CONCISE EXPLANATORY STATEMENT

In accordance with the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.6, the following is a concise explanatory statement:

AGENCY: Department of Administration ("DOA")

DIVISION: Rhode Island Health Benefit Exchange d/b/a HealthSource RI ("Exchange")

RULE IDENTIFIER: 220-RICR-90-00-1

RULE TITLE: Rules and Regulations Pertaining to HealthSource RI

TYPE OF RULEMAKING: Amendment

REASON FOR RULEMAKING: The reason for this rulemaking is to establish the eligibility and enrollment requirements for an automatic enrollment and premium payment program. Under this program, the Exchange may automatically enroll an eligible individual who loses Medicaid at the end of the Medicaid continuous enrollment condition into a Qualified Health Plan ("QHP") and/or pay the individual's first and second month's premium, as applicable.

TESTIMONY AND COMMENTS SUMMARY:

§ 1.8(D)(1) Eligibility

Comment: Two commenters expressed support for extending automatic enrollment to eligible individuals with household incomes up to 250% FPL. One of the commenters stated that while some individuals between 200% and 250% FPL may be better served in a more robust gold- or platinum-tier plan, or may only wish to purchase a less expensive bronze-tier plan, the default CSR-73 silver plan is preferable to not being automatically enrolled given the opt-out option.

Exchange Response: We are finalizing the 200% FPL eligibility cap for automatic enrollment as proposed. For individuals with household incomes above 200% FPL, not only are monthly premiums more expensive, but CSRs available to them decrease significantly. As a result, a higher income eligibility threshold would require additional complexity in plan assignment to better suit the needs of the individual. Additionally, focusing automatic enrollment on the lowest income levels allows us to maximize the impact of available funding.

As described more fully below in our response to the comments on § 1.8(D)(7), we plan to coordinate with the Rhode Island Medicaid program to ensure that eligible individuals with an expected household income of 200% to 250% FPL are notified of their eligibility for a special enrollment period and the premium payment program under § 1.8(D)(3). Accordingly, we decline to increase the eligibility threshold for automatic enrollment to 250% FPL and are finalizing § 1.8(D)(1) as proposed.

§ 1.8(D)(2) Plan Assignment and APTC Authorization

Comment: Several commenters recommended that the Exchange revise § 1.8(D)(2) to require that eligible individuals be automatically assigned to QHPs that include coverage for abortion services. One commenter explained that it is concerned some individuals automatically enrolled in QHPs will only find out when it is too late that they do not have coverage for abortion services if they have been automatically assigned to a plan that does not cover such services.

Exchange Response: We appreciate the comments on our proposed approach to QHP auto assignment. Under § 1.8(D)(2) of the proposed rule, the Exchange proposed to automatically assign an eligible individual to either the second lowest cost silver plan, a silver-level plan offered by the eligible individual's previous MCO issuer, or if no such plan exists, a similar plan. To determine the appropriate plan to automatically assign an eligible individual to in accordance with the standards specified in § 1.8(D)(2), we will consider several factors, including the QHP's provider networks, pharmacy formulary, benefit limits and exclusions, as well as out of pocket costs.

While we have not automatically assigned individuals terminated from Medicaid to QHPs in the past, we automatically assign QHP enrollees into the same or a similar plan at the end of each QHP plan year in accordance with § 1.8(C) and 45 C.F.R. § 155.335(j). Consistent with § 1.8(C)(1), our longstanding policy has been to not automatically assign QHP enrollees to QHPs that add or remove coverage of comprehensive abortion services, as such services are defined in 45 C.F.R. § 156.280(d)(1) ("comprehensive abortion services"). (See §1.8(C)(1) and HealthSource RI Policy Manual, c. 3, § F). We find that policy to be instructive here.

Currently, Rhode Island Medicaid MCOs do not cover comprehensive abortion services. Therefore, consistent with existing policy, we decline to revise § 1.8(D)(2) to require us to automatically assign an individual coming from a Medicaid MCO that does not cover comprehensive abortion services to a QHP that does. If, after the issuance of this final rule, Medicaid MCOs are permitted or required to cover comprehensive abortion services, we will revisit this decision in light of that change and based on an analysis of the factors described above. This consideration would also include an analysis of whether funds for the program may be used to pay for comprehensive abortion services, as this program is being paid for at least in part with federal funds, which generally may not be used to pay for such services. We would also need to consider the impact to eligible individuals if funds for this program are not able to be used for such services.

