EXCHANGE

Regulatory Section	Provision	Proposed Rule Summary
§155.20	Definitions.	Proposes to revise three definitions from the Exchange final rule to change cross-references from section 36B of the Internal Revenue Code to implementing regulations at 26 CFR 1.36B and adds a definition of the term "catastrophic plan". Changes the cross-reference for the term "lawfully present" to allow for the planned alignment of the Exchange definition of "lawfully present" with the definition of "lawfully residing", as included in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), codified at 42 CFR 435.4.
§155.105	Approval of a State Exchange.	Changes cross-reference from section 36B of the Internal Revenue Code to implementing regulations at 26 CFR 1.36B-5.
§155.200	Functions of an Exchange.	Proposes that the Exchange perform the minimum functions described in proposed subpart F concerning appeals.
§155.205	Consumer assistance tools and programs of an Exchange.	Clarifies that any individual providing such consumer assistance, as described in §155.205(d), must be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the state, prior to providing such assistance.
§155.225	Certified application counselors.	Proposes that the Exchange will certify staff and volunteers of Exchange-designated organizations and organizations designated by state Medicaid and CHIP agencies to act as application counselors. Outlines the duties perform by certified application counselors, which include helping individuals and employees apply for enrollment in a QHP through the Exchange and for insurance affordability programs. Specifies that the Exchange will certify an individual as an application counselor if he or she meets specified standards, including compliance with privacy and security standards. Specifies that application counselors may not charge fees.

Regulatory Section	Provision	Proposed Rule Summary
§155.227	Authorized representatives.	Proposes that the Exchange will permit an individual or employee, subject to privacy and security requirements, to designate an individual or organization to act on his or her behalf in the eligibility process. Provides that the designation of an authorized representative will be in writing including a signature or through another legally binding format. Outlines the times and channels through which an individual or employee may choose to designate an authorized representative. Describes the duties of an authorized representative, in addition to other related standards.
§155.230	General standards for Exchange notices.	Proposes standards related to the provision of notices by the Exchange, detailing required content and options for individuals regarding how the Exchange transmits such notices (including electronically).
§155.300	Definitions and general standards for eligibility determinations.	Proposes to amend three definitions to change cross-references from section 36B of the Internal Revenue Code to implementing regulations at 26 CFR 1.36B.
§155.302	Options for conducting eligibility determinations.	Clarifies that the ability of the Exchange to contract eligibility determinations is subject to the standards in 42 CFR 431.10(c)(2). Proposes that the Exchange will not consider an application withdrawn if an individual who withdraws his or her application for Medicaid or CHIP appeals his or her eligibility determination for advance payments of the premium tax credit or cost-sharing reductions and the Exchange appeals entity finds that the individual is potentially eligible for Medicaid or CHIP. Proposes that the Exchange adhere to the appeals decision for Medicaid or CHIP made by the state Medicaid or CHIP agency, or the appeals entity for such program.

Regulatory Section	Provision	Proposed Rule Summary
§155.305	Eligibility standards.	Proposes limits on the ability of an Exchange to deny or terminate an individual who otherwise meets the residency requirements but for a temporary absence from the service area of the Exchange in certain circumstances. Proposes to amend provisions to change cross-references from section 36B of the Internal Revenue Code to implementing regulations at 26 CFR 1.36B. Proposes the eligibility standards for enrollment through the Exchange in a QHP that is a catastrophic plan (noting that the Affordable Care Act does not permit individuals enrolled in catastrophic plans to receive premium tax credits or cost-sharing reductions for such coverage) as follows: (1) a qualified individual who has not attained the age of 30 before the beginning of the plan year, or (2) a qualified individual who has a certification that he or she is exempt from the shared responsibility payment under section 5000A of the Internal Revenue Code based on a lack of affordable coverage or hardship.
§155.310	Eligibility process.	Proposes standards regarding a certification program pursuant to the Secretary's authority to establish a program for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions in accordance with section 1411 of the Affordable Care Act. We propose that the certification to the employer will consist of methods adopted by the Secretary of Treasury as part of the determination of potential employer liability under section 4980H of the Code. Proposes changes that correspond to the change in §155.335 that specifies that the Exchange will redetermine eligibility on an annual basis for all qualified individuals, not only enrollees.

Regulatory Section	Provision	Proposed Rule Summary
§155.315	Verification process related to eligibility for enrollment in a QHP through the Exchange.	Clarifies that a response from SSA that indicates that an applicant is deceased will be treated like a SSN validation failure. Proposes to modify the verification process such that when required electronic data are required but not immediately available, the Exchange will wait two days prior to requesting additional information from an individual. Proposes the verification processes related to eligibility to enroll through the Exchange in a QHP that is a catastrophic plan (concerning both age and exemption from the shared responsibility payment in specified categories), and specifies that an applicant would not receive eligibility to enroll through the Exchange in a QHP that is a catastrophic plan until verification of necessary information can be completed.

Regulatory Section	Provision	Proposed Rule Summary
§155.320	Verifications related to eligibility for insurance affordability programs.	Proposes that the Exchange incorporate SSA benefits when verifying annual household income for MAGI purposes. Proposes to clarify when additional verification is necessary to substantiate an expected increase in projected annual household income. Proposes to clarify the circumstances under which annualized current income data will be sufficient to support an expected decrease in projected annual household income (using the same 10% threshold from the Exchange final rule that is used when comparing with annual income data). Proposes that the Exchange verify that neither advance payments of the premium tax credit nor cost-sharing reductions are already being provided on behalf of an individual, serving an important program integrity function. Proposes the process for verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. Proposes the data sources the Exchange will use as a part of this verification. In most cases, proposes that if an applicant's attestation is not reasonably compatible with the information obtained through accepted data sources, the Exchange will follow the procedures specified in §155.315(f). Proposes that if the Exchange does not have any data from the specified data sources for an applicant, or for data regarding employment that is not reasonably compatible with an applicant's attestation, the Exchange must select a statistically significant random sample and contact employers to obtain necessary information. Also proposes that the Exchange may rely on HHS to conduct this verification.

