in the "General Guidance on Federally-facilitated Exchanges."

The number of Navigators per state served by a Federally-Facilitated Exchange will be contingent upon the total amount of funding available as well as the number of applications that we receive in each state in response to the forthcoming Navigator Grant Funding Opportunity Announcement that we plan to issue early next year to support the Federally-Facilitated Exchanges.

Additionally, a state or Exchange cannot require Navigators to hold a producer license (i.e., a license as an agent or broker) for the purpose of carrying out any of the duties required of Navigators in section 1311(i)(3) of the Affordable Care Act and 45 C.F.R. section 155.210(e). Because the law directs Navigators to carry out all required duties, linking a producer license to any one of those specific duties would have the effect of requiring all Navigator entities, their employees, and their sub-grantees to hold a producer license. As described above, this would prevent the application of the standard set forth in 45 C.F.R. section 155.210(c)(2) that at least two different types of entities must serve as Navigators. As such, and as provided by section 1321(d) of the Affordable Care Act, any state laws which would require all Navigators to hold a producer license would be preempted by 45 C.F.R. section 155.210(c)(2).

In Federally-Facilitated Exchanges and State Partnership Exchanges, individuals selected to receive Navigator grants or working for entities selected to receive Navigator grants must successfully participate in an HHS-developed and administered training program, which will include a certification examination pursuant to 45 C.F.R. section 155.210(b). In addition, under state law, states may impose Navigator-specific licensing or certification requirements upon individuals and entities seeking to operate as Navigators, so long as such licenses or certifications are not preempted by the requirement to award to different types of entities identified in 45 C.F.R. section 155.210(c)(2), such as producer licenses.

19. What does HHS expect that states in a State Partnership Exchange must do to fulfill their obligations regarding in-person consumer assistance? How will the state-specific in-person consumer assistance programs be integrated with the Navigator program?

A. In-person assistance programs are an additional mechanism through which Exchanges may meet the consumer assistance responsibilities of the Exchange under 45 C.F.R. section 155.205(d) and (e). As described in the Federally-facilitated Exchange Guidance, states operating under a State Partnership Exchange will build and operate an in-person assistance program, for which grant funding is available under section 1311 of the Affordable Care Act, distinct from the Navigator program for that Exchange. State-Based Exchanges may do so as well. The purpose of providing multiple tools for in-person assistance is to ensure that all consumers can receive help when accessing health insurance coverage through an Exchange.

Consumer Eligibility and Enrollment

20. What information will consumers provide in the single streamlined application? What is the process/timeline for the approval of a state-specific single streamlined application?

A. Section 1413 of the Affordable Care Act directs HHS to develop a single, streamlined application that will be used to apply for coverage through qualified health plans, Medicaid and CHIP. In addition, it can be used by persons seeking the advance payment of premium tax credits and cost sharing reductions available for qualified health plans through the Exchange. In consultation with states and other stakeholders, and with the benefit of extensive consumer testing, HHS has been developing an on-line and paper version of the single, streamlined application. We are releasing information on a rolling basis both to seek public comment and to support states in their eligibility system builds.

In July 2012, HHS published a notice in the Federal Register outlining the initial data elements that will be included in the streamlined application for public comment. HHS received over 60 comments from states and other stakeholders that have helped inform our ongoing development work. These comments, coupled with ongoing consumer testing, have helped us refine and improve the application.

Consumer testing and extensive consultation with states and consumer groups continues. HHS expects to provide the final version of the online and paper application in early 2013 and will also work with states that seek Secretarial approval for their own application.

21. What will consumers be told if it appears they are not eligible for Medicaid, CHIP, or advance payments of premium tax credits?

A. A qualified individual still will have the option to purchase a qualified health plan through the Exchange if he or she is not eligible for Medicaid. CHIP or an advance payment of a premium tax credit. As outlined in 45 C.F.R. section 155.310(g), Exchanges will provide timely written notice to an applicant of any eligibility determination made by the Exchange. 45 C.F.R. section 155.230(a) provides further detail on the content of notices, including that notices contain contact information for available customer service resources and an explanation of appeal rights, if applicable.