We also note that eligible individuals who are automatically assigned to a QHP that does not cover comprehensive abortion services may elect to change to a plan that does cover such services during their special enrollment period resulting from their loss of Medicaid. Additionally, as described more fully below in our responses to comments on § 1.8(D)(7), these enrollees will receive a Summary of Benefits and Coverage from their QHP issuer at the time of enrollment indicating that their QHP does not cover comprehensive abortion services.

Accordingly, we decline to revise § 1.8(D)(2) to require us to automatically assign individuals under this automatic enrollment program to a QHP that covers comprehensive abortion services.

Comment: One commenter stated that the proposed rule does not sufficiently protect individuals against unknowingly assuming financial obligations. The commenter proposed that instead of automatically enrolling eligible individuals beyond the initial two months, the Exchange should be required to confirm with an enrollee that they wish to remain enrolled before premiums can be charged. The commenter also recommended that the Exchange allow individuals opting out of automatic enrollment to maintain their QHP coverage for the entire two-month period during which their premium is paid.

Exchange Response: We appreciate this comment and agree it is important to protect individuals against unknowingly assuming financial obligations. the Exchange automatically assigns most QHP enrollees into the same or a new QHP at the end of each plan year. As such, we already have the necessary outreach and communications framework necessary to protect individuals against unknowingly assuming financial obligations. Through notices, emails, phone calls and text messages (where permitted), we plan to be in regular contact with individuals enrolled through this automatic enrollment program to ensure that they are aware of their financial obligations and remain enrolled beyond the initial two months knowingly and deliberately.

We also recognize that automatic enrollment creates some financial risk on enrollees if they do not need or want QHP coverage. However, we note that once an eligible individual is enrolled in a QHP, we may only involuntarily terminate their QHP if permitted by federal regulations at 45 C.F.R. § 155.430(b)(2). Under 45 C.F.R. § 155.430(b)(2)(ii)(A), for an enrollee receiving APTCs, we may only involuntarily terminate coverage after the exhaustion of the enrollee's 3-month grace period, which is described in 45 C.F.R. §§ 156.270(d) and (g). We are not permitted to terminate coverage prior to the expiration of the 3-month grace period. Accordingly, we decline to adopt a requirement to disenroll enrollees from their QHPs after two months if they have not indicated that they wish to remain enrolled.

We generally agree with the commenter's recommendation that we allow individuals to maintain their QHP coverage for the entire two-month period during which their premium is paid. Under existing policy, codified in § 1.10(G)(1), an enrollee who voluntarily terminates QHP coverage will be disenrolled effective the last day of the month in which the request is made. In the proposed rule, we proposed to establish an opt-out option for eligible individuals under § 1.8(D)(6), which would allow the individual to cancel enrollment if they wish to opt out of automatic enrollment. Therefore, eligible individuals may elect to either: (1) opt out of automatic enrollment under the new § 1.8(D)(6), in which case their QHP enrollment would be cancelled; or (2) voluntarily terminate QHP coverage under § 1.10(G)(1), in which case their QHP coverage would end on the last day of the month in which the voluntary termination request was made. Accordingly, eligible individuals may retain their QHP coverage for the entire two-month period and terminate QHP coverage going forward so long as they duly terminate coverage before the end of their second month of coverage.

Comment: One commenter recommended that the State convene interagency sessions to revise, develop, and refine plans that are in greater alignment with Medicaid program designs around eligibility, redeterminations, and enrollment. The commenter noted that there are differences

between Medicaid and QHPs and believes it can be difficult to facilitate automatic enrollment in a product that would be similar enough to the individual's Medicaid MCO to not cause confusion for the individual. The commenter recommended that the Rhode Island Executive Office of Health and Human Services ("EOHHS") partner with Medicaid MCOs to proactively do outreach and educate beneficiaries who may be losing Medicaid about their QHP options, and provide MCOs with disenrollment reasons. The commenter recommended that the State prioritize examining its redetermination plans prior to developing regulations that establish a process to automatically enroll individuals from Medicaid into QHPs.

Exchange Response: These regulations were developed in consultation with the Rhode Island Medicaid program to ensure consistency with Medicaid program designs around eligibility, redeterminations, and enrollment, and to reduce the administrative burden on individuals losing Medicaid at the end of the continuous enrollment condition to the greatest extent practical. We recognize that there are differences between Medicaid MCOs and QHPs, but do not agree that comprehending these differences is too difficult to automatically enroll eligible individuals in a product that's similar enough to the individual's Medicaid MCO. As described elsewhere in these responses, we routinely auto-assign QHP enrollees to new QHPs each plan year. Based on this experience, we have developed clear messaging in collaboration with QHP issuers to ensure that individuals are familiar with the QHP they are enrolled in, including the benefits, exclusions, and cost sharing obligations. While there are notable differences between Medicaid and QHP coverage, we believe the adjustment represents a significantly lower risk of disruption than potentially going uninsured if automatic enrollment were not implemented.

