

The Hilltop Institute



analysis to advance the health of vulnerable populations

Overview of the August 29, 2013 Final Rule on Program Integrity: Exchange, SHOP, and Eligibility Appeals

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Overview of the August 29, 2013 Final Rule on Program Integrity: Exchange, SHOP, and Eligibility Appeals

Introduction

On August 29, 2013, the U. S. Department of Health and Human Services (HHS) issued a final rule on *Program Integrity: Exchange, SHOP, and Eligibility Appeals*, <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>. This rule finalizes Exchange standards on eligibility appeals, agents and brokers, privacy and security, issuer direct enrollment, and the handling of consumer cases. In addition, it establishes standards for a state's operation of the Exchange and Small Business Health Options Program (SHOP).

This document provides a high-level summary of these rules and highlights key changes to the regulation since the issuance of the proposed rule.

Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

Fair Health Insurance Premiums (45 CFR §147.102)

In this section, HHS provided standards for health insurance premium rating. Rating is restricted to individual or family coverage, rating area, age (*rate may not vary by more than 3:1 for individuals 21 years and older*), and tobacco use (*rate may not vary by more than 1.5:1 and applies to individuals who may legally use tobacco*). In addition, HHS outlines uniform age bands (*child, 0 – 20 years; adult, 21 – 63 years; older adult, 64 years and older*) and geographic rating areas.

HHS proposed three clarifications:

- Clarify the connection between Affordable Care Act (ACA) §1312(c), “single risk pool,” and §2701 of the Public Health Service Act (PHSA) with regard to the development of rates and premiums for health insurance coverage in the individual and small group markets.
- Clarify that the geographic rating area is determined in the small group market using the principal business address of the group policyholder and in the individual market using the home address of the primary policyholder.
- Clarify that where issuers can demonstrate that they have relied in good faith on different guidance from a state insurance regulator prior to the issuance of this final rule, the amendments to this provision will not apply until the first plan year beginning on or after January 1, 2015, with regard to coverage in the small group market.



HHS finalized these provisions as proposed.

Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

Subpart F – Health Insurance Issuer Standards Related to the Risk Corridors Program

Definitions (45 CFR §153.500)

In this section, HHS provided definitions of terms relating to the reinsurance, risk corridors, and risk adjustment programs. This includes administrative costs, after-tax premiums earned, allowable administrative costs, allowable costs, charge, direct and indirect remuneration, payment, premiums earned, profits, risk corridors, target amount, and taxes and regulatory fees.

HHS proposed the following revision to the definition of qualified health plan (QHP) with regard to plans that would be subject to participation in the risk corridors program:

- For an off-Exchange plan to be considered the same as one offered through the Exchange (QHP), the benefits package, provider network, service areas, and cost-sharing structure of the two offerings must be identical

OR

- Plans that are “substantially the same” as a QHP will be subject to participation in the risk corridors program

HHS noted the following conditions where an off-Exchange plan would not be subject to participation in the risk corridors program: (1) if differences in service area, benefits, cost-sharing structure, premium, or provider network between off-Exchange and QHPs exist that are not tied directly and exclusively to federal or state requirements or (2) if prohibitions on the coverage of benefits apply differentially to a plan depending on whether it is an off-Exchange plan or QHP.

HHS acknowledged that the Office of Personnel and Management (OPM) may issue additional standards for multi-state plan (MSP) issuers. HHS will consider whether a plan that differs from a QHP based on these standards would be considered “substantially the same” for the purposes of participation in the risk corridors program. HHS may address this topic in future rulemaking.

HHS noted its intent to publish guidance on the operational aspects of this standard to include how HHS and issuers will identify plan submissions (including those submitted for the 2014 benefit year) that are “substantially the same” as a QHP for the purposes of being subject to participate in the risk corridors program. In addition, HHS emphasized that the modified QHP



definition is limited to the risk corridors program and does not expand the definition of a QHP for other purposes, including parts 155 (“*Exchange Establishment Standards and Other Related Standards under the Affordable Care Act*”) and 156 (“*Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchange*”).

HHS finalized this provision as proposed.

Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

Subpart A – General Provisions

Definitions (45 CFR §155.20)

In this section, HHS provided definitions related to Exchange establishment standards and other related standards, including advance payment of the premium tax credit, agent or broker, federally facilitated Exchange (FFE), grandfathered health plan, and minimum essential coverage.

HHS proposed changes to the following definitions:

- *Exchange* – HHS amended the definition to note that Exchanges to mean governmental agencies or nonprofit entities that makes QHPs available to qualified individuals and/or qualified employers. The definition includes an Exchange that serves the individual market and SHOP that serves the small group market for qualified employers, regardless of whether the Exchange is state-based (including a regional or subsidiary Exchange) or an FFE.
- *Issuer Application Assistants* – HHS maintained this term instead of “issuer customer service representative.” An issuer application assister is an employee, contractor, or agent of a QHP issuer that provides assistance to applicants and enrollees, but is not licensed as an agent, broker, or producer under state law.
- *Qualified Health Plan* – HHS amended the definition for a plan offered outside an Exchange to be considered the same plan as a QHP offered through the Exchange. Specifically, HHS noted that the benefits package, provider network, service areas, and cost-sharing structure of the two offerings would have to be identical. However, an issuer of a plan that has been certified as a QHP by an Exchange is not required to charge the same premium for the QHP sold to consumers outside an Exchange. HHS does not include the proposed policy that would have required a plan sold to consumers outside an Exchange to be the same plan as a QHP offered through an Exchange for purposes of participating in the risk corridors program.