Regulatory Section	Provision	Proposed Rule Summary
§155.330	Eligibility redetermination during a benefit year.	Proposes to clarify that the Exchange will only conduct periodic data matching regarding Medicare, Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, for an enrollee on whose behalf APTC or CSR are being provided. Proposes modifying the procedures the Exchange would follow for data matching that indicates that an individual is deceased, such that the Exchange will modify eligibility to account for the data after 30 days without a response to the notice sent by the Exchange. Proposes modifying the eligibility effective dates, including to accommodate changes as a result of eligibility appeals decisions, and changes that affect only enrollment or premiums, but do not affect eligibility, in order to more closely align with enrollment effective dates. Proposes to provide additional flexibility related to eligibility effective dates in situations of errors, contract violations, and other exceptional circumstances.
§155.335	Annual eligibility redetermination.	Proposes that the Exchange conduct an annual eligibility redetermination for all qualified individuals, not only those who are enrolled in a QHP. Proposes that if a qualified individual does not select a QHP prior to redetermination or is not enrolled in a QHP through the Exchange during a benefit year for which such redetermination is made, the Exchange will not conduct a redetermination of his or her eligibility for the subsequent benefit year.
§155.340	Administration of advance payments of the premium tax credit and cost-sharing reductions.	Proposes to amend provisions to change cross-references from section 36B of the Internal Revenue Code to implementing regulations at 26 CFR 1.36B.

Regulatory Section	Provision	Proposed Rule Summary
§155.345	Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan.	Proposes enhanced coordination and communication between the Exchange and state Medicaid/CHIP agencies. Proposes a phased-in approach for the use of combined eligibility notices, with a January 1, 2015 deadline for Exchanges to implement the use of a combined eligibility notice. Proposes that the agreement the Exchange enters into with agencies administering insurance affordability programs addresses the responsibilities of each agency to, as of January 1, 2015, in order to provide for a combined eligibility notice (to the extent feasible) promptly and without undue delay to an applicant and the members of his or her household. Proposes that prior to January 1, 2015, the Exchange include coordinated content into the notice of eligibility determination provided to the individual when state Medicaid/CHIP agencies transfer an individual's account to the Exchange, or that the Exchange issue a combined eligibility notice when the Exchange is the last agency to make an eligibility determination, except for an eligibility determination for Medicaid on a non-MAGI basis. Proposes to amend provisions to change cross-references from section 36B of the Internal Revenue Code to implementing regulations at 26 CFR 1.36B.
§155.350	Special eligibility standards and process for Indians.	Proposes to amend provision to change cross-references from section 36B of the Internal Revenue Code to implementing regulations at 26 CFR 1.36B-1(e).
§155.400	Enrollment of qualified individuals into QHPs.	Proposes that the Exchange would send HHS updated information concerning all enrollment-related transactions.
§155.420	Special enrollment periods.	Proposes clarifications regarding special enrollment periods, additional flexibility in enrollment effective dates related to specified events (errors, contract violations, and exceptional circumstances), clarifications regarding the applicability of special enrollment periods to family members, and a new special enrollment period for those enrolled in an eligible employer-sponsored plan that does not provide qualifying coverage (and who are allowed to terminate their existing coverage).
§155.430	Termination of coverage.	Proposes an additional coverage termination option for enrollees gaining access to other minimum essential coverage.

Regulatory Section	Provision	Proposed Rule Summary
§155.500	Definitions.	Proposes definitions for: "appeal record," "appeal request," "appeals entity," "appellant," "de novo review," "evidentiary hearing," and "vacate."
§155.505	General eligibility appeals requirements.	Proposes that the provisions of this subpart apply to Exchange eligibility appeals processes, regardless of whether the appeals process is provided by a state-based Exchange appeals entity or HHS. Proposes the determinations and redeterminations that are subject to appeal, including those found in §155.305(a)-(h) as well as determinations for exemptions and a failure by the Exchange to provide timely notice of an eligibility determination or redetermination. Proposes that Exchange eligibility appeals may be conducted by the Exchange, if it establishes an appeals process, or by HHS upon exhaustion of the Exchange appeals process or if the Exchange has not established an appeals process. Proposes standards for entities eligible to provide appeals. Proposes standards for the use of authorized representatives, accessibility requirements, and the availability of judicial review.
§155.510	Appeals coordination.	Proposes that the appeals entity or the Exchange must enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes for such programs as are necessary to fulfill the requirements of this subpart. Proposes that appellants must be informed of the opportunity to opt into having his or her appeal of an adverse Medicaid or CHIP determination made by the Exchange heard directly by the Medicaid or CHIP agency. Proposes standards for coordinating with Medicaid and CHIP agencies in situations where these agencies delegate or do not delegate appeals authority to the Exchange appeals entity. Proposes standards for data exchanges as part of the appeals process.

Regulatory Section	Provision	Proposed Rule Summary
§155.515	Notice of appeal procedures.	Proposes that notice of appeal procedures be provided at the time of application and in the eligibility determination notice. Also proposes content that should be included in these notices, including an explanation of the appellant's appeal rights, a description of the procedures by which the applicant or enrollee may request an appeal, information on representation during the appeal, an explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated during the appeal, and an explanation that an appeal decision for one household member may result in a change in eligibility for other household members.
§155.520	Appeal requests.	Proposes that the Exchange and appeals entity must accept appeal requests submitted by telephone, mail, in person (if the Exchange or appeals entity is capable of receiving in-person requests), or via the internet. Proposes that the Exchange or the appeals entity must send an acknowledgement of the appeal request to the appellant. Also proposes that where the appeal request is initially received by the Exchange, the Exchange must transmit the appeal request to the appropriate appeals entity and provide access to the appellant's record. If the appeal request is initially received by the appeals entity, the appeals entity must notify the Exchange of the request and request the appellant's record.
§155.525	Eligibility pending appeal.	Proposes that eligibility may be maintained or reinstated during the course of the appeal.
§155.530	Dismissals.	Proposes that an appeal may be dismissed if the appellant withdraws the request in writing, fails to appear at a scheduled hearing, fails to submit a valid appeal request, or dies while the appeal is pending. Also proposes that a dismissal may be vacated if the appellant demonstrates a good cause reason in writing within 30 days of the date of the dismissal.