22. How will HHS help Exchanges with the eligibility process for exemptions from the shared responsibility payment for individuals?

A. Section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange will issue certificates of exemption from the shared responsibility payment described in section 5000A of the Internal Revenue Code, which otherwise applies to individuals who do not maintain minimum essential coverage. In the "State Exchange Implementation Questions and Answers" released on November 29, 2011, we indicated that a State-Based Exchange could either conduct this assessment itself or use a federally-managed service for exemptions from the shared responsibility payment. We included this option in the Exchange Blueprint. State-Based Exchanges can also choose to conduct this function independently.

With this service, the Exchange will accept an application for an exemption, and then transfer the information contained on the application to HHS through a secure, electronic transaction. HHS will conduct relevant verifications and return an eligibility determination to the Exchange, which will then notify the individual who submitted the application. The Exchange and HHS will share responsibility for customer service. To the extent that an individual's situation changes during the year, he or she would be required to submit an update to the Exchange, which will then transfer it to HHS to process. This configuration limits the level of effort required on the part of the Exchange, while ensuring that the Exchange complies with the statutory direction to issue certificates of exemption.

HHS will provide additional information regarding exemptions shortly, including technical specifications for the application and for the application transfer service.

Consumer Experience

23. How will the Federally-Facilitated Exchange display qualified health plan options to consumers? Will consumers see all of their options or just those that are "best" for them? Will the Federally-Facilitated Exchange allow individuals who are eligible for Medicaid or CHIP to purchase qualified health plans instead?

A. Consumers will see all qualified health plans, including stand-alone dental plans, certified to be offered through the Federally-Facilitated Exchange, offered in their service area. HHS is developing ways for consumers to sort qualified health plan options based on their preferences.

Qualified individuals who are Medicaid or CHIP eligible are allowed to purchase qualified health plans instead of receiving coverage through the Medicaid or CHIP programs. However, they are not eligible to receive advance payments of premium tax credits or cost-sharing reductions to help with the cost of purchasing qualified health plans through an Exchange.

MEDICAID

Expansion

24. Is there a deadline for letting the federal government know if a state will be proceeding with the Medicaid expansion? How does that relate to the Exchange declaration deadline? Is HHS intending to provide guidance to states as to the process by which state plan amendments are used to adopt Medicaid expansion under the Affordable Care Act?

A. No, there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion. Nor is there any particular reason for a state to link its decision on the Exchange with its decision on the Medicaid expansion. States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions.

As with all changes to the Medicaid state plan, a state would indicate its intention to adopt the new coverage group by submitting a Medicaid state plan amendment. If a state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS. The state plan amendment process is itself undergoing modernization. As part of an overall effort to streamline business processes between CMS and states, in early 2013 CMS will begin implementing an online state plan amendment system to assist states in filing state plan amendments. We will be discussing the submission process for Affordable Care Act-related state plan amendments on our monthly State Operations and Technical Assistance calls with states and will be available to answer questions through that process.

While states have flexibility to start or stop the expansion, the applicable federal match rates for medical assistance provided to "newly eligible individuals" are tied by law to

specific calendar years outlined in the statute: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent by 2020, remaining at that level thereafter.

25. If a state accepts the expansion, can a state later drop out of the expansion program?

A. Yes. A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.

26. Can a state expand to less than 133% of FPL and still receive 100% federal matching funds?

A. No. Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate. For the newly eligible adults, states will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations. We also intend to propose further changes related to cost sharing.

In 2017, when the 100% federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstrations. This demonstration authority offers states significant flexibility while ensuring the same level of coverage, affordability, and comprehensive coverage at no additional costs for the federal government. We will consider section 1115 Medicaid demonstrations, with the enhanced federal matching rates, in the context of these overall system demonstrations.

27. Do you still support the Medicaid blended FMAP (matching rate) proposal in your budget?

A. No. We continue to seek efficiencies and identify opportunities to reduce waste, fraud and abuse in Medicaid, and we want to work with Congress, states, and stakeholders to achieve those goals while expanding access to affordable health care. The Supreme Court decision has made the higher matching rates available in the Affordable Care Act for the new groups covered even more important to incentivize states to expand Medicaid coverage. The Administration is focused on implementing the Affordable Care Act and providing assistance to states in their efforts to expand Medicaid coverage to these new groups.