Subpart B – General Standards Related to the Establishment of an Exchange

Establishment of a State Exchange, Approval of a State Exchange (45 CFR §§155.100, 155.105, and 155.140)

In these sections, HHS outlined the parameters and conditions for establishing a state-based Exchange, including eligible entities, the approval process, and the structure of a regional Exchange or subsidiary Exchange. HHS made the following technical amendments for states operating a SHOP only:

- Consistent with other language, states would be permitted to establish a state-based SHOP while the individual market Exchange would be an FFE. States are prohibited from operating an individual market Exchange only.
- States have the opportunity to operate only a state-based SHOP in 2014 as long as such states provide “reasonable assurances” to the Centers for Medicare and Medicaid Services (CMS) that they are prepared to establish and operate only a SHOP in 2014.
- Exchange approval criteria permit HHS to operate an FFE only that will make QHPs available to qualified individuals where a state has elected to operate a state-based SHOP only.
- HHS clarified provisions that will apply in an FFE to include nondiscrimination requirements and includes cross-references to the Exchange minimum functions with regard to eligibility appeals and exemptions. Moreover, HHS made a technical amendment to apply the nondiscrimination standards to all Exchanges.
- HHS clarified how a subsidiary or regional Exchange may operate in light of the proposed amendments to permit a state to establish and operate an Exchange only providing for the establishment of a SHOP.

Subpart C – General Functions of the Exchange

General Functions of the Exchange (45 CFR §155.200)

In this section, HHS proposed that states operating a SHOP Exchanges only (and not individual Exchanges) need only perform the minimum functions related to SHOP Exchanges. Under these circumstances, an FFE need not perform the minimum functions relating to the establishment of a SHOP. HHS finalized this provision as proposed with technical amendments that include cross-referencing with regard to eligibility appeals and exemptions from the shared responsibility payment.



Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (45 CFR §155.220)

In this section, HHS proposed several standards for web brokers that assist qualified individuals, qualified employees, and qualified employers with QHP enrollment. HHS proposed the following:

- Web brokers would be required to have a prominent display of a standardized disclaimer provided by HHS stating that required QHP information is available on the FFE website. This standardized disclaimer must state that (1) the web broker's website is not the Exchange website; (2) the web broker's website may not contain all QHP information available on the Exchange website; (3) the web-broker is subject to privacy and security standard as specified by HHS; and (4) the web broker must adhere to federal standards that govern web brokers.
- Web brokers would be required to provide a link to the Exchange website for use when not all required QHP information is displayed on the web broker's website.
- Web brokers who make websites available to other agents or brokers are required, as a condition of the agreement or contract, to comply with standards related to §155.220.

HHS proposed that, for agents or brokers entering into an agreement with a web broker for the purposes of utilizing their website to enroll consumers into a QHP through the FFE, the web broker would be required to:

- Provide HHS with a listing of agents and brokers entering into such arrangements if requested by HHS
- Ensure that the agent or broker is licensed in the state in which the consumer is selecting the QHP
- Verify that the agent or broker has completed training and registration and has signed all required agreements with the FFE
- Ensure that its name and any identifier required by HHS prominently appear on the website and on written materials containing QHP information that can be printed from the website
- Terminate the agent's or broker's access to its website if HHS determines that the agent or broker is in violation of the provisions of this section and/or HHS terminates any required agreement with the agent or broker
- Report to HHS and the applicable state department of insurance (DOI) any potential material breach of the standards in §155.220(c) and (d), or the agreement entered into pursuant to §155.260(b), by the agent or broker accessing the Internet website



In the case of severe privacy and security incidences or breach, HHS is permitted to temporarily suspend a web broker's ability to transact information with HHS while it conducts an investigation and such incident or breach is remedied. In addition, HHS may terminate an agent's or broker's agreement with an FFE for cause with a 30-day notice. Similarly, agents or brokers may terminate their agreement with HHS with a written notice at least 30 days in advance of the date of intended termination.

HHS *did not* finalize §155.220(d)(4), which includes requirements for web brokers entering into an agreement with other agents or brokers for purposes of utilizing their website to enroll consumers into a QHP. HHS finalized the remaining provisions as proposed with modifications to correct a typographical error.

Electronic Information Exchanges with Covered Entities (45 CFR §155.270)

In this section, HHS directed Exchanges that perform electronic transactions with a Health Insurance Portability and Accountability Act (HIPAA)-covered entity to use standards, implementation specifications, operating rules, and code sets adopted by the Secretary. HHS noted its work with the Accredited Standards Committee X12 in developing and finalizing the HIX 820. HHS noted that the HIX 820 is the only method that provides the program-level payment information necessary for the risk adjustment, reinsurance, and risk corridors programs. HHS noted its intent to use the HIX 820 for these purposes.

HHS proposed that to the extent that an Exchange performs electronic transactions with a HIPAA-covered entity, an Exchange must use standards, implementation specifications, operating rules, and code sets that are adopted by the Secretary. HHS finalized this provision as proposed.

Oversight and Monitoring of Privacy and Security Requirements (45 CFR §155.280)

In this section, HHS noted that it will monitor any individual or entity that would be subject to the privacy and security requirements as established by an Exchange. HHS did not finalize the following provisions:

- Definition of the terms “incident” and “breach”
- Requirement that an entity where an incident or breach occurs manage the incident or breach in accordance with such entity's documented incident handling and breach notification procedures
- Requirement that incidences or breaches be reported to HHS within one hour of discovery



HHS finalized the remaining provisions as proposed with the following modifications:

- HHS will oversee and monitor the FFEs and non-Exchange entities associated with FFEs for compliance with the privacy and security standards established and implemented by the FFEs.
- HHS will monitor state-based Exchanges for compliance with privacy and security standards established and implemented by such Exchanges. State-based Exchanges will oversee and monitor non-Exchange entities associated with the state-based Exchange for compliance.
- HHS may conduct oversight activities in order to ensure adherence to the privacy and security requirements, to include audits, investigations, inspections, and any reasonable activities necessary for appropriate oversight of compliance with the Exchange privacy and security standards as permitted under ACA §1313(a)(2) and (a)(3).