Regulatory Section	Provision	Proposed Rule Summary
§155.535	Informal resolution and hearing requirements.	Proposes that HHS will provide an opportunity for informal resolution and that a state-based Exchange appeals entity may provide an opportunity for informal resolution. Proposes that the appellant's right to a hearing is preserved if the appellant remains dissatisfied with the outcome of the informal resolution and that, otherwise, decisions from informal resolution are final and binding. Proposes standards for providing a notice of hearing and for conducting a hearing. Also proposes the procedural rights of the appellant, the scope of information to be considered in an appeal decision, and the standard of review.
§155.540	Expedited appeals.	Proposes that the appeals entity must establish and maintain an expedited appeals process for appellants who have an immediate need for health services and a standard appeal could seriously jeopardize the appellant's life or health, or ability to attain, maintain, or regain maximum function. Also proposes that a request for an expedited appeal which is denied should be handled under the standard process .
§155.545	Appeal decisions.	Proposes the information, evidence, and rules on which an appeal decision must be based. Also proposes the content of the appeal decision and standards for providing notice of the appeal decision to the appellant and the Exchange or Medicaid or CHIP agency, as applicable. Proposes standards for implementing appeal decisions, including retroactive implementation to remedy an incorrect eligibility determination, where applicable. Proposes the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility is affected by an appeal decision be treated as redeterminations.
§155.550	Appeal record.	Proposes standards for the appellant's and the public's access to appeal records, subject to privacy, confidentiality, and disclosure laws.

Regulatory Section	Provision	Proposed Rule Summary
§155.555	Employer appeals process.	Proposes implementing 1411(f)(2) of the ACA so that employers may, in response to a notice under §155.301(h), appeal a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide coverage but it is not affordable coverage with respect to an employee. Proposes that states will be offered the flexibility to establish a state-based appeals process for employer appeals and HHS will provide the process if the state does not opt to do so. However, employers may not elevate appeals to HHS from a state-based appeals process. Proposes employers may request an appeal within 90 days from the date of the notice informing them of their potential liability is sent. Proposes that employers and employees have the opportunity to submit additional information to be reviewed as part of the appeal. Proposes that the appeals entity may provide the employer with a specific set of information regarding the employee (to the extent allowable by law), including the employee's name, whether the employee is eligible for APTC/CSR, and information regarding whether the employee's income is above or below the threshold by which the affordability of employer-sponsored MEC is measured. Proposes that the appeal will be reviewed by an impartial official who has not been involved with the eligibility determination as a desk review. Proposes that the appeal decision must be issued within 90 days from the date the appeal request is received. If the decision impacts the employee's eligibility, it will be treated as a redetermination.

Regulatory Section	Provision	Proposed Rule Summary
§155.705	Functions of a SHOP.	Proposes that the SHOP will provide data to the corresponding individual market Exchange to support verifications for enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan.
§155.740	SHOP eligibility appeals process.	Proposes that small business employers and employees may appeal a denial of eligibility or a failure of the SHOP to make a determination in a timely manner. Proposes that any state that operates a SHOP also be required to operate the SHOP appeals process (SHOP appeals will not elevate to HHS). And proposes that HHS will provide the appeals process for states that do not operate a SHOP. Proposes that appeal requests must be made within 90 days from the date the eligibility determination notice is sent. Proposes that employers and employees have the opportunity to submit additional information to the appeals entity to be reviewed as part of the appeal. Proposes that the appeal will be reviewed by an impartial official who has not been involved with the eligibility determination as a desk review. Proposes that the appeals entity must issue a written decision within 90 days from the date the appeal request is received.

MEDICAID

Regulatory Section	Provision	Proposed Rule Summary
§430.12	Submittal of State plans and plan amendments.	Proposes that States use the newly created automated format for submission of state plan amendments, replacing previous paper-based documents. States would have up to one year from the automated template release to transition to the new system.
§431.10	Single state agency.	Adds definitions of "Medicaid agency," "Appeals decision," Exchange," and "Exchange appeals entity." Proposes that the Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings only to a government agency which maintains personnel standards on a merit basis. This is a modification to our previous final rule issued on March 23, 2012 related to delegation of authority of eligibility determinations. Proposes that authority to conduct fair hearings may be delegated to an Exchange or Exchange appeals entity (FFE or SBE), provided individuals have the choice to have their hearing conducted by the Medicaid agency. Delegations must be subject to safeguards to protect the integrity of those processes.
§431.11	Organization for administration.	Proposes to delete the requirements for the state plan to provide for a medical assistance unit within the Medicaid agency, as well as for certain detailed requirements regarding the organization, the types, numbers and responsibilities of professional medical personnel used in the administration of the plan.
§431.200 §431.201	Basis and scope. Definitions.	Proposes to revise the definition of "action" as it relates to adverse actions taken by the state to include a termination, suspension, or reduction of Medicaid eligibility or a reduction in the level of benefits and services, or a determination of income for the purposes of imposing cost sharing. Defines "local evidentiary hearing" as a hearing held on the local or county level serving a specified portion of the state.
§431.205	Provisions of hearing system.	Proposes to align the fair hearing rules related to the entity that may have authority to conduct Medicaid fair hearings to include an Exchange. Proposes that information about the hearing must be accessible to persons who are limited English proficient and persons with disabilities, consistent with our accessibility policy proposed in §435.905(b).

Regulatory Section	Provision	Proposed Rule Summary
§431.206	Informing applicants and beneficiaries.	Proposes that states that choose to delegate fair hearings to an Exchange must inform individuals of this choice and the method by which an individual makes such an election. Clarifies that notices of adverse action must be provided when an individual is denied eligibility or benefits. Proposes that notices and communications be accessible to people who are limited English proficient and persons with disabilities consistent with our accessibility policy at §435.905(b) and may be offered in an electronic format with proposed regulation §435.918.
§431.210	Content of notices.	Proposes that notices include a statement of the action the agency or facility intends to take, the effective dates and reasons for that action. Clarifies that an individual would be provided an explanation of the individual's right to request a local evidentiary hearing if one is available or a State agency hearing.
§431.211 §431.213 §431.230	Advance notice. Exceptions from advance notice.	Modifies language related to "mailing" a notice to "sending" a notice to align with our proposed regulation at §435.918 related to permitting choice of how to receive electronic notices.
§431.220 §431.241	When a hearing is required. Hearing and matters to be considered at the hearing.	Proposes to clarify that opportunities for a hearing and matters to be considered at the hearing include denial of eligibility, level of benefits, services or claims, including that determinations of the amount of medical expenses which must be met to establish eligibility or a determination of income for the purposes of imposing cost sharing. Aligns with the proposed definition of action at §431.201.
§431.221	Request for a hearing.	Proposes that the agency establish procedures to permit an individual or an authorized representative to submit a hearing request by telephone, mail, in-person, or through other commonly available electronic means, and at state option through an internet website. Proposes if an individual has been denied eligibility for Medicaid by the agency or other authorized entity, the agency must treat an eligibility appeal to the Exchange appeals entity as a request for a hearing.
§431.224	Expedited appeals.	Proposes that each agency establish and maintain and expedited review process for hearings if the standard time for a hearing could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function.