28. How does the Supreme Court ruling affect the interaction between the Exchanges and Medicaid? Will a state's decision whether or not to proceed with the Medicaid expansion have implications for the Exchange's ability to make Medicaid eligibility determinations?

A. As the letter from Secretary Sebelius to Governors sent on July 10, 2012 and the letter from the CMS Acting Administrator Marilyn Tavenner sent on July 13, 2012 stated, the Supreme Court's decision affects the financial penalty that applies to a state that does not expand Medicaid coverage to 133% of the federal poverty level under the Affordable Care Act. No

other provisions of the law were affected. Thus regardless of whether a state adopts the Medicaid expansion, the provisions related to coordination with the Exchange, including the use of standard income eligibility methods, apply. An Exchange in each state will make either a Medicaid eligibility determination or a Medicaid eligibility assessment (at the state's option) based on the Medicaid rules in the state, including the income levels at which the state's Medicaid program provides coverage.

29. What help will be available to states to accommodate the added administrative burdens and costs they will have to bear if they expand coverage in Medicaid?

A. We have provided 90 percent federal matching funds for the new or improved eligibility systems that states are developing to accommodate the new modified adjusted gross income rules and to coordinate coverage with the Exchange. To further reduce system costs, we have promoted ways for states to share elements of their system builds with each other, and we will be sharing the business rules for adopting modified adjusted gross income in the new eligibility systems. In addition we are designing, with extensive state and stakeholder consultation, a new combined and streamlined application that states can adopt (or modify subject to Secretarial approval). And, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes. These and other initiatives relating to state systems development will lower administrative costs.

Implementation of the on-line application system, the new data-based eligibility rules, verification and renewal procedures and states' access to the federally-managed data services hub ("the hub") will collectively help defray states' ongoing costs and result in greater efficiency in the long term. For example, states will be able to electronically verify eligibility factors through the hub, where previously they had to verify through multiple federal venues. This is expected to lower the per-person administrative costs of enrollment and renewal for both newly and currently eligible individuals. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there. In addition, it is anticipated that many individuals—both those who are eligible under current state eligibility rules as well as those who are eligible under the adult expansion—will apply for coverage via the Exchange. Our rules provide states the option to have the Exchange determine eligibility for Medicaid or to assess eligibility for Medicaid, in both cases using the state's eligibility rules and subject to certain standards. No charge will be imposed on states for the Medicaid determinations or assessments conducted by the Exchanges.

30. CMS has released 90/10 funding in order for states to improve their eligibility systems for Medicaid. Will that funding continue?

A. Yes. "90/10" funding remains available through December 31, 2015 for Medicaid eligibility system design and development, and the enhanced 75 percent matching rate will be available indefinitely for maintenance and operations of such systems as long as the systems meet applicable program requirements.

In previous guidance, we have assured states that the 90/10 and 75/25 percent funding for eligibility systems will be available without regard to whether a state decides to expand its program to cover newly eligible low-income adults. We reiterate that system modernization will be supported and the enhanced matching funds will be available

regardless of a state's decision on expansion. Additionally, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes.

31. Will low-income residents in states that do not expand Medicaid to 133 percent of the FPL be eligible for cost sharing subsidies and tax credits to purchase coverage through an Exchange?

A. Yes, in part. Individuals with incomes above 100 percent of the federal poverty level who are not eligible for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage will be eligible for premium tax credits and cost sharing reductions, assuming they also meet other requirements to purchase coverage in the Exchanges.

32. Can states that are "expansion states" under the law receive newly eligible matching rate for some populations in their state?

A. Yes. The expansion state Federal Medical Assistance Percentage, or matching rate, described in section 1905(z)(2) of the Social Security Act is available to some states that expanded Medicaid coverage prior to enactment of the Affordable Care Act, but does not exclude those states from receiving the increased newly eligible match for expenditures for beneficiaries who meet the statutory qualifications. If a population covered by a state that qualifies as an expansion state meets the criteria for the newly eligible matching rate, the state will receive the newly eligible matching rate for that population. States will receive the highest matching rate possible for a given population; being an expansion state will never disadvantage the state in terms of matching rates for that population.