Subpart D – Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Eligibility Process (45 CFR §155.310)

In this section, HHS proposed a standardized process for handling applications that are submitted without information that is necessary for determining eligibility. The Exchange is required to provide notice to an application filer who does not provide sufficient information on an application for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange, or for insurance affordability programs. The Exchange would provide the applicant with a period of no less than 15 days and no more than 90 days from the notice date to provide necessary information. HHS finalized this provision as proposed with the following modification:

- The Exchange must provide the applicant with a period of no less than *10* days from the notice date to provide the information needed to complete the application to the Exchange.

Verification of Eligibility for Minimum Essential Coverage Other Than through an Eligible Employer-Sponsored Plan (45 CFR §155.320)

In this section, HHS clarified that the Exchange would submit specific identifying information from the federal and state agencies or programs that provide information regarding eligibility for and enrollment in minimum essential coverage, including but not limited to the Veterans Health Administration, TRICARE, and Medicare. The disclosure of information on eligibility and enrollment in a health plan is expressly authorized, for the purposes of verification of applicant



eligibility for minimum essential coverage, as part of the eligibility determination process for advance payment of the premium tax credit or cost-sharing reductions.

HHS noted its intent to work with appropriate federal and state agencies to complete the proper computer matching agreements, data use agreements, and information exchange agreements that will comply with all applicable federal privacy and security laws and regulations.

HHS finalized this provision as proposed. HHS noted that this provision does not enable disclosure by 45 CFR §164.512(k)(6)(i), government programs providing public benefits, of clinical or other health records to the Exchange. This information is not used in the eligibility determination.

Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Condition Insurance Plan (45 CFR §155.345)

In this section, HHS specified standards for coordination across insurance affordability programs. HHS proposed that the Exchange adhere to a state decision regarding Medicaid and/or the Children’s Health Insurance Program (CHIP) eligibility determination. HHS finalized this provision as proposed with only technical corrections.

Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

Allowing Issuer Customer Service Representatives to Assist with Eligibility Applicants (45 CFR §155.415)

In this section, HHS proposed to permit—at the Exchange’s option and to the extent permitted by state law—issuer customer service representatives who do not meet the definition of agent or broker to assist qualified individuals in the individual market with applying for an eligibility determinations/redetermination and insurance affordability programs. Issuer customer service representatives may also facilitate the selection of a QHP offered by the issuer represented, provided that such issuer customer service representatives meet specified requirements. HHS finalized this provision as proposed with the following modifications:

- HHS will use the term “issuer application assisters” in place of “issuer customer service representative” to clearly articulate the role of such individuals
- HHS did *not* finalize the language indicating that facilitating selection of a QHP would be a function of issuer application assisters



Subpart F – Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

This section of the rule provided standards around appeals of advanced premium tax credit (APTC)/cost-sharing reduction (CSR) determination, including coordination with the state Medicaid agency, notice of appeal, appeal requests, and the manner by which the Exchange should conduct appeals. In this final rule, HHS is allowing states to use a paper-based appeals process in the first year of operations.

Definitions (45 CFR §155.500)

The definitions in this section were finalized as proposed with technical modifications to update the references in the definitions of “appeal request” and “appeals entity.” A minor edit was also made to the definition of “evidentiary hearing” to remove the word “new.” “Evidentiary hearing” means a hearing conducted where evidence may be presented.

General Eligibility Appeals Requirements (45 CFR §155.505)

This section included standards for eligibility appeals for both state and HHS appeals processes and applies to appeals of initial eligibility determinations and redeterminations. Exchange eligibility appeals may be conducted by the Exchange or HHS, upon exhaustion of the state-based appeals process or if the Exchange has not established an appeals process. CMS anticipates that a state-based Exchange may elect to establish the appeals function within the Exchange or to authorize an eligible state entity to carry out the appeals function. Appeals entities must comply with the standards set forth for providing fair hearings established by Medicaid at 42 CFR 431.10(c)(2). An appellant may designate an authorized representative to act on his or her behalf. Further, the appeals processes must comply with the accessibility requirements and an appellant may seek judicial review to the extent it is available by law.

HHS finalized this section as proposed with some minor technical and referencing corrections. HHS also added a new paragraph to clarify that a denial of a request to vacate a dismissal made by a state Exchange appeals entity may be appealed. HHS made modifications to clarify that states may delegate exemption appeals to HHS, even if the state is performing individual determination appeals.

HHS noted that it does not intend to impose a fee for the adjudication of individual eligibility appeals from state-based Exchanges. HHS will issue further guidance on operational details on the escalation process from state-based appeals entities to HHS.

Appeals Coordination (45 CFR §155.510)

This section outlined general coordination requirements for the appeals entities and the agencies administering insurance affordability programs. The agreement between entities must clearly



outline the responsibilities of each entity to support the eligibility appeals process and must minimize burden on appellants, ensure prompt issuance of appeal decisions, and comply with the coordination requirements established by Medicaid. If an appellant elects to pursue his or her appeal of an adverse Medicaid determination directly to Medicaid, the appeals entity must transmit the eligibility determination and all information provided via secure electronic interface, promptly and without undue delay, to the Medicaid agency.