Regulatory Section	Provision	Proposed Rule Summary
§431.231 §431.232	Reinstating services. Adverse decision of local evidentiary hearing	Proposes to align the timeframe of the notice rules with the reasonable opportunity period notice rule at §435.956. Proposes that the date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows that they did not receive the notice within the five-day period. Proposes to align the new terminology of "sending" a notice with other notice regulations.
§431.232	Adverse decision of local evidentiary hearing.	Clarifies that an agency will inform an applicant or beneficiary that they have ten days from the notice of an adverse decision following a fair hearing to appeal the decision.
§431.240	Conducting the hearing.	Proposes to specify that a hearing officer must have access to the agency's information, such as state policies and regulations necessary to ensure a proper hearing decision.
§431.242	Procedural rights of the applicant or beneficiary.	Proposes that an individual must have access to his or her electronic account, in the same manner as for a case file review prior to a fair hearing. Proposes to align the procedural rights for individuals who request a hearing with those available for individuals who request an expedited hearing.
§431.244	Hearing decisions.	Clarifies that the 90-day timeframe to issue a decision after an individual files an appeal is not limited to managed care appeals decisions. Proposes to permit that a decision of the Medicaid fair hearing be issued within 45 days from the date the Exchange appeals entity issues an appeal decision relating to coverage through the Exchange. Proposes to modify the appeals decision timeframe to account for the expedited appeals process being proposed at §431.224, aligning it with current timeframes in place for expedited managed care appeals decisions.
§433.138	Identifying liable third parties.	Proposes to update or eliminate references to verification regulations which were eliminated or revised in the Medicaid eligibility final rule.
§433.145	Assignment of rights to benefits-State plan requirements.	Proposes technical corrections to update references to pregnant women eligibility as promulgated in the March 2012 Medicaid Eligibility final rule.

Regulatory Section	Provision	Proposed Rule Summary
§433.147	Cooperation in establishing paternity and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be liable to pay.	Technical corrections, including, removing references to obsolete regulations.
§433.148	Denial or termination of eligibility.	Builds on current practice among states to enforce the cooperation requirements of section 1912 of the Act to establish paternity and obtain medical support payments post-enrollment in order to coordinate with other insurance affordability programs that do not have the same requirement.
§433.152	Requirements for cooperative agreements for third party collections.	Technical correction to remove references to obsolete regulations.
§435.3	Basis.	Proposes to revise language regarding implementing 1903(v) of the Act, which provides for optional coverage of lawfully residing children and pregnant women in Medicaid and payment for emergency services under Medicaid provided to certain non-citizens.
§435.4	Definitions	Adds definitions of "citizenship," "combined eligibility notice," "coordinated content," "lawfully present," "non-citizen," and "qualified non-citizen." Proposes to revise the definition of "electronic account."
§435.110	Parents and other caretaker relatives.	Proposes to revise §435.110to require that states' minimum income standard for this group, which is the state's AFDC payment standard in effect as of May 1, 1988 for the applicable family size, be converted to a MAGI-equivalent income standard for 2014. The Medicaid eligibility final rule did not require conversion of the minimum standards.

Regulatory Section	Provision	Proposed Rule Summary
§435.112	Families with Medicaid eligibility extended because of increased earnings or hours of employment.	Proposes to revise for consistency with MAGI the existing provision for a 4-month Medicaid extension due to increased earnings that is superseded by Transitional Medical Assistance (TMA) under section 1925 of the Act and will take effect if TMA sunsets at the end of 2013.
§435.113	Removed	Proposes to delete the obsolete provision at §435.113 for individuals who are ineligible for AFDC because of requirements that do not apply under title XIX of the Act.
§435.114	Removed	Deletes the obsolete provision at §435.114 for individuals who would be eligible for AFDC except for increased OASDI income.
§435.115	Families with Medicaid eligibility extended because of increased collection of spousal support.	Proposes to revise for consistency with MAGI the current 4-month Medicaid extension for low-income families eligible under §435.110 and section 1931 of the Act who would otherwise lose coverage due to increased income from collection of child or spousal support. The proposed rule would limit this requirement to spousal support because child support will not be counted as income under MAGI. Deletes the obsolete paragraphs relating to individuals "deemed to be receiving AFDC" and relating to eligibility for children receiving assistance under title IV-E of the Act as duplicative of §435.145.
§435.116	Pregnant Women	Proposes to revise §435.116 to require that the minimum income for full coverage of pregnant women, which is the State's AFDC income standard in effect as of May 1, 1988 for the applicable family size, be converted to a MAGI-equivalent standard. The eligibility final rule did not require for this minimum income standard to be converted for MAGI.
5.117	Deemed newborn children.	Revises existing provision to codify revisions related to deemed newborn eligibility included in CHIPRA so that newborns remain eligible until the child's first birthday regardless of whether the mother would remain eligible if still pregnant, and whether the infant is in the mother's household. Medicaid deemed newborn provision is amended to address the requirement for deemed newborn eligibility under the Medicaid or CHIP state plan for a child born to a mother covered under the CHIP state plan as a targeted low-income pregnant woman. State option to provide deemed newborn eligibility to a child if the child's mother was covered by Medicaid in another state, as a child under CHIP, or under an 1115 waiver.

Regulatory Section	Provision	Proposed Rule Summary
§435.145	Children with adoption assistance, foster care, or guardianship care under title IV-E.	Revises current provision to add the statutory requirement for Medicaid eligibility for children receiving guardianship assistance maintenance payments under title IV-E of the Act.
§435.150	Former foster care children.	Codifies the Affordable Care Act's requirement for a new Medicaid eligibility group for former foster care children who are under age 26 under section 1902(a)(10)(A)(i)(IX) of the Act. Such individuals qualify for Medicaid if they are not eligible and enrolled for mandatory coverage (except that this group supersedes the adult group) and were in foster care and Medicaid upon reaching the age of 18 or the higher age at which the state's or tribe's foster care assistance ends. States would have the option to cover individuals under this group if they were in foster care and Medicaid at the relevant point in time in **any** state.
§435.170	Pregnant women eligible for extended or continuous eligibility.	Proposes to revise the existing regulation for consistency with the statutory requirements at sections 1902(e)(5) and (6) of the Act for extended or continuous eligibility of pregnant women for pregnancy-related services through the last day of the month in which the 60-day post-partum period ends.
§435.213	Individuals needing treatment for breast or cervical cancer.	Adds a new section to codify section 1902(a)(10)(A)(ii)(XVIII)of the Act, which provides states with the option to cover individuals (women and men) needing treatment for breast or cervical cancer.
§435.214	Eligibility for Family Planning Services.	Proposes to give states the option to provide Medicaid coverage limited to family planning or family planning-related services under the state plan. Individuals who are not pregnant and have incomes that do not exceed the income eligibility level established by the state would be eligible for coverage.