While we acknowledge the commenter's recommendation that EOHHS partner with Medicaid MCOs and provide Medicaid MCOs with disenrollment reasons, we did not propose and are not finalizing any changes with respect to Medicaid MCOs because it would be beyond the scope of the proposed rule and our statutory authority. As described more fully above, these regulations were developed in consultation with the Rhode Island Medicaid program. We have interagency workstreams designed to ensure a coordinated approach to noticing, communications, and necessary system enhancements to our integrated eligibility system. Accordingly, we believe this final rule is in alignment with Medicaid program designs around eligibility, redeterminations, and enrollment, and are finalizing § 1.8(D)(2) as proposed.

§ 1.8(D)(4) Premium Payment Applies After APTCs

Comment: Several commenters requested that the Exchange be clear with enrollees about when they will be responsible for premium payments. One commenter noted that at § 1.8(D)(4), the proposed rule states that "If an individual elects to accept less than the full amount of APTCs for which the individual is determined eligible … the Exchange will not utilize funds under § 1.8(D)(3) of this Part to pay that portion of the premium." The commenter recommended that communication to enrollees through the notice under § 1.8(D)(7) be clear about what it means to accept less than the full amount of APTCs for which they are eligible.

Exchange Response: Under this automatic enrollment program, eligible individuals will not be responsible for making a premium payment until the payment deadline for their third month of QHP coverage, which is the 23rd day of the month prior to their third month of coverage. We

routinely communicate payment deadlines to our existing QHP enrollees, including through monthly invoices and reminders in the form of phone calls, emails, and text messages, where applicable. We believe these communications clearly inform enrollees about when they are responsible for premium payments. We will consider the most appropriate form of communication to notify eligible individuals of what it means to accept less than the full amount of APTCs but decline to require that this information be included in the notice under § 1.8(D)(7).

Accordingly, we are finalizing § 1.8(D)(4) as proposed.

§ 1.8(D)(6) Opt Out

Comment: One commenter recommended that the Exchange engage in sufficient consumer outreach to ensure eligible individuals are aware of the actions being taken on their behalf. The commenter also recommended aligning the opt-out period in § 1.8(D)(6) with proposed federal regulations extending the SEP for loss of Medicaid coverage to five months (2 months prior to Medicaid disenrollment and 3 months post). Finally, the commenter recommended that prior to disenrollment from Medicaid, the State should consider an outreach grace period for Medicaid.

Exchange Response: We have developed a comprehensive consumer outreach program to ensure eligible individuals are aware of the actions being taken on their behaves. The proposed 60-day opt-out period was approved by the Centers for Medicaid and Medicare Services (CMS) through an amendment to our Blueprint under 45 C.F.R. § 155.105. Any changes to the duration of this period would require additional federal approval and present considerable additional barriers in the form of modifications to our integrated eligibility system. We believe the 60-day opt-out period will provide eligible individuals with sufficient time to opt out of automatic enrollment if they so choose.

We did not propose and are not finalizing any changes with respect to an outreach grace period for Medicaid because such changes would be beyond the scope of the Exchange's authority and this regulation.

Accordingly, we are finalizing § 1.8(D)(6) as proposed.

§ 1.8(D)(7) Notice

Comment: Two commenters proposed that the notice content requirements of the notice under § 1.8(D)(7) be revised to specify that the QHP covers abortion services, and the enrollee may switch to a plan that does not cover such services.

Exchange Response: As explained above in our responses to comments on §1.8(D)(2), we are declining to revise the proposed rule to require us to automatically assign eligible individuals to a QHP that covers comprehensive abortion services. Upon enrollment, eligible individuals will be provided with a Summary of Benefits and Coverage from their QHP issuer, which indicates whether the QHP includes coverage for comprehensive abortion services, among other important coverage details. Further, the notices we send to eligible individuals will clearly inform them of their ability to switch plans during their special enrollment period.

Comment: Several commenters recommended that the Exchange provide comprehensive information to individuals automatically enrolled into a QHP. Specifically, these commenters recommended the Exchange send the notice under § 1.8(D)(7) via all available modes of communication, including postal mail, phone, text message, and email. They also recommended that the Exchange include instructions and contact information in the notice on how to connect with a Navigator or Certified Application Counselor ("CAC").

Two of these commenters recommended the Exchange include in the notice information about the benefits covered by the enrollee's QHP and its cost-sharing requirements, compared to other QHPs available through the Exchange.