When the Medicaid agency has delegated appeals authority to the Exchange appeals entity and the appellant has elected to have the Exchange appeals entity hear the appeal, the appeals entity may include in the appeal decision a determination of Medicaid eligibility. When the Medicaid agency has not delegated appeals authority to the appeals entity and the appellant seeks review of a denial of Medicaid eligibility, the appeals entity must transmit the eligibility determination and all information provided as part of the appeal via secure electronic interface—promptly and without undue delay—to the Medicaid agency.

The Exchange must consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid as ineligible for Medicaid based on the applicable Medicaid modified adjusted gross income (MAGI)-based income standards for purposes of determining eligibility for APTCs and CSRs.

HHS finalized this section as proposed with modifications to remove references to CHIP in the requirement to provide the appellant with the opportunity to pursue a denial of eligibility with the state agency. This option is only relevant to Medicaid as there is no corresponding requirement in federal CHIP laws. HHS also replaced the word “may” with “must” in paragraph (b)(2) to read “Where the Medicaid or CHIP agency has not delegated appeals authority to the appeals entity and the appellant seeks review of a denial of Medicaid or CHIP eligibility, the appeals entity *must* transmit the eligibility determination and all relevant information provided as part of the initial application or appeal.” HHS made other technical corrections to this section.

Notice of Appeal Procedures (45 CFR §155.515)

This section included standards for providing notice of appeal procedures at the time of application and in the eligibility determination notice. The Exchange must provide notice of appeal procedures at the time that the applicant submits an application and when the notice of eligibility determination is sent. The notice of appeal procedures must contain an explanation of the applicant or enrollee’s appeal rights; a description of the procedures by which the applicant or enrollee may request an appeal; information on the applicant or enrollee’s right to represent himself or herself or be represented by legal counsel or an authorized representative; an explanation of the circumstances under which the appellant’s eligibility may be maintained or reinstated pending an appeal decision; and an explanation that an appeal decision for one household member may result in a change in eligibility for other household members and may be handled as a redetermination in accordance with the standards specified in §155.305.



HHS finalized this section as proposed with minor technical corrections. HHS added language to the household explanation requirement to clarify that the appeal decision for one household member may result in a change for *all* household members.

Appeals Requests (45 CFR §155.520)

This section included the modes through which Exchanges and appeals entities must accept appeal requests, including by telephone, by mail, in person (if capable of receiving in-person appeal requests), or via the Internet. The Exchange and the appeals entity must allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination. If the appellant disagrees with the appeal decision of a state-based Exchange appeals entity, he or she may make an appeal request to HHS within 30 days of the date of the state-based Exchange appeals entity's notice of appeal decision.

Upon receipt of a valid appeal request, the appeals entity must send a timely acknowledgment to the appellant of the receipt of his or her valid appeal request, including information regarding the appellant's eligibility pending appeal and an explanation that any APTC paid on behalf of the tax filer pending appeal are subject to reconciliation under 26 CFR § 1.36B-4. Further, the appeals entity must send timely notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal to the Exchange and to the agencies administering Medicaid or CHIP, where applicable. If the appeal request is made to HHS, the appeals entity must send timely notice via secure electronic interface of the appeal request to the state-based Exchange appeals entity. The appeals entity must promptly confirm receipt of the records transferred to the Exchange or the state-based Exchange appeals entity. Upon receipt of an appeal request that is invalid because it fails to meet the requirements of the rule, the appeals entity must promptly and without undue delay send written notice to the applicant or enrollee that the appeal request has not been accepted and indicate the nature of the defect in the appeal request. The appeals entity must also treat as valid an amended appeal request that meets the requirements. Upon receipt of a valid appeal request, the Exchange must transmit via secure electronic interface to the appeals entity the appeal request (if the appeal request was initially made to the Exchange) and the appellant's eligibility record. Finally, upon receipt of a notice of an appeal of a decision to HHS, the Exchange appeals entity must transmit to HHS via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange.

HHS finalized the rule as proposed with a revision to allow states to use a paper-based appeals process for the first operational year. In the final rule, HHS also provided states with the choice of either allowing an applicant or enrollee to request an appeal within 90 days *or within a timeframe* consistent with the state Medicaid agency's requirement for submitting fair hearing requests if the timeframe is no less than 30 days. HHS further added new language to provide that an appeal may be requested at the HHS appeals entity within 30 days of the date of a state Exchange appeals entity's notice of appeal decision or notice of denial to vacate a dismissal. HHS added a new requirement that the appeals entity include an explanation that the applicant or



enrollee may cure the defect and resubmit the appeal request by the date determined under paragraph (b) or (c), or within a reasonable timeframe. HHS made other minor technical corrections.

Eligibility Pending Appeal (45 CFR §155.525)

This section described the standards by which appellants may receive eligibility pending appeal. After receipt of a valid appeal request or notice under §155.520(d)(1)(ii) that concerns an appeal of a mid-year or annual redetermination, the Exchange—or the Medicaid or CHIP agency, as applicable—must continue to consider the appellant eligible while the appeal is pending. The Exchange must continue the appellant’s eligibility for enrollment in a QHP, APTC, and CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.¹ During the appeal, qualified appellants will receive eligibility that corresponds to that which they had immediately before the redetermination being appealed. Eligibility pending appeal will not be offered to appellants who are appealing their initial denial of eligibility. Finally, an applicant who receives an initial eligibility determination that is not a denial and who requests an appeal will receive eligibility per the original determination during the course of the appeal.

HHS finalized this section as proposed with a modification to clarify that pended eligibility must be afforded only if the appellant or tax filer accepts it.