Regulatory Section	Provision	Proposed Rule Summary
§435.215	Individuals Infected with Tuberculosis.	Medicaid eligibility may be provided to individuals who are infected with tuberculosis, are not otherwise eligible for mandatory coverage under the Medicaid state plan and have income and resources that do not exceed the maximums for disabled individuals.
§435.220	Optional eligibility for parents and other caretaker relatives.	Proposes a separate provision at §435.220 for optional coverage of parents and other caretaker relatives who meet the income standard established by the state, to be converted to MAGI in 2014.
§435.222	Optional eligibility for reasonable classifications of individuals under age 21.	Revises existing regulation for optional eligibility of reasonable classifications of children under age 21 (or, at state option, under age 20, 19, or 18) who meet certain income standards, to be converted to MAGI in 2014.
§435.223	Removed	Proposes to delete the obsolete provision at §435.223 for individuals who would be eligible for AFDC if coverage under the state's AFDC plan were as broad as allowed under title IV-A of the Act.
§435.226	Independent foster care adolescents.	Proposes to codify the existing optional eligibility group for independent foster care adolescents--individuals under age 21 (or, at state option under age 20 or 19) who were in foster care on their 18th birthday and meet the income standard established by the state.
§435.227	Individuals under age 21 who are under State adoption assistance agreements.	Revises for consistency with the MAGI income conversion requirements the existing regulation for optional Medicaid eligibility for children with a non-IV-E state adoption assistance agreement in effect.
§435.229	Optional targeted low-income children.	Proposes to revise for consistency with the MAGI income conversion requirements the existing regulations for optional Medicaid eligibility for individuals under age 19 (or at state option within a range of ages under 19) who meet the definition of optional targeted low-income child and meet the income standard established by the state.
§435.301	General rules.	Proposes to remove the provision that provided that babies born to medically needy pregnant women receive deemed newborn eligibility as a medically needy child. These babies will receive coverage under revised §435.117. Revises the definition of "specified relatives" to "parents and other caretaker relatives."

Regulatory Section	Provision	Proposed Rule Summary
§435.310	Medically needy coverage of parents and other caretaker relatives.	Proposes that if a state provides Medicaid coverage to the medically needy, it may also provide coverage to parents and other caretaker relatives who meet the "caretaker relative" definition and the medically needy income and resource requirements.
§435.401	General rules.	Revises existing regulation to remove the obsolete reference to requirements for Medicaid families and children's groups as based on the state's AFDC plan.
§435.406	Citizenship and non-citizen eligibility.	Proposes to modify who can declare citizenship or immigration status on behalf of another person to align with who can file an application for enrollment under §435.907. Proposes that states must verify the citizenship of individuals declaring to be citizens in accordance with §435.956 and codifies section 211 of CHIPRA by adding deemed newborns as exempt from the citizenship verification requirements. Requires that states exempt individuals who are deemed newborns in Medicaid and CHIP in another state. Proposes to permit states to provide Medicaid coverage to children, pregnant women, or both who are lawfully residing in the United States, and otherwise eligible for Medicaid as allowed by section 214 of CHIPRA and clarifies who is eligible to receive coverage for an emergency medical condition.
§435.407	Types of acceptable documentary evidence of citizenship.	Proposes to simplify and consolidate the tiers and the types of acceptable documents that can be used to provide evidence of citizenship and identity for Medicaid and CHIP eligibility when paper documentation is required.
§435.510	Removed	Proposes to delete the obsolete provision at §435.510 related to determinations of dependency with its reference to AFDC requirements.
§435.522	Removed	Proposes to delete the obsolete provision at §435.522 regarding determination of age for the AFDC and SSI programs.
§435.603	Application of modified adjusted gross income (MAGI).	Proposes revising the applicability of the 5 percent across-the-board disregard to apply to determining eligibility on the basis of MAGI but not in determining the particular eligibility category under which someone is covered, clarifying the exception from MAGI methods for individuals needing long-term care services, and simplifying language referring to natural, adopted and step parents, siblings and children.

Regulatory Section	Provision	Proposed Rule Summary
§435.610	Assignment of rights to benefits.	Builds on current practice among states to enforce the cooperation requirements of section 1912 of the Act to establish paternity and obtain medical support payments post-enrollment in order to coordinate with other insurance affordability programs that do not have the same requirement.
§435.831	Income eligibility.	Proposes a new method for determining medically needy eligibility for individuals under age 21, pregnant women, and parents and other caretaker relatives.
§435.905	Availability of program information.	Proposes to clarify that the provision of language services for individuals who are limited English proficient includes oral interpretation, written translations, and taglines. Additionally, proposes to require the state to inform individuals of availability of these services, and how to access them.
§435.907	Application.	Adds a new provision that states must reinstate a withdrawn application if such application was withdrawn following an assessment of ineligibility by the Exchange and potential eligibility for Medicaid by the Exchange appeals entity. The application would be reinstated effective on the date the application was first received by the Exchange.
§435.908	Certified Application Assistance with application and renewal.	Proposes standards for states electing the option to certify providers and other organizations to assist applicants and beneficiaries with the application and renewal process, including use of a designated web portal and compliance with applicable laws and regulations related to confidentiality and preventing conflicts of interest.
§435.909	Automatic entitlement to Medicaid following a determination of eligibility under other programs.	Proposes to delete references to automatic eligibility for Medicaid following a determination of eligibility for cash assistance under the former AFDC.
§435.910	Use of social security number.	Technical correction reinstating the reference to the verification of social security numbers with SSA, which was inadvertently deleted in the Medicaid eligibility final rule.