Exchange Response: We appreciate these comments, and plan to conduct comprehensive outreach to eligible individuals. Available outreach and communications tools include text messaging, mobile application notifications, auto-dial phone calls and flyers or "stuffers" included as supplements to notices or other official Exchange communications.

Notices to these individuals will be sent via their chosen mode of communication; paper or electronic notification. Because the Exchange and Medicaid utilize a single-streamlined application through their integrated eligibility system, an individual's chosen mode of communication for Medicaid notifications is the same for QHP under this automatic enrollment and premium payment program. These notices will include instructions for contacting the Exchange for enrollment support, including how to find information about connecting with a Navigator or CAC.

Enrollees will be provided with a Summary of Benefits and Coverage by their QHP issuer at the time of enrollment. Additionally, we plan to conduct a comprehensive outreach campaign to eligible individuals in addition to sending the notice under § 1.8(D)(7).

Comment: Two commenters recommended the Exchange provide comprehensive information to individuals eligible for payment of premiums but not automatic enrollment. Specifically, one commenter expressed concern that individuals losing Medicaid coverage with expected household incomes of 200% to 250% FPL would not be aware that they are eligible to have the first two months of their QHP premium paid.

One of these commenters stated that it believes the Exchange must provide notice to individuals losing Medicaid coverage with household incomes of 200% to 250% FPL that (1) they are being disenrolled from their Medicaid coverage, and (2) if they select a QHP available through the Exchange within five months of disenrollment, the premium for their first two months of coverage will be paid for them. The commenter further recommended that the Exchange ensure that it communicates with all Rhode Islanders who are losing Medicaid coverage during redetermination to ensure that they know their coverage status, coverage options, how to enroll in other health plans, and the financial assistance available to them.

Exchange Response: We have collaborated with the Rhode Island Medicaid program to provide notification to individuals who lose Medicaid and have an expected household income of 200% to 250% FPL that they may be eligible for the premium payment program under § 1.8(D)(4).

Individuals losing Medicaid are notified by the Rhode Island Medicaid program of their disenrollment in accordance with applicable law. Accordingly, we are finalizing § 1.8(D)(7) as proposed.

§ 1.8(D)(8) Notice Timing

Comment: Several commenters recommended that the Exchange issue the eligibility enrollment notice under § 1.8(D)(7) no later than 30 days before QHP coverage begins. One of these commenters recommended that the notice be issued in advance of an enrollee's QHP effective date.

Exchange Response: We agree that it is important to provide eligible individuals with sufficient notice in advance of QHP enrollment, and we will make every effort to provide the notice under § 1.8(D)(7) as soon as reasonably practical. However, under federal regulations pertaining to Medicaid programs, termination notices sent at the conclusion of the Medicaid annual redetermination process must be sent a minimum of 10 days in advance of losing Medicaid (See 42 C.F.R. 431 Subpart E). Pursuant to §1.8(D)(1), an individual is not eligible for automatic enrollment until we can confirm that they will be disenrolled from Medicaid. As such, we cannot send the notice under § 1.8(D)(7) until the Medicaid redetermination process is complete and the Rhode Island Medicaid program has notified the individual that they will be terminated from Medicaid.

Accordingly, we decline to adopt this recommendation and are finalizing § 1.8(D)(8) as proposed.

§ 1.8(D)(9) Duration of Program

Comment: One commenter recommended revising the proposed rule by linking the duration of the program under § 1.8(D)(9) to the end of the period for initial post-unwinding redeterminations established by EOHHS after the sunset of the Medicaid continuous enrollment condition. The commenter explained that it believes Rhode Island's Medicaid continuous enrollment unwinding plan, as proposed by EOHHS and approved by CMS, provides that Medicaid will begin termination in the third month following the sunset of the Medicaid continuous enrollment condition, with terminations conducted over a twelve-month period and therefore ending 14 months after the end. Additionally, under the 2022 federal omnibus appropriations package, the end of the PHE and the end of the continuous enrollment condition are no longer directly linked.

Exchange Response: We generally agree with this recommendation and have revised § 1.8(D)(9) in the final rule accordingly.

§ 1.8(D)(10) Availability of Funds

Comment: One commenter recommended that a section be added to the final rule that would require the Exchange to notify enrollees at least 30 days in advance if their premiums for their first or second month of coverage cannot be covered because of insufficient funds.