Dismissals (45 CFR §155.530)

In the proposed rule, this section laid out the instances in which an appeals entity is required to dismiss an appeal, including when an appellant withdrew his appeal, failed to appear at a hearing, or failed to submit a valid appeals request. Further, the proposed rule explained that when an appeals entity dismisses an appeal, it must provide a notice of such dismissal to the applicant. Finally, this proposed section explained that the appeals entity may vacate a dismissal if the appellant submits a request to vacate and shows good cause.

Under the final rule, HHS slightly amended this section to include additional consumer protections in response to comments. First, the final rule explained that the appeals entity may dismiss an appeal based on failure to appear at a hearing only when the appellant is unable to show good cause for his failure to appear. HHS explained that this is meant to more closely align the Exchange appeals regulations to Medicaid fair hearing rules. Second, the rule clarified that the notice of dismissal provided by an appeals entity must be in writing. Third, the rule explained that an appeals entity is required to vacate a dismissal where the appellant shows good cause; HHS replaced “may vacate” to “must vacate.” Finally, the rule stated that where an appeals

¹ Continued receipt of APTC during the appeal may impact the amount owed or due at the IRS reconciliation process, depending on the appeal decision.



entity denies the request to vacate, it must provide timely, written notice of such denial to the appellant.

Informal Resolution Process and Hearing Requirements (45 CFR §155.535)

In this section, the proposed rule explained that state-based Exchanges are allowed to have an informal resolution process prior to undertaking a formal appeal. The informal process must comply with the scope of review specified in the rule: the appellant’s right to a hearing must be preserved in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process; if the appeal advances to hearing, the appellant must not be asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process; and if the appeal does not advance to hearing, the informal resolution decision must be considered final and binding.

Further, the proposed rule explained that, upon the scheduling of a hearing, the appeals entity must send written notice to the appellant no later than 15 days prior to the date of the hearing. The rule also set standards for conducting hearings, including that hearings must be held at reasonable dates, times, and locations, and that hearings must be conducted by impartial officials. The rule additionally explained that the appeals entity must give the appellant a right to review the appeal record, bring witnesses to testify at the hearing, establish relevant facts, present an argument, and question or refute evidence. Finally, the rule explained that the appeals entity will use a de novo standard when reviewing an appeal, considering all relevant facts and evidence.

HHS finalized this section as proposed, making only one technical correction: changing the word “appeal” to “appeal process” in §§155.535(e) and (f).

Expedited Appeals (45 CFR §155.540)

This section proposed that the appeals entity must have an expedited appeals process for appellants to request where there is an immediate need for health services and a standard process could *seriously* jeopardize the appellant’s life. Where an appeal request meets the criteria for an expedited appeal, the appeals entity must issue the notice as expeditiously as the appellant’s health condition requires but no later than three working days after the appeals entity receives the request for an expedited appeal. If the appeals entity denies a request for an expedited appeal, it must handle the appeal request under the standard process; issuing the appeal decision and making reasonable efforts to inform the appellant through electronic or oral notification of the denial and, if notified orally, follow up with the appellant by written notice within two days of the denial.

HHS modified two provisions of this section. First, it removed the word “seriously” from the standard used to determine whether an appellant should be granted an expedited appeal; therefore, an appeals entity must have an expedited appeals process for appellants to request



where there is an immediate need for health services and a standard process could jeopardize the appellant's life (note the difference from the standard stated in the proposed rule above). Second, HHS removed the two-day written denial notice requirement and is instead now requiring that, if an appellant is notified of a denial orally, he be notified of such a denial in writing "within the timeframe established by the Secretary." Further, the written notice of denial must include the reason for the denial and an explanation that the appeal will be transitioned to the standard appeals process, including an explanation of the appellant's rights under the standard process.

Appeal Decisions (45 CFR §155.545)

Under this section in the proposed rule, HHS described the standards by which appeals decisions are to be made, including the basis, content, notice, and implementation of appeals decisions. First, appeal decisions must be based exclusively on the information and evidence specified under the eligibility and appeals rules. Further, appeals decisions must state the decision, including a plain language description of the effect of the decision on the appellant's eligibility; summarize the facts relevant to the appeal; identify the legal basis, including the regulations that support the decision; state the effective date of the decision; and, if the appeals entity is a state-based Exchange appeals entity, provide an explanation of the appellant's right to pursue the appeal at HHS if the appellant remains dissatisfied with the eligibility determination. The appeals entity must issue written notice of an appeal decision to the appellant within 90 days of the date an appeal request is received. The appeals entity must further provide notice of the appeal decision. The Exchange or the Medicaid or CHIP agency, as applicable, must promptly implement appeal decisions upon receiving the notice. The proposed rule required that such decisions be retroactive to the eligibility date that is the basis of the appeal.

HHS finalized these provisions with some key modifications. First, the final rule explained that the appeals entity must take into account all relevant information, including any new information that the appellant did not provide at the time of the eligibility determination. Second, the notice of the appeal decision must state that the appeal entity's decision is final unless the appellant pursues an appeal before HHS. Third, HHS modified the requirement that the decision of an appeal be implemented retroactively; the rule now states that the decision may be implemented prospectively or retroactively at the option of the appellant.

Employer Appeals Process (45 CFR §155.555)

Under this section of the proposed rule, HHS explained that the Exchange may establish an employer appeals process through which an employer may appeal a notice regarding an employer's potential tax liability, a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan, or a determination that the employer does provide such coverage but it is not affordable coverage. Where an Exchange has not established an employer appeals process, HHS will provide an employer appeals process. The Exchange and appeals entity must allow an employer to:



- Request an appeal within 90 days from the date the notice is sent.
- Submit relevant evidence to support the appeal.
- Submit an appeal request to the Exchange or the Exchange appeals entity. For Exchanges that have not established an appeals process, the employer must be allowed to submit the appeal to HHS.