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§435.911	Determination of eligibility.	Technical correction to update references to the reasonable opportunity period in §435.956(g) and clarify that the period includes the state completing the verification process, as well as an individual providing documentation. Makes technical changes to include parents/caretaker relatives who are elderly or eligible for Medicare in the "MAGI screen" so that their eligibility as a parent or caretaker relative can be quickly determined using MAGI-based income.
§435.917	Notice of agency's decision concerning eligibility.	Proposes that states provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including denial, termination or suspension of eligibility, or denial or change in benefits and services. Notices must be written in plain language, be accessible to persons who are limited English proficient and individuals with disabilities, and if provided in electronic format, comply with §435.918. The proposed rule lays out the content that would be included in the notice of eligibility as well as the notice of adverse action including denial, termination, or suspension of eligibility or a change in benefits and services.
§435.918	Use of electronic notices.	Proposes that applicants and beneficiaries have the option to receive notices in electronic format or by regular mail. Lays out proposed requirements for electronic communications.
§435.923	Authorized Representative	Proposes standards and procedures to ensure applicants and beneficiaries can authorize a representative to act on their behalf during and between the application and renewal process.
§435.926	Continuous eligibility for children.	Proposes to add a new section §435.926 to codify section 1902(e)(12) of the Act, which provides states with the option to provide up to 12 months of continuous eligibility for children under age 19, or a younger age selected by the state, once they are determined eligible for Medicaid, regardless of changes in income or other circumstances throughout that time period with certain exceptions. The state specifies in the state plan the length of a continuous eligibility period, not to exceed 12 months.

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§435.952	Use of information and requests of additional information from individuals.	Proposes to align Medicaid and Exchange policy by permitting self-attestation on a case-by-case basis in special circumstances for individuals who do not have access to documentation (e.g. individuals who have experienced domestic violence or a natural disaster, or homeless individuals). The exception would not apply if documentation is specifically required under statute or regulation, such as in the case of verifying citizenship and immigration status.
§435.956	Verification of other non-financial information.	Proposes to codify the requirement to verify citizenship and immigration status through the federal data services hub before resorting to other verification processes as required by §435.949. Would establish the reasonable opportunity period for individuals while verification is being conducted and require benefits during that period, if the individuals meets all other eligibility criteria. The reasonable opportunity period would be 90 days for all verification of citizenship, whether done through the hub, SSA, or other electronic data source, or if SSA identifies an inconsistency, as well as for immigration status. States would have the option to extend the period beyond 90 days based on a "good faith effort" to provide information.
§435.1001	FFP for administration.	Proposes to revise the current provision, which only mentions administrative costs for presumptive eligibility for children, to specify generally that the federal government will provide funding for the administration of presumptive eligibility.
§435.1002	FFP for services.	Proposes to revise the current provision, which specifies that FFP be available for expenditures for services that are covered under the plan that are furnished during a presumptive eligibility period to children determined to be presumptively eligible, in order to specify that the federal government will provide funding for all individuals determined to be presumptively eligible.
§435.1004	Beneficiaries overcoming certain conditions of eligibility.	Revises the existing provision to delete obsolete references to AFDC.

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§435.1008	FFP in expenditures for medical assistance for individuals who have declared citizenship or nationality or satisfactory immigration status.	Proposes revisions to reflect that states are entitled to receive Federal Financial Participation (FFP) for benefits provided to individuals declaring U.S. citizenship or satisfactory immigration status during the reasonable opportunity period, regardless of whether eligibility ultimately is approved.
§435.1015	Premium Assistance for Plans in the Individual Market.	Proposes to establish new rules regarding premium assistance for individual non-group coverage, which does not currently exist in regulation for individual coverage. Proposes that the same coverage protections, including the requirement that a state demonstrate cost effectiveness that apply to premium assistance options for group coverage, apply to this option.
§435.1100 §435.1101	Basis for presumptive eligibility. Definitions related to presumptive eligibility for children.	Proposes to revise the current regulation, which only addresses presumptive eligibility (PE) for children, to establish the basis for all types of PE, including those added by the Affordable Care Act.
§435.1102	Children covered under presumptive eligibility.	Revises the current regulation for consistency with the requirements proposed for the other types of PE.
§435.1103	Presumptive eligibility for other individuals.	Adds a new section to codify the existing statutory requirements at section 1916 of the Act.
§435.1110	Presumptive eligibility determined by hospitals.	Proposes to add a new section to codify the requirements for this new presumptive eligibility option for hospitals provided by the Affordable Care Act. The Affordable Care Act gives hospitals the option to determine, on the basis of preliminary information and according to policies and procedures established by the state Medicaid agency, whether an individual meets the requirements to be covered for a presumptive eligibility period under the state's Medicaid state plan or 1115 demonstration. Proposes requirements for hospitals that choose to do presumptive eligibility and permits states to limit the types of presumptive eligibility that hospitals can perform.

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§435.1200	Medicaid agency responsibilities for coordinated eligibility and enrollment process with other insurance affordability programs.	To the maximum extent feasible, we propose that, effective January 1, 2015, individuals will receive a single notice communicating the determination or denial of eligibility for all applicable insurance affordability programs and for enrollment in a QHP through the Exchange, rather than separate notices from the Medicaid and/or CHIP agencies and the Exchange. We propose to include the provision of a combined eligibility notice and coordinated content when a combined notice is not feasible, in the agreements with the Exchange, Exchange appeals entity and the agencies administering other insurance affordability programs. In the absence of a combined eligibility notice, we propose that coordinated content is required to ensure that applicants and beneficiaries are informed of the status of their application with respect to other insurance affordability programs. Proposes provisions to coordinate appeals processes for states that either delegate authority to conduct appeals to an Exchange or retain the appeals function to reduce administrative and consumer burden.
§435.1205	Alignment with Exchange Initial Open Enrollment Period.	Proposes that during the period of October 1, 2013 to January 1, 2014, state Medicaid and CHIP agencies would accept the single streamlined application in use by the, as well as electronic accounts of individuals submitting applications to and transferred by the Exchange, and generally fulfill the responsibilities set forth in §435.1200 to effectuate enrollment of individuals in the appropriate insurance affordability program effective January 1, 2014. For eligibility effective in 2013, proposes that states either use the single streamlined application or in the electronic account, requesting any additional information from the individual needed, or inform the individual of the opportunity to submit a separate application and information on how to do so.
§440.130	Diagnostic, screening, preventive, and rehabilitative services.	Proposes to change language that limits preventive services "provided by" to "recommended by" a physician or other licensed practitioner to align with statute.
§440.305	Scope.	Establishes requirements for states to offer alternative benefit plans (benchmark and benchmark-equivalent plans) and specifies that targeting criteria must be made based on characteristics of the people served through this provision not on federal matching funding. Requires that people in the new adult group must receive benefits through alternative benefit plans. Establishes the applicability of exemptions from mandatory benchmark/benchmark equivalent plan enrollment to the new VIII group.