Exchange Response: We appreciate this comment and share the commenter's concern with ensuring that enrollees are informed in the event we reduce eligibility for this program under § 1.8(D)(10). We will closely monitor the budget for this program and plan to only determine individuals eligible for premium payment if funds are available. Any changes to eligibility or the availability of the premium payment program will be clearly communicated in advance of QHP enrollment under this program. When an individual is determined eligible for premium payment, the premium payments for both the first and second month will be applied at the time of enrollment. Accordingly, there should not be an instance where an enrollee would need to be notified of premiums not being covered because once an individual is enrolled under this program, we have already obligated and applied the premium payments for the enrollee's first two months of QHP coverage.

Accordingly, we are finalizing § 1.8(D)(10) as proposed.

CHANGES TO TEXT OF THE RULE: We are revising § 1.8(D)(9) of the rule to align it with a recent change in federal law. After the Exchange released the proposed rule for public comment, the Consolidated Appropriations Act, 2023, was enacted. Among other things, this federal law decoupled the Medicaid continuous enrollment condition from the COVID-19 Public Health Emergency and terminates this condition on March 31, 2023. Starting April 1, 2023, states may resume Medicaid disenrollments, consistent with the Center for Medicaid and CHIP Services Information Bulletin issued by the Centers for Medicare and Medicaid Services on January 5, 2023. Accordingly, we are revising § 1.8(D)(9) in the final rule to reflect this recent change in federal law.

REGULATORY ANALYSIS: The following regulatory analysis was prepared for the proposed rule in accordance with R.I. Gen. Laws § 42-35-2.9. It is included with this concise explanatory statement as required by R.I. Gen. Laws § 42-35-2.6.

I. Introduction

As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, a public health emergency (PHE) was determined to exist nationwide in the United States by Alex M. Azar II, Secretary of Health and Human Services on January 31, 2020.[1] This declaration has been renewed every 90 days since its inception. As an additional response to the pandemic, the "Families First Coronavirus Relief Act" was enacted in March of 2020. Included in this Act was a provision which requires states to keep most Medicaid enrollees enrolled in Medicaid coverage continuously until the end of the public health emergency was declared[2].

Over time, Rhode Island's Medicaid enrollment has grown by over 50,000 because of the continuous enrollment condition of the Families First Act. Consequently, when the continuous enrollment condition ends, either due to end of PHE, or a change to federal legislation, a challenging scenario will emerge where thousands of Rhode Islanders may find themselves ineligible for the Medicaid coverage which they have relied on without redetermination for two

[1] Renewal of Determination That a Public Health Emergency Exists, https://aspr.hhs.gov/legal/PHE/Pages/COVID19-14Jan2022.aspx
[2] https://www.healthreformbeyondthebasics.org/wp-content/uploads/2021/12/PHE-MOE-Unwinding-12.21.pdf

years or more. Nationally, the Urban Institute projected last fall that more than fifteen million Americans may lose access to Medicaid when the PHE ends[3].

In response, the Rhode Island Health Benefit Exchange, d/b/a HealthSource RI ("Exchange") proposed to amend the Rules and Regulations Pertaining to HealthSource RI for the purposes of establishing a process by which the Exchange may automatically enroll those individuals who are no longer eligible for Medicaid coverage after the PHE ends on a monthly basis, for up to 12 months into a QHP, if they are so eligible. Additionally, the Exchange proposed regulatory amendments that include a mechanism by which the Exchange will pay for the cost of the first and second month's premium in the plan that the eligible resident is automatically enrolled into. For eligible residents with household income between 200% FPL and 250% FPL, they will not be automatically enrolled. The Exchange proposed making the first and second month's premium payment for medical or dental plans when the resident actively selects such a plan. The Exchange also proposed to give potential beneficiaries of this program the ability to appeal.

Pursuant to the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.9 ("APA"), the Exchange has conducted a regulatory analysis for the amendments. The Exchange used the best available information at the time of publication to estimate the benefits and costs of the regulatory provisions. The following analysis examines the costs and benefits of a reasonable range of regulatory alternatives reflecting the scope of discretion provided by R.I. Gen. Laws §§ 42-157-11, 14 and R.I. Gen. Laws § 44-30-101(e)(2).

II. Analysis of Regulatory Alternatives

Program Eligibility

The amendments to 220-RICR-90-00-1(8)(D) permit the Exchange to facilitate a direct transition from Medicaid to QHP at such time that the Medicaid continuous enrollment condition ends. This direct transition will only be available to individuals who meet all the following requirements:

- are disenrolled from Medicaid due to the end of the Medicaid continuous enrollment condition,
- are eligible for a special enrollment period under 45 CFR §155.420(d)(1),
- have been redetermined as eligible for advance premium tax credits (APTC) and cost-sharing reductions (CSR) by the Exchange, and
- has a household income, as defined in 26 CFR§1.36B-1(e), that is expected to be under 200% of the federal poverty level (FPL) at the time of redetermination.