Upon receipt of a valid appeal request from an employer, the appeals entity must send timely acknowledgement of the receipt of the appeal request to the employer and employee. This acknowledgement must include an explanation of the appeals process; instructions for submitting additional evidence for consideration by the appeals entity, and, for the employee, an explanation of the potential effect of the employer's appeal on the employee's eligibility. The appeals entity must promptly notify the Exchange of the appeal if the employer did not initially make the appeal request to the Exchange. Upon receipt of an appeal request that is not valid, the appeals entity must promptly and without undue delay send written notice to the employer that the appeal request has not been accepted and of the nature of the defect in the appeal request. Under the proposed rule, the appeals entity was required to treat as valid an amended appeal request that meets the requirements of this section, including standards for timeliness. Further, the appeals entity must provide timely notice of the dismissal to the employer, employee, and Exchange, including the reason for dismissal. It may vacate a dismissal if the employer makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

The appeals entity must provide the employer the opportunity to provide relevant evidence for review of the determination of an employee's eligibility for APTC or CSR and other relevant evidence, including information regarding whether the employee's income is above or below the threshold by which the affordability of employer-sponsored minimum essential coverage is measured.

The requirement of an impartial officer and presentation of relevant evidence are the same as the standards set for conduct of hearings for individual eligibility appeals.

The appeals entity must provide written notice of the appeal decision within 90 days of the date the appeal request is received, as administratively feasible, to the employer, employee, and Exchange. After receipt of the notice, if the appeal decision affects the employee's eligibility, the Exchange must promptly redetermine the employee's eligibility.

Under this final rule, most provisions of this section were finalized as proposed. Substantive changes were (1) that the notice of an invalid appeal request inform the employer that the employer may cure the defect in the appeal request and resubmit the request within a timeframe established by the appeals entity and (2) that any redeterminations made pursuant to the eligibility decision that are adverse to an employee's family members are appealable by such family members.



Subpart H – Exchange Functions: SHOP

Standards for the Establishment of a SHOP (45 CFR §155.700)

In this section, HHS amended §155.700 by defining “SHOP application filer” to mean an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by law. HHS finalized this provision as proposed.

Functions of a SHOP (45 CFR §155.705)

HHS proposed language to coordinate SHOP functions with the functions of the individual market Exchange for determining eligibility for insurance affordability programs with an exemption for a state opting to operate a state-based SHOP independent of an individual market FFE. Except in the case where a state is operating only a SHOP, a SHOP must provide data to the state’s corresponding individual market Exchange related to eligibility and enrollment of qualified employees in the SHOP. This data sharing may improve the accuracy of the individual market Exchange’s eligibility determinations for affordability programs.

HHS proposed that when a state establishes and operates a SHOP independently of an individual market FFE, the SHOP would have the flexibility to allow SHOP navigators to fulfill their statutory and regulatory obligations to (1) facilitate enrollment in QHPs and (2) refer consumers with complaints, questions, and grievances to applicable offices of health insurance consumer assistance or ombudsmen (by directing small businesses to agents and brokers for these types of assistance), so long as state law permits agents and brokers to carry out these functions.

HHS noted its intent to finalize §155.705(b)(6)(i) in future rulemaking when it finalized the provisions proposed in §156.80(d) with regard to the frequency of rate updates in the small group market, including coverage offered through the SHOPS. The remaining provisions were finalized as proposed.

Application Standards for SHOP (45 CFR §155.730)

In this section, HHS proposed to amend the SHOP application filing standard to relieve SHOPS of having to accept paper applications and accept applications by telephone. In addition, HHS also clarified that an employer or an employee application may be filed by a “SHOP application filer.” HHS finalized this provision as proposed with one technical correction.

Termination of Coverage (45 CFR §155.735)

Under this section, HHS proposed that each SHOP would be required to develop uniform standards for the termination of coverage in a QHP, clarified the authority for SHOPS to establish termination standards, and set such standards for the federally facilitated SHOP (FF-SHOP). HHS finalized these provisions as proposed.



SHOP Employer and Employee Eligibility Appeals Requirements (45 CFR §155.740)

In this section, HHS proposed standards for SHOP employer and employee eligibility appeals. HHS proposed that a state operating a SHOP must provide a SHOP eligibility appeals process. In the case where a state does not elect to establish and operate a SHOP, the HHS appeals entity will provide a SHOP appeals process.

HHS proposed the process and standards for requesting an appeal and the standards for providing notice of the appeal request to the SHOP employer or employee and to the SHOP. HHS proposed requirements for transmitting and receiving records related to the appeal between the SHOP and the appeals entity. HHS also provided standards for dismissing SHOP appeals and providing an opportunity for a SHOP appellant to request that a dismissal be vacated. HHS proposed procedural rights for SHOP appellants. HHS proposed standards for reviewing the appeal, the content and notice of the appeal decision, and implementing the appeal decision.

HHS finalized these provisions as proposed with some technical corrections and additional language to provide detail about what happens when an appeals entity sends notice of an invalid appeal request. Moreover, HHS added language that clarifies the content requirements of the notice, all of which mirrors similar modifications in the individual and employer appeals provisions of this final rule.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

Subpart A – General Provisions

Definitions (45 CFR §156.20)

HHS proposed to add the definition of “Exchanges,” “delegated entity,” and “downstream entity.” They are defined as:

- *Exchange*: a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and an FFE.
- *Delegated Entity*: any party, including an agent or broker, that enters into an agreement with a QHP issuer to provide administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.
- *Downstream Entity*: any party, including an agent or broker, that enters into an agreement with a delegated entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer. HHS noted that the term “downstream entity” is intended to



reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

HHS finalized this provision as proposed.