The following are several examples of circumstances in which an expansion state will receive the newly eligible matching rate for some beneficiaries:

- States are considered expansion states if, as of March 23, 2010, they provided coverage that meets the standards specified in section 1905(z)(3) of the Act to both childless adults and parents up to at least 100 percent of the federal poverty level. If a state provided Medicaid coverage up to 100 percent of the federal poverty level but not above, expenditures for individuals between 100 and 133 percent of the federal poverty level would qualify for the newly eligible matching rate.
- States that qualify as expansion states may have offered less than full benefits, benchmark benefits, or benchmark-equivalent benefits. Individuals who received limited benefits under a Medicaid expansion will qualify as "newly eligible" individuals and the newly eligible matching rate will apply.
- States that qualify as expansion states based on the provision of state-funded coverage will receive the newly eligible matching rate for people previously covered by the state-only program, since they will be newly eligible for Medicaid coverage.

The expansion state matching rate is only available for expenditures for non-pregnant, childless adult populations described in the new low-income adult group. CMS will work with states to ensure that the correct matching rate is applied to expenditures for populations in expansion states that qualify as newly eligible.

Flexibility for States

33. What specific plans and timeline do you have for enacting the reforms and flexibility options for Medicaid that you spoke of in 2009? When can states give further input on the needed reforms?

A. CMS continues to work closely with states to provide options and tools that make it easier for states to make changes in their Medicaid programs to improve care and lower costs. In the last six months, we have released guidance giving states flexibility in structuring payments to better incentivize higher-quality and lower-cost care, provided enhanced matching funds for health home care coordination services for those with chronic illnesses, designed new templates to make it easier to submit section 1115 demonstrations and to make it easier for a state to adopt selective contracting in the program, and developed a detailed tool to help support states interested in extending managed care arrangements to long term services and supports. We have also established six learning collaboratives with states to consider together improvements in data analytics, value-based purchasing and other topics of key concern to states and stakeholders, and the Center for Medicare and Medicaid Innovation has released several new initiatives to test new models of care relating to Medicaid populations. Information about these and many other initiatives are available on Medicaid.gov. We welcome continued input and ideas from states and others.
States can implement delivery system and payment reforms in their programs whether or not they adopt the low-income adult expansion. With respect to the expansion group in particular, states have considerable flexibility regarding coverage for these individuals. For example, states can choose a benefit package benchmarked to a commercial package or design an equivalent package. States also have significant cost-sharing flexibility for individuals above 100% of the federal poverty level, and we intend to propose other cost-sharing changes that will modernize and update our rules.

34. Will the federal government support options for the Medicaid expansion population that encourage personal responsibility?

A. Yes, depending on its design. We are interested in working with states to promote better health and health care at lower costs and have been supporting, under a demonstration established by the Affordable Care Act, state initiatives that are specifically aimed at promoting healthy behaviors. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and state Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite states to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes. We note in particular that states have considerable flexibility under the law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100% of the federal poverty level, to accomplish these objectives, including Secretary-approved benchmark coverage

35. Will CMS approve global waivers with an aggregate allotment, state flexibility, and accountability if states are willing to initiate a portion of the expansion?

A. Consistent with the guidance provided above with respect to demonstrations available under the regular and the enhanced matching rates, CMS will work with states on their

proposals and review them consistent with the statutory standard of furthering the interests of the program.

MAGI

36. Will states still be required to convert their income counting methodology to Modified Adjusted Gross Income (MAGI) for purposes of determining eligibility regardless of whether they expand to the adult group? If so, how do states link the categorical eligibility criteria to the MAGI?

A. Yes, as required by law. Conversion to modified adjusted gross income eligibility rules will apply to the nonelderly, nondisabled eligibility groups covered in each state, effective January 2014, without regard to whether a state expands coverage to the low-income adult group. The new modified adjusted gross income rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through Exchanges; the application of modified adjusted gross income to Medicaid and CHIP will promote a simplified, accurate, fair, and coordinated approach to enrollment for consumers. CMS has been working with states to move forward with implementation of the modified adjusted gross income rules, and consolidation and simplification of Medicaid eligibility categories.