As mentioned above, since early 2020, Medicaid Departments nationwide have been prohibited from terminating enrollment of any enrollee except in instances where an enrollee:

- has moved out of state,
- has requested to have their coverage terminated, or
- has died.

This has led to an increased level of enrollment. When the provision of the Families First Coronavirus Relief Act that requires continuous enrollment ends, either due to end of PHE, or

[3] https://ccf.georgetown.edu/2021/09/20/loss-of-medicaid-after-the-phe-will-likely-exceed-15-million-estimated-by-urban

other federal legislation, RI Medicaid will then be able to resume normal operations and processes of renewal and redetermination.

Prior to the continuous enrollment condition, an average of 6,900 enrollees were terminated monthly from RI Medicaid. Typically, some of these individuals are eligible to purchase a QHP through the Exchange, while others are not. Among those who are eligible to purchase a QHP, some may be eligible for financial assistance, and some are not. In order to retain coverage, individuals must, on their own or with assistance, make any necessary application updates, enroll in a plan, and then pay for the first month of coverage. There has never been a high proportion of successful transitions from Medicaid to QHP and the transition process has long been a challenge for consumers and the Exchange.

The amendments to 220-RICR-90-00-1(8)(D) permit the Exchange to pay for the first- and second-month's premium for individuals transitioning from Medicaid to QHP at such time that the continuous enrollment condition ends. These payments will only be available for individuals who meet all the following requirements:

- are disenrolled from Medicaid due to the end of the Medicaid continuous enrollment condition,
- are eligible for a special enrollment period under 45 CFR §155.420(d)(1),
- have been redetermined as eligible for advance premium tax credits (APTC) and cost-sharing reductions (CSR) by the Exchange, and
- has a household income, as defined in 26 C.F.R. § 1.36B-1(e), that is expected to be less than or equal to 250% FPL; and is either automatically enrolled in a QHP available through the Exchange; or actively selects a QHP and/or dental plan available through the Exchange.

When considering automating enrollment for this program, the risk must be considered that without action, thousands of Rhode Islanders previously eligible for Medicaid may become uninsured when redeterminations resume. As described below, the program design serves to simplify their transition between coverage, mitigate risks to the enrollees by creating opportunity for changes or cancellation to be made, and limiting the automatic enrollment program to enrollees with household incomes below 200% FPL[4] to target the automatic enrollment program to those that need it most and to make the most cost-effective use of federal subsidy increases currently available.

The Exchange also considered increasing the income eligibility limit for this program. Financial assistance for coverage purchased through the Exchange exists on a sliding scale and households with lower income levels are eligible for the most assistance and households with higher income levels are eligible to receive less assistance. As a result, maximum out-of-pocket[5] expenses and premium costs for consumers are higher at higher income levels. Capping the automated enrollment program at 200% FPL leverages the maximum cost-sharing reduction[6] and tax credit

[4] See

assistance to keep coverage affordable for consumers and administrative costs lower for the State.

Modifying this program to increase the income eligibility limit above 200% FPL is feasible but for the following reasons required a shift from automatic enrollment for the population. For consumers with incomes above 200% FPL, not only are monthly premiums more expensive, but cost-sharing reductions available to them decrease significantly above 200% FPL and end altogether at 250% FPL. Without cost-sharing reductions, silver level plans are cost prohibitive to consumers and would therefore make a poor choice for automatic enrollment. As a result, a higher income eligibility threshold would require additional complexity in plan assignment to better suit the needs of the consumer.

As a result of these considerations, choosing an auto-enrollment plan for customers with income over 200% FPL therefore becomes infeasible. However, for eligible Rhode Islanders with income is between 200% and 250% FPL the program may make two months premium payments for medical or dental coverage enrollments when a resident actively enrolls through the Exchange.

Auto Assignment

If an individual is determined eligible for automated enrollment through this program, the Exchange may use the information available in the Integrated Eligibility System (IES) to authorize APTCs on behalf of the tax filer and enroll the individual(s) in a silver plan available through the Exchange. This plan selection will maximize the financial assistance available to enrollees with household income is below 200% FPL. Only silver plans have CSR variants that tie lower household income to lower out-of-pocket costs.

For enrollees with incomes between 100 and 150% FPL, they will receive the maximum APTC and CSR available to assist in covering the cost of coverage. APTC lowers an individual's monthly premium while CSR lowers the cost a consumer must bear out-of-pocket at times of service, or for their deductible[7]. In this income bracket, for the duration of federal subsidy increases[8] enrollees will have $0 deductible and a monthly premium of less than $1.