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§440.315	Exempt individuals.	Updates the definition of medically frail. Adds individuals in the former foster care children eligibility group to the list of eligibility groups that can only be voluntarily enrolled in a benchmark or benchmark-equivalent plan.
§440.330	Benchmark health benefits coverage.	Broadens Secretarial approved coverage from benefits of the type that are available under 1 or more of the standard benchmark coverage packages and state plan benefits described in section 1905(a), to include 1915(i), 1915(j), 1915(k) or section 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in 45 CFR §156.100.
§440.335	Benchmark-equivalent health benefits coverage.	Adds prescription drugs and mental health benefits as required benefits within benchmark-equivalent plans. Also adds the same options as added to 440.330 as choices for states to cover through Secretary-approved coverage within the benchmark-equivalent option of section 1937.
§440.345	EPSDT and Other Required Benefits.	Establishes required coverage of family planning, mental health parity and essential health benefits within alternative benefit plans. Establishes timeframes for updating of benefits.
§440.347	Essential Health Benefits	Lists the essential health benefits that must be included in alternative benefit plans. Establishes process by which states establish essential health benefits within the alternative benefit plans. States may select more than one option for establishing essential health benefits in different alternative benefit plans. Essential health benefits must be non-discriminatory by design.
§440.360	State plan requirements for providing additional services.	Except for people eligible through the new adult group, additional benefits may be selected from one or more of the standard benchmark coverage packages described in §440.330(a-c) or State plan benefits including those described in sections 1905(a), 1915(i), 1915(j), 1915(k) and 1945 of the Act and any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in section §156.100.

Regulatory Section	Provision	Proposed Rule Summary
§440.386	Public Notice.	Changes public notice requirements so that public notice takes place no less than 2 weeks prior to submission of any SPA that seeks to provide coverage that is less than the coverage provided by the State's approved State plan or includes cost sharing of any type or modifies an approved alternative benefit plan by adding or increasing cost-sharing, or reducing benefits. Public notice must take place prior to the implementation of any SPA that seeks to establish an Alternative Benefit Plan that provides the same or more benefits than currently are provided in the State's approved State plan or modifies an approved Alternative Benefit Plan by reducing cost-sharing or adding additional benefits.
§447.50-64	Medicaid premiums and cost sharing	We replace the current premium and cost sharing rules at 42 CFR 447.50-82 to consolidate the cost sharing rules between the two statutory authorities -1916 and 1916A and make it clear what cost sharing is allowed for individuals with income under 100 percent of the FPL and what flexibilities exist for imposing premiums and cost sharing on individuals with higher income.
§447.50	Premiums and cost sharing: Basis and purpose	Provides the statutory basis for the Medicaid premiums and cost sharing - Sections 1902(a)(14), 1916 and 1916A of the Act
§447.51	Definitions	Add definitions for premiums, cost sharing, preferred drugs, emergency and non-emergency services, and alternative non-emergency service provider,
§447.52	Cost sharing	We propose to change the nominal maximum cost sharing amount to be a flat $4 for outpatient services versus being based on what the agency pays for the service (current maximums range from $.60 to $3.90). We also freeze the next CPI-U increase of the maximum allowable amount until October 2015.
§447.53	Cost sharing for drugs	Proposes to change the nominal amounts for preferred drugs to a flat $4 amount and $8 for non-preferred drugs for individuals with income at or below 150% of the FPL
§447.54	Cost sharing for services furnished in a hospital emergency department	Proposes to change the nominal amounts for non-emergency use of the emergency department to a flat $8 for individuals with income at or below 150% of the FPL

Regulatory Section	Provision	Proposed Rule Summary
§447.55	Premiums	Consolidates the allowable premiums under 1916 and 1916A. We propose a slight modification to the option under section 1916 of the Act to impose premiums on pregnant women to only allow premiums if their income exceeds 150 percent of the FPL versus at or above 150 percent of the FPL to align with other allowable premiums. In addition we are removing the reference to infants under age one described in 1902(l)(1)(B) on whom the state may impose premiums under 1916 because they are included in the group of children who may be charged premiums under 1916A of the Act. Finally, we are revising requirements related to premiums imposed on medically needy individuals whose income is under 150 percent of the FPL to remove the current income-related scale and provide states with the flexibility to determine their own sliding scale for establishing premiums for the medically needy up to a maximum of $20 instead of the $19 in current regulation.
§447.56	Limitations on premiums and cost sharing	We propose one single section that describes the general premium and cost sharing limitations and provide for a streamlined approach wherever the policies align between 1916 and 1916A. We propose to apply the exemption under 1916A for individuals covered under Breast and Cervical Cancer Treatment and Prevention Program to apply to all premiums and cost sharing and to extend it to men to align with the new eligibility rules. We propose that those Indians who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services are exempt from all cost sharing. We propose to revise the exemption for pregnancy-related services so that all services provided to pregnant women shall be considered pregnancy-related unless specifically identified in the state plan as not pregnancy-related. We are also codifying the requirement in the Affordable Care Act to exempt smoking cessation counseling and drugs for pregnant women from cost sharing. We update the requirements around aggregate limits for premiums and cost sharing to be based on the Medicaid household as defined in §435.603(f) of the Medicaid eligibility final rule and revised in this proposed rule.

Regulatory Section	Provision	Proposed Rule Summary
§447.57	Beneficiary and public notice requirements	We slightly modify the requirements related to beneficiary, provider and public notice of premiums and cost sharing to ensure that the notice is in a format that beneficiary or provider would likely have been made aware of the premium or cost sharing changes and are provided with opportunity to comment on proposed changes in certain cases.