Subpart C – Qualified Health Plan Minimum Certification Standards

Termination of Coverage for Qualified Individuals (45 CFR §156.270)

In this section, HHS proposed standards for QHP issuers on the termination of coverage for individuals enrolled in QHPs through the Exchange. HHS finalized this provision as proposed with the following technical correction: making the appropriate cross-reference to accurately describe situations in which the QHP issuer may terminate an enrollee's coverage.

Additional Standards Specific to SHOP (45 CFR §156.285)

In this section, additional standards were specified to include SHOP rating and premium payment requirements; enrollment periods for the SHOP; enrollment process for the SHOP; termination of coverage in the SHOP; and rules for QHP issuers to participate in SHOP.

HHS proposed an amendment to ensure that all QHP issuers offering coverage in a SHOP comply with the termination of coverage requirements as a condition of certification for plan years beginning on or after January 1, 2015. HHS finalized these provisions as proposed with a technical correction to a referencing error.

Subpart D – Federally Facilitated Exchange Qualified Health Plan Issuer Standards

Standards for Downstream and Delegated Entities (45 CFR §156.340)

In this section, HHS prescribed standards for delegated and downstream entities, similar to existing standards for such entities that contract with Medicare Advantage organizations. HHS proposed the general requirement that, notwithstanding any relationship(s) that a QHP issuer may have with delegated or downstream entities, the QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, with all applicable standards. HHS proposed that the QHP issuer be required to comply with federal standards, specifically the obligations that govern QHP minimum certification standards, Exchange functions pertaining to QHP certification, Exchange functions of the SHOP, assisting with enrollment in QHPs, and maintenance of records and compliance reviews for QHP issuers operating in an FFE and an FF-SHOP.

HHS proposed that all agreements among the QHP issuer's delegated and downstream entities be required to specify delegated activities and reporting standards and either provide for revocation



of the delegated activities and reporting standards or specify other remedies in instances where HHS or the QHP issuer determinates that such parties have not performed satisfactorily.

HHS proposed that all agreements among the QHP issuer's delegated and downstream entities be required to specify that the delegated or downstream entity must comply with all applicable laws and regulations. HHS proposed that the QHP issuer's agreement with any delegated or downstream entity must specify that the delegated or downstream entity must permit access by the Secretary and the Office of the Inspector General or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with federal standards until ten years from the final date of the agreement period.

HHS proposed that all existing agreements contain specifications by no later than January 1, 2015. For agreements that are newly entered into as of October 1, 2013, HHS proposed an effective date for the specifications to be no later than the effective date of the agreement. HHS finalized these provisions as proposed.

Subpart I – Enforcement Remedies in Federally Facilitated Exchanges

Available Remedies; Scope (45 CFR §156.800)

In this section, HHS proposed that it may impose civil monetary penalties (CMPs) on QHP issuers that are not in compliance with the FFE standards and decertify QHPs offered by non-compliant QHP issuers. HHS finalized this provision as proposed with the following modification: adding clarification that if CMS is able to determine that an issuer offering QHPs in an FFE is making good-faith efforts to comply with Exchange standards applicable to issuers offering QHPs in the FFEs, it will not seek to impose CMPs or initiate decertification during 2014. At the appropriate time, HHS will consider extending this good-faith compliance through 2015. HHS will coordinate closely with states to avoid unnecessary duplication of monitoring and oversight efforts.

Bases and Process for Imposing Civil Money Penalties in Federally Facilitated Exchanges (45 CFR §156.805)

In this section, HHS proposed the bases and process for imposing a CMP in FFEs. HHS finalized this provision as proposed with technical edits to reflect that the proposed administrative hearing process for enforcement actions are not being finalized in this rule.



Bases and Process for Decertification of a QHP Offered by an Issuer through the FFE (45 CFR §156.810)

In this section, HHS proposed the bases for decertifying QHPs in the FFE, as well as standard and expedited processes for decertification. HHS proposed that when decertification is based on §156.810(a)(7),(8), or (9), HHS may pursue the decertification on an expedited process. HHS finalized this provision as proposed with the following changes:

- The proposed administrative hearing process for enforcement actions was not finalized in this rule.
- HHS made technical corrections to typographical errors.

Subpart K – Cases Forwarded to QHPs and QHP Issuers in Federally Facilitated Exchanges by HHS

Standards (45 CFR §156.1010)

In this section, HHS proposed requirements for resolving cases forwarded by HHS to a QHP issuer operating in an FFE. HHS proposed the definition of a case as a communication brought by a complainant that expresses dissatisfaction with a specific person or entity subject to state or federal laws regulating insurance, concerning the person or entity’s activities related to the offering of insurance, other than a communication with respect to an adverse benefit determination.

For a case forwarded by a state to a QHP issuer operating in an FFE, HHS proposed that the QHP issuer be required to comply with applicable state laws and regulations. HHS proposed that cases received by a QHP issuer operating in an FFE directly from a complainant or the complainant’s authorized representative be handled by the issuer through its internal customer service process.

For cases received by a QHP issuer operating in an FFE from HHS, HHS proposed that the QHP issuer be required to investigate and resolve cases, as appropriate, pursuant to the proposed standards in §156.1010.

