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Overview of the January 14, 2013 Proposed Rule on Medicaid, CHIP, and Exchanges

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Table of Contents

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Section I. Medicaid Eligibility Expansion Part II

Background

Overall, the proposed regulations issued January 14, 2013, aim to: provide additional flexibility in beneficiary appeals, notices, and related procedures; update the Centers for Medicare and Medicaid Services (CMS) regulations to fully reflect changes in Medicaid eligibility created by the Affordable Care Act (ACA); and modernize administrative procedures to further promote coordination across multiple insurance affordability programs.[1]

Overview of the Proposed Rule

This section's proposed amendments to Chapter 42 of the Code of Federal Regulation (CFR) are as follows:

- Allowing for electronic submission of state plans and state plan amendments (SPAs).
- Requiring an updated, streamlined, and coordinated eligibility, beneficiary notice, and appeal functions for Medicaid and the Children's Health Insurance Program (CHIP).
- Reflecting statutory changes to Medicaid eligibility.
- Reflecting statutorily-required changes to state procedures to verify citizenship.
- Reflecting the statutorily-required shift to modified adjusted gross income (MAGI)-based financial eligibility methods for most populations.
- Delineating responsibilities of state Medicaid agencies with respect to the establishment of the coordinated eligibility and enrollment system.
- Proposing necessary requirements that facilitate the creation of an Exchange eligibility and enrollment system.

Provision of the Proposed Rule

Appeals

In addition to technical amendments, the proposed revisions in this section specify the process and rules for a state Medicaid agency to delegate fair hearing authority regarding a beneficiary's appeal to an Exchange. The proposed revisions are as follows:

[1] The definition of "insurance affordability programs" includes Medicaid, CHIP, Exchange coverage, and the Basic Health Plan (BHP).

Framework of Appeals Process

- A fair hearing is required if an individual requests it because the Medicaid agency has denied the individual's eligibility, level of benefits, services, or claim or if the Medicaid agency has failed to act with reasonable promptness (§431.220).
- The Medicaid agency is permitted to delegate authority to conduct fair hearings of eligibility for Medicaid, premium tax credits or cost-sharing to the Exchange. However, the individual maintains the right to appeal and have a fair hearing directly by the Medicaid agency. Any delegation of fair hearing authority would be subject to safeguards to ensure that the beneficiary receives the same due process rights and substantive review of their case. Such delegation would be effectuated through a written agreement outlining roles and responsibilities. The Medicaid agency is required to exercise appropriate oversight over the delegated hearing process (§431.10, 431.200).
- An Exchange appeals entity is defined as a state-based Exchange appeals or U.S. Department of Health and Human Services (HHS) appeals entity. An Exchange appeals entity is responsible for individuals filing an appeal for the determination of eligibility in a qualified health plan (QHP), advance payment of premium tax credit (APTC), or cost-sharing reductions (CSRs) (§431.10).
- A Medicaid agency may only delegate authority to conduct fair hearings of Medicaid eligibility (and subsequent determination) to an Exchange that is a governmental agency maintaining merit protections for its employees (§431.10).
- A Medicaid agency may delegate authority to conduct fair hearings to a state-based Exchange that is also a state agency (§431.10).
- For states choosing to delegate fair hearing authority with respect to Medicaid eligibility to the Exchange, there is an additional option for Medicaid agencies to review decisions made by the Exchange on Medicaid-related interpretations of state or federal policies (§431.10).
- Proposed revisions maximize the coordination of appeals and minimize the burden on consumers and states, regardless of the Medicaid agency's decision on delegating authority. For example, an individual appealing the APTC or CSR level will automatically be treated as an appeal to a Medicaid eligibility determination. Furthermore, an individual may request a hearing by (1) telephone, (2) mail, (3) in person, (4) through available electronic means, and (5) at state option (via an Internet website). This is done without having to file a separate hearing request. HHS is considering a later effective date, such as January 1, 2015, to allow states more time to establish and implement this policy (§431.221).
- Expedited appeals language is added to align fair hearing process with existing policies in managed care where individuals having urgent health needs may have their appeals addressed in an appropriate and time-sensitive manner (§431.224).

- The reasonable notice opportunity period is considered received five days after the date of such notice (§431.231).
- A hearing officer must have access to the agency's information, such as state policies and regulations necessary to issue a proper hearing decision (§431.240).

Issuing a Decision

The proposed rules suggest that a decision of the Medicaid fair hearing should be issued within 45 days from the date the Exchange appeals entity renders its decision on enrollment in a QHP with APTC and CSR. Existing regulations are clarified so that the 90-day timeframe to issue a decision after an individual files an appeal applies to all appeals decisions, not only to managed care appeals decisions. Other proposed regulations make administrative corrections to account for the proposed timeframe of 45 days and expedited appeals process (§431.244).

Applicability to CHIP (42 CFR §§457.10, 457.340, 457.348, 457.350, 457.1180, 457.351)

- This section applies the rules for eligibility screening and enrollment in other insurance affordability programs when it has been determined that the individual is not eligible for CHIP. Similar to proposed Medicaid regulations, CHIP review is assumed and required of Exchange appeals entities (§457.348, 457.350, 457.1180).
- An individual must be notified of his or her right to review (§457.340).

Items for Comment

- Whether Medicaid agencies should have authority under the regulations to delegate fair hearing authority to any state agency, subject to the same limitations as those proposed for delegations to a state-based Exchange.
- Whether the timeframe from the date the Exchange appeals entity makes its decision for the Medicaid agency to render its fair hearing decision should be 30, 45, 60, 90, or 120 days.
- Making the Internet option for enrollment a requirement at a date "sometime after" January 1, 2014.

Notices

Content and Accessibility Standards (42 CFR §§435.917, 435.918)

- A Medicaid or CHIP agency can inform applicants and beneficiaries of adverse actions through electronic notices (§431.206).
- The proposed rules consolidate current regulations on the state's responsibility to communicate content in a clear and timely manner when issuing a notice of approved

eligibility, denial, or other action. Such notices must be written in plain language and include descriptions of other bases of eligibility. Notices must be accessible to individuals with limited English proficiency and individuals with disabilities (§435.917).

- The requirement for paper-based, written notices is maintained, but states are also required to provide individuals with the option to receive notices through a secure electronic format instead of a written notice (§435.918).

Provision of Coordinated Notice – Medicaid Agency Responsibilities (42 CFR §435.1200)

- The proposed rule defines "combined eligibility notice" and "coordinated