DSH

37. The Disproportionate Share Hospital allotments will be reduced starting in 2014 using a methodology based on the reduction in the number of uninsured. One, when will HHS issue the regulations and methodology for this reduction? Two, for a state that does not see a decrease in its uninsured population, will the remaining states absorb the full reduction? Is HHS planning any modification to the manner in which it will reduce DSH allotments as it relates to states that do not expand?

A. The law directs HHS to develop a methodology to reduce Disproportionate Share Hospital (DSH) funding over time in a way that is linked to reductions in the number of uninsured or how states target their funds. We have heard from states and health care providers about their concerns related to this change and are exploring all options. The Department will propose this methodology for public comment early next year.

COORDINATION BETWEEN EXCHANGES AND OTHER PROGRAMS

38. How can states use premium assistance to help families that are split among the Exchange, Medicaid, and the Children's Health Insurance Program (CHIP) enroll in the same plans?

A. In 2014, some low-income children will be covered by Medicaid or CHIP while their parents obtain coverage on the Exchange with advance payments of the premium tax credit. Premium assistance, an option under current law, provides an opportunity for state Medicaid and CHIP programs to offer coverage to such families through the same coverage source, even if supported by different payers. Under Medicaid and CHIP statutory options, states can use federal and state Medicaid and CHIP funds to deliver Medicaid and CHIP coverage through the purchase of private health insurance. Most commonly, states have used premium assistance to help Medicaid/CHIP eligible families pay for available

employer-based coverage that the state determines is cost effective. There are cost sharing assistance and benefit wrap-around coverage requirements, to the extent that the insurance purchased with Medicaid and/or CHIP funds does not meet Medicaid or CHIP standards. In both Medicaid and CHIP, premium assistance is authorized for group health coverage and, under some authorities, for health plans in the individual market, which, in 2014 would include qualified health plans available through the Exchange. Please note that advance payments of the premium tax credit and cost-sharing reductions are not available for an individual who is eligible for Medicaid or CHIP. The statutory authorities that permit use of title XIX or title XXI funds to be used for premium assistance for health plans in the individual market, including qualified health plans in the Exchange, are sections 1905(a) and 2105(c)(3) of the Social Security Act.

For example, beginning in 2014, when a child is eligible for Medicaid/CHIP and the parent is enrolled in a qualified health plan through the Exchange, a state Medicaid or CHIP program could use existing premium assistance authority to purchase coverage for a Medicaid or CHIP-eligible child through that qualified health plan. The premium tax credit would not be available to help cover the cost of coverage for these children. As noted above, with respect to the children, the state would adhere to federal standards for premium assistance, including providing wrap-around benefits, cost sharing assistance, and demonstrating cost-effectiveness, as appropriate. A State-Based Exchange may be able to support such an option, and in states where a Federally-Facilitated Exchange is operating, a State Medicaid or CHIP agency may be able to take this approach by making arrangements with qualified health plans to pay premiums for individuals. We will be working with states interested in this option to consider how the state Medicaid and CHIP agency can coordinate with the Exchange to establish and simplify premium assistance arrangements.

39. How can states use premium assistance to promote continuity of care when individuals move between Exchange, CHIP, and Medicaid coverage?

A. The Affordable Care Act envisions and directs that there be a coordinated system for making eligibility determinations between Medicaid, CHIP and the Exchange to avoid gaps in coverage as individuals' income fluctuates. Smooth eligibility transitions will not necessarily prevent people from having to select a new plan and/or provider when they lose eligibility for one insurance affordability program and gain eligibility for another. The extent to which such changes in plans and providers occur will depend on whether and to what degree plans participate in both the Exchange and in Medicaid and CHIP, and the networks in such plans.