For enrollees with incomes between 150% and 200% FPL, they will also receive APTC and CSR assistance to cover costs of coverage. In this income bracket, for the duration of the federal subsidy increases, enrollees will have an $1,100 individual and $2,200 family deductible and a monthly premium between $1 and $50 per month, as well as assistance towards coverage of out-of-pocket expenses.

When considering alternative options for the selection of the auto-assignment plan, the higher cost of non-silver plans outweighed other potential benefits for individuals and families with household income less than 200% FPL. See table below for a comparison of what options might look like for a single Rhode Island consumer who is 43 years old and earns $20,000 annually (155% FPL):

[7] The deductible is the amount you must pay out-of-pocket for certain health care services before your insurance plan begins to pay. The deductible amount is in addition to your monthly premium. Services subject to the deductible vary by plan and may include doctor visits and hospital stays, as well as prescription medications.
[8] Currently set to end on December 31, 2022.

Metal Level	Monthly Premium (w/out APTC)	Monthly Premium (w/ max. APTC)	Annual Maximum Out of Pocket	Annual Deductible
Bronze	$563 - 707	$0.12 - 2.64	$6,900 - 8,550	$6,300 - 6,825
Silver	$799 - 1,121	$2.40 - 278	$2,500 - 2,800	$150 - 1,100
Gold	$818 - 1,220	$0.33 - 377	$3,900 - 8,000	$1,250 – 2,500
Platinum	$1,469	$626	$1,800	$750

Compared to alternatives, the selection of a silver plan for auto-enrollment ensures that enrollees will receive the most financial assistance available to facilitate their continued coverage beyond the second month of the program. For enrollees who would prefer a different plan than the one selected, there is a special enrollment period (SEP) that lasts sixty days from the date their Medicaid coverage ends and allows them to select a different plan if they so choose. An individual eligible for automatic enrollment may also elect to opt out of automatic enrollment for up to 60 days after the last day the individual had coverage under his or her previous Medicaid managed care plan. If an individual elects to opt out during this 60-day period, the individual's QHP enrollment will be cancelled.

Coverage Effectuation

The auto-enrollment and auto-assignment program is designed to include making payment on behalf of the enrollee for the first- and second-month's premium cost, which effectuates the health insurance coverage. This design ensures that there will be no gap in coverage for eligible enrollees. It does create some risk on the consumer, in the instance they do not need or want health insurance coverage. To mitigate this, the consumer will be able to cancel the coverage or change plans for up to 60 days after the last day the consumer had coverage under his or her previous Medicaid managed care plan. The consumer may also elect to update missing information and be reevaluated for Medicaid eligibility if needed.

An alternative to making this payment on a consumer's behalf would be to require individuals to take action to effectuate their coverage. This creates the risk that they do not act and find themselves uninsured.[9] The process of Medicaid renewal or redetermination after two years of not being required to do so may mean that consumers could be confused or miss deadlines in the process. Without the Exchange making the first payments, significantly higher numbers of Rhode Islanders would have short or long-term periods without insurance.

This design allows consumers to remain covered for an additional two months without cost to them, and the Exchange will provide opportunity for the consumer to change their enrollment for the duration of the sixty days following enrollment. Their coverage in the silver plan for auto-enrollment will begin on the first day of the month in which their Medicaid coverage ends, ensuring continued access to health coverage.

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[9] *See* Adrianna McIntyre & Mark Shepard, *Automatic Insurance Policies – Important Tools for Preventing Coverage Loss*, New Engl. J. Med., 386;5 at 408, February 2022, https://www.jstor.org/stable/27000409, (explaining that administrative burdens and complexity associated with transitioning from Medicaid to QHP substantially hinder consumers' ability to secure and maintain health coverage, and proposes automatic enrollment as a potential solution).

Noticing

Automatic enrollees will receive notification of their enrollment in the program at multiple instances. Prior to the start of their coverage, they will receive a combined notice of benefit determination and termination of their Medicaid coverage. This notice will inform the enrolled of the effective dates of their Medicaid termination and their QHP enrollment. Additionally, it will contain their determination of eligibility for APTC and CSR and information about how to choose a different plan or opt-out of the automatic enrollment program if needed.

Subsequently, an enrollment notice will also be received including the enrollees plan details, costs, as well as what next steps they may need to take. For example, instruction on how to change plans, or cancel coverage if needed. Additionally, information about how to log in to their customer portal account to access more information.

For those not auto-enrolled but eligible for premium payment, similar noticing will inform them of their eligibility for the payment program before they select a plan and later that a payment was made on their behalf.