CHIP

Regulatory Section	Provision	Proposed Rule Summary
§457.10	Definitions and use of terms.	Proposes definitions for CHIP for "combined eligibility notice," "coordinated content," "electronic account," and "Exchange appeals entity," consistent with the definitions proposed for Medicaid in §435.4. Proposes to define "dental benefits coverage" as an arrangement under which enrolled individuals are protected from some or all liability for dental care services, without annual, lifetime or other time-related limitations.
§457.50	State plan.	Proposes that States use the newly created automated format for submission of state plan amendments, replacing previous paper-based documents. States would have up to one year from the automated template release to transition to the new system.
§457.60	Amendments.	Proposes that states can amend their approved state plan at any time through the automated submission of an amendment to CMS.
§457.110	Enrollment assistance and information requirements.	Proposes to clarify that the provision of language services for individuals who are limited English proficient includes oral interpretation, written translations, and taglines. Also proposes that applicants and beneficiaries be given a choice to receive notices in electronic format.
§457.310	Targeted low-income child.	Proposes to clarify that a targeted low-income child cannot be found eligible or potentially eligible for Medicaid either through the Medicaid application process or through screening by other insurance affordability programs, except that eligibility for limited coverage of family planning services does not preclude an individual from being eligible for CHIP.
§457.320	Other eligibility standards.	Codifies the requirement to verify citizenship and immigration status for CHIP applicants in accordance with revised section §457.380. Proposes who may declare citizenship or immigration status in the same manner that is being proposed for Medicaid at §435.406. Proposes to indicate that states cannot exclude otherwise eligible individuals from coverage if they are U.S. citizens or nationals, or qualified non-citizens as long as they have been verified in accordance with §457.380.

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§457.340	Application for and enrollment in CHIP.	Proposes that states must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including denial or termination or suspension of eligibility. Lays out the content that would be included in the notice of eligibility and in the notice of adverse actions. Proposes that states reinstate a withdrawn application if an individual submitted an application to the Exchange and withdrew their application from CHIP, but then is assessed as potentially eligible for CHIP by the Exchange appeals entity. The application would be reinstated effective on the date the application was first received by the Exchange. Also proposes to apply provisions related to certified application assisters and notices to CHIP.
§457.342	Continuous eligibility for children.	Proposes to add a new section to codify the current option for continuous eligibility for children under CHIP for up to 12 months.
§457.348	Determinations of CHIP eligibility by other health insurance affordability programs.	Proposes that states must provide individuals, as well as members of the same household applying on the same application, with combined eligibility notices and coordinated content with other insurance affordability programs, consistent with proposed Medicaid rules. Provides for use of a combined eligibility notice to the maximum extent feasible. For electronic accounts transferred from other insurance affordability programs to CHIP which are screened as potentially eligible for CHIP , this provision is amended to require a combined eligibility notice effective January 1, 2015; and includes a requirement that the CHIP agency must notify the other programs of the final determination of the individual's eligibility.
§457.350	Eligibility screening and enrollment in other insurance affordability programs.	For applicants found potentially eligible for Medicaid based on MAGI, proposes that the State must include in the agreement that such other program will issue a combined eligibility notice, effective January 1, 2015; and clarify that the requirement to find the individual ineligible, provisionally ineligible, or suspend the individual's application for CHIP until the Medicaid application is denied applies at initial application and not at redetermination. Families must be informed of the availability other insurance affordability programs, in addition to Medicaid. For applicants found potentially eligible for other insurance affordability programs potentially eligible for Medicaid on a non-MAGI basis, revisions propose the agreement entered into with the Exchange that such other program will issue a combined notice, effective January 1, 2015, and prior to January 1, 2015 the notice will include coordinated content to provide information relating to the transfer of the individuals account.

Regulatory Section	Provision	Proposed Rule Summary
§457.351	Coordination involving appeals entities for difference insurance affordability programs.	Proposes requirements to effectuate the coordination of appeals between CHIP agencies and Exchange appeals entities through an electronic interface and to reduce burden on consumers.
§457.355	Presumptive eligibility for children.	Proposes to add a new section to codify the current option for presumptive eligibility of children under CHIP, consistent with Medicaid PE for children at §435.1102.
§457.360	Deemed newborn children.	Proposes to add a new section to codify the CHIPRA requirement for deemed newborn eligibility under the Medicaid or CHIP state plan, as appropriate, for a child born to a mother covered under the CHIP state plan as a targeted low-income pregnant woman. States would have the options to provide deemed newborn eligibility to a child if for the date of the child's birth the child's mother was covered by CHIP in another state, as a child under CHIP, or under an 1115.
§457.380	Eligibility verification.	Codifies the requirement to verify citizenship and immigration status for CHIP applicants and proposes to use the process being codified at §435.956, including providing a reasonable opportunity period. Propose to apply the deemed newborn exemption from the citizenship verification and other citizenship documentation requirements to CHIP. The proposed rule would establish the reasonable opportunity period for individuals while verification is being conducted and require benefits during that period. The reasonable opportunity period would be 90 days for all verification of citizenship, whether done through the hub, SSA, or other electronic data source, or if SSA identifies an inconsistency. States would have the option to extend the 90 day reasonable opportunity period.
§457.370	Alignment with Exchange Initial Open Enrollment Period.	Proposes that during the period of October 1, 2013 to January 1, 2014, state Medicaid and CHIP agencies would accept both the single streamlined application and the application in use by the state agency in 2013, as well as the electronic accounts transferred by the Exchange serving the state. States would be expected to make timely eligibility determinations and notify applications of the determination based on both sets of rules.

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§457.570	Disenrollment protections.	Proposes to prohibit the use of "lock-out periods" of greater than 90 days for non-payment of premiums and requires that eligible children cannot be prohibited from reenrollment once the outstanding premium payments have been paid.
§457.616	Application and tracking of payments against the fiscal year allotments	Propose to revise this regulation, based on CHIPRA, to eliminate the requirement for states to claim enhanced match under title XXI of the Act for children during a Medicaid presumptive eligibility period.
§457.805	State plan requirement: Procedures to address substitution under group health plans.	Proposes to limit waiting periods in CHIP to not more than 90 days and to require certain exemptions to such waiting periods such as following a loss of Medicaid eligibility; if the premiums paid by the family exceed 5% of household income; if the cost of family coverage exceeds 9.5% of household income; the employer stops offering coverage; a change in employment; if the child has special health care needs; and if the child lost coverage due to the death or divorce of a parent.
§457.810	Premium assistance programs: required protections against substitution.	Proposed that any waiting period imposed under the state child health plan shall apply to the same extent to the provision of premium assistance subsidy for the child and that states must permit the same waiting period exemptions described in §457.805 for children in premium assistance.
§457.1180	Program-specific review process: Notice.	Proposes that if an individual has been denied eligibility for CHIP by the state or other authorized entity, the agency must treat an appeal of eligibility for APTC to the Exchange appeals entity as a request for a review of CHIP eligibility.