Premium assistance can help address this issue, while encouraging robust plan participation in Medicaid, CHIP, and the Exchange. As discussed above, this option permits state Medicaid or CHIP programs to use premium assistance to enroll a Medicaid or CHIP eligible individual or family in a qualified health plan through the Exchange. States may be most interested in this option for families close to the top of the Medicaid income limit. Under this arrangement, if a family's income changes such that some or all members of the family become ineligible for Medicaid or CHIP and eligible for a premium tax credit to help cover the cost of a qualified health plan through the Exchange, it would be less likely that members moving into Exchange coverage would need to change plans or providers. Similarly, premium assistance could help increase the likelihood that individuals moving from Exchange coverage into Medicaid or CHIP may remain in the same qualified health plan in which they had been enrolled through the Exchange.

As discussed above, premium assistance options in Medicaid and CHIP are subject to federal standards related to wrap around benefits, cost sharing and cost effectiveness. There may also be an opportunity for states to promote continuity of coverage through "bridge plans" as described earlier.

EXHIBIT B

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Center for Medicaid and CHIP Services

August 31, 2012

The Honorable Mike Beebe
Governor of Arkansas
Little Rock, AR 72201

Dear Governor Beebe:

I am writing to follow up on our discussion and to respond to the question you have asked about the Medicaid low-income adult eligibility expansion in light of the Supreme Court's decision in *NFIB v. Sebelius*. As you know, beginning in 2014, the Affordable Care Act provides for the expansion of Medicaid eligibility to adults under the age of 65 with incomes up to 133 percent of the federal poverty level who were not previously eligible for Medicaid. Pursuant to the Court's decision, a state may choose not to undertake this expansion without losing federal funding for its existing Medicaid program. The Court's decision did not affect other provisions of the law.

A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage. The federal financial support for this coverage established under the Affordable Care Act is 100 percent in 2014, 2015, and 2016, gradually declining to 90 percent by 2020 and remaining at that level thereafter. While states have flexibility with respect to whether and when to start or stop the expansion, the match rates that are available are tied by law to the specific calendar years noted. Ultimately, I am hopeful that state leaders will take advantage of the opportunity provided to insure their poorest families with these unusually generous federal resources while dramatically reducing the burden of uncompensated care on their hospitals and other health care providers.

I hope this information is helpful and look forward to continuing to work with you and others in Arkansas on ensuring the Arkansas Medicaid program is as strong and effective as it can be.

Sincerely,

Cindy Mann
Director

EXHIBIT C

Code of Federal Regulations
Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter C. Medical Assistance Programs
Part 440. Services: General Provisions (Refs & Annos)
Subpart C. Benchmark Benefit and Benchmark–Equivalent Coverage (Refs & Annos)

42 C.F.R. § 440.315

§ 440.315 Exempt individuals.

Effective: January 1, 2014
Currentness

Individuals within one (or more) of the following categories are exempt from mandatory enrollment in an Alternative Benefit Plan, unless the individuals are eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Individuals in that eligibility group who meet the conditions for exemption must be given the option of an Alternative Benefit Plan that includes all benefits available under the approved State plan.

(a) The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act.

(b) The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

(c) The individual is entitled to benefits under any part of Medicare.

(d) The individual is terminally ill and is receiving benefits for hospice care under title XIX.

(e) The individual is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or other medical institution, and is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(f) The individual is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in § 438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with

a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

(g) The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

(h) The individual is eligible and enrolled for Medicaid under § 435.145 of this chapter based on current eligibility for assistance under title IV–E of the Act or under § 435.150 of this chapter based on current status as a former foster care child.

(i) The individual is a parent or caretaker relative whom the State is required to cover under section 1931 of the Act.

(j) The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

(k) The individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

(l) The individual is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

(m) The individual is determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

Credits
[78 FR 42306, July 15, 2013]

SOURCE: 43 FR 45224, Sept. 29, 1978; 51 FR 41338, Nov. 14, 1986; 73 FR 73724, Dec. 3, 2008; 74 FR 5809, Feb. 2, 2009; 74 FR 15221, April 3, 2009; 74 FR 62501, Nov. 30, 2009; 75 FR 23101, April 30, 2010; 77 FR 29028, May 16, 2012, unless otherwise noted.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Current through June 15, 2018; 83 FR 28150.

End of Document