HHS proposed that QHP issuers operating in an FFE must investigate and resolve, as appropriate, cases brought by a complainant or the complainant’s authorized representative and forwarded to the issuer by HHS. HHS proposed that this would not apply to adverse benefit determinations, which are subject to the regulations governing internal claims appeals and external review.

HHS proposed that cases may be forwarded to a QHP issuer operating in an FFE through a casework tracking system developed by HHS or through other means as determined by HHS.



HHS proposed that cases forwarded by HHS to a QHP issuer operating in an FFE must be resolved within 15 calendar days of receipt of the case. HHS proposed that such cases involving an immediate need for health services must be resolved no later than 72 hours after receipt of the case unless a state law or regulation established a stricter timeframe, in which case the state law or regulation would then control.

HHS proposed that an urgent case is one in which there is an immediate need for health services because the non-urgent standard could seriously jeopardize the enrollee's or potential enrollee's life, health, or ability to attain, maintain, or regain maximum function.

HHS proposed that, for cases forwarded by HHS, QHP issuers operating in an FFE are required to provide notice to complainants regarding the disposition of a case as soon as possible upon resolution of the case but in no event later than seven business days after the case is resolved. Such notification may be by verbal or written means as determined most appropriate by the QHP issuer. HHS proposed that a QHP issuer operating in an FFE must document in a casework tracking system developed by HHS, or by other means as determined by HHS, that the case has been resolved—no later than seven business days after resolution of the case—and that the resolution record must include a clear and concise narrative explaining how the case was resolved, including information about how and when the complainant was notified of the resolution.

HHS proposed that cases received by a QHP issuer operating in an FFE from a state in which the issuer offers QHPs must be investigated and resolved according to applicable state laws and regulations and that QHP issuers operating in an FFE must cooperate fully with the state, HHS, or any other appropriate regulatory authority that is handling a case. HHS finalized these provisions as proposed with the following modifications:

- Clarifying that §156.1010 does not include cases otherwise address in subpart F.
- Expanding the definition of “urgent care” to include instances in which application of the non-urgent standard would jeopardize a consumer's ability to enroll in a QHP through the FFE.
- Requiring issuers to provide notification to consumers about the disposition of a case within three business days of the resolution by verbal or written means as determined most appropriate by the QHP issuer operating in an FFE.
- Requiring that in instances when a QHP issuer operating in an FFE notifies the consumer about the disposition of a case using non-written means, the issuer must provide the consumer with written notification of the disposition in a timely manner following the verbal communication.
- HHS is requiring that a QHP issuer operating in an FFE provide the date of resolution of a case in the HHS-developed tracking system. QHP issuer documents the case resolution



summary no later than seven business days after resolution of the case, including a clean and concise narrative with specified content.

- HHS is requiring that a QHP issuer operating in an FFE provide information in the HHS-developed tracking system about any compliance issues found as part of an investigation of a case by a state agency, including but not limited to a state DOI.

Subpart M – Qualified Health Plan Issuer Responsibilities

Direct Enrollment with the QHP Issuer in a Manner Considered to Be through the Exchange (45 CFR §156.1230)

In this section, HHS proposed language that would allow, at the Exchange’s option, a QHP issuer to enroll an applicant who initiates enrollment directly with the QHP issuer in a manner that is considered enrollment through the Exchange if such QHP follows the federal standards related to the enrollment process for qualified individuals (45 CFR §156.265).

HHS proposed that QHP issuers seeking to directly enroll qualified individuals in a manner considered to be through the Exchange using the issuer’s website must clearly distinguish between (1) QHPs the consumer is eligible for and (2) non-QHPs offered by the issuer. HHS clarified that the distinction must clearly articulate that advance payments of the premium tax credit and cost-sharing reductions apply only to QHPs offered through the Exchange. Moreover, the QHP issuer would be required to ensure that the applicant is allowed to select and apply an advance premium tax credit amount.

HHS would require such QHP issuers to notify applicants of the availability of other QHP products offered through the Exchange to consumers, regardless of whether they apply through a website, in person, or by phone. QHP issuers would be required to display a web link to or describe how to access the Exchange website.

With regard to customer service representatives of QHP issuers seeking to enroll individuals through the Exchange, HHS proposed that a QHP issuer require its customer service representatives, at a minimum:

- Receive training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations, including the minimum payment methods that issuers must accept for all payments (all payment method options must be presented equally for a consumer to select their preferred payment method)
- Comply with the Exchange’s privacy and security standards
- Comply with applicable state law related to the sale, solicitation, and negotiation of health insurance products, including applicable state law related to agent, broker, and producer licensure; confidentiality; and conflicts of interest.



HHS proposed that a premium a QHP issuer charges to a qualified individual or enrollee is the same as was accepted by the Exchange in its certification of the QHP issuer after taking into account any advance payment of the premium tax credit. If the QHP issuer identifies any error in the amount it charged, the QHP issuer must retroactively correct the error no later than 30 calendar days after its discovery. Within the FFE, HHS may review the premiums charged to qualified individuals through compliance review.

Enrollment Process for Qualified Individuals (45 CFR §156.1240)

In this section, HHS proposed that QHP issuers, at a minimum, accept a variety of payment formats so that individuals without a bank account or a credit card will have readily available options for making monthly premium payments. This includes paper checks, cashier's checks, money orders, replenishable pre-paid debit cards, electronic funds transfer from a bank account, and an automatic deduction from a credit or debit card. HHS finalized this provision as proposed with the following modifications:

- HHS included minimum payment methods that issuers must accept. HHS noted that these methods must be accepted for all payments and apply to the individual market only.
- HHS clarified that all payment options must be presented equally for a consumer to select the preferred method.





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