Alternate Income Verification Process

The Exchange will, on a limited basis, modify its verification process for annual household income under 45 C.F.R. § 155.320 by using data available to the Exchange from the State Wage Information Collection Agency instead of the individual's application attestation regarding projected annual household income. This alternate income verification process will be available if:

1. the individual did not complete the Medicaid renewal form required by 42 CFR §§ 435.916 and 457.343 in the timeframe required by the Rhode Island Medicaid agency;
2. the Exchange determines that the individual's application attestation regarding annual household income for the applicable Benefit Year is not reasonably compatible with the data available to the Exchange from the State Wage Information Collection Agency;
3. the data available to the Exchange from the State Wage Information Collection Agency indicates that the individual's annual household income is expected to be greater than or equal to 100% FPL for the applicable Benefit Year; and
4. the individual otherwise meets the eligibility requirements specified in § 1.8(D)(1) of this Part.

The Exchange has obtained approval from the U.S. Department of Health and Human Services (HHS) to modify its Blueprint in order to institute an alternate verification process. This alternate verification process is consistent with 45 CFR § 155.320(a)(2), which requires an Exchange to verify income information in accordance with that section unless HHS approves a modification to its Blueprint under 45 CFR § 155.315(h). HHS may approve a modification to an Exchange's Blueprint under 45 CFR § 155.315(h) if it finds that the alternate verification processes would:

- reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay;

- that it would not undermine coordination with Medicaid and CHIP; and
- that applicable requirements with respect to the confidentiality, disclosure, maintenance, or use of such information will be met.

Modifying the income verification process, as set forth above, meets the standards for HHS approval in a number of important ways. Self-attested income for people being terminated from Medicaid is likely to be outdated since the Program has paused redeterminations, including income verifications, pending the expiration of the COVID-19 PHE. For this reason, inconsistent income information from an external data source is expected to be one of the top reasons for Medicaid terminations. External data source information is therefore likely to be more recent than attested income for those leaving Medicaid and using the external source will increase accuracy in APTC calculation. This will also permit the Exchange and Medicaid programs to take a coordinated approach to these eligibility determinations, as they will be using the same external data source. This will result in a better customer experience. For example, Medicaid using external data sources and the Exchange using attestation would lead to inconsistent and confusing results, such as denial of both Medicaid and APTC, but use of the same source will likely avoid such a result.

This approach will also reduce administrative costs and burdens by increasing the Exchange's ability to automatically enroll customers, which in turn will minimize delays and improve access to coverage for Rhode Islanders. It will also reduce inflated APTC eligibility results, thereby reducing the occurrence of tax credit reconciliation. Finally, the Exchange will maintain security and privacy standards for use of the information.

III. Determinations

Upon review of all the costs and benefits, the Exchange has determined that the benefits of the rule justify the costs of the rule. Further, the rule will achieve the objectives of the authorizing statutes in a more cost-effective manner, or with greater benefits, than other regulatory alternatives.

IV. Supporting Documentation

- Nour Kattih, et al., *The Power of Suggestion: Automatic Enrollment and Employee Health Insurance Coverage Take-Up Rates*, Journal of Insurance Issues, 44;1 at 90–107, Spring 2021, https://www.jstor.org/stable/27000409 .

- Matthew Buettgens & Andrew Green, *What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?*, Urban Institute, September 2021, https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf.
- Adrianna McIntyre & Mark Shepard, *Automatic Insurance Policies – Important Tools for Preventing Coverage Loss*, New Engl. J. Med., 386;5 at 408, February 2022, https://www.jstor.org/stable/27000409 .
- Table of Federal Poverty Level Percentages Matched to Income in Dollars:

2021 Federal Poverty Level *(for use for plan coverage year 2022 QHP eligibility)*							
Household/ Family Size	***100%***	***150%***	***200%***	***250%***	***300%***	***350%***	***400%***
1	$12,880	$19,320	$25,760	$32,200	$38,640	$45,080	$51,520
2	$17,420	$26,130	$34,840	$43,550	$52,260	$60,970	$69,680
3	$21,960	$32,940	$43,920	$54,900	$65,880	$76,860	$87,840
4	$26,500	$39,750	$53,000	$66,250	$79,500	$92,750	$106,000
5	$31,040	$46,560	$62,080	$77,600	$93,120	$108,640	$124,160
6	$35,580	$53,370	$71,160	$88,950	$106,740	$124,530	$142,320
7	$40,120	$60,180	$80,240	$100,300	$120,360	$140,420	$160,480
8	$44,660	$66,990	$89,320	$111,650	$133,980	$156,310	$178,640
Add for each additional person	$4,540	$6,810	$9,080	$11,350	$13,620	$15,890	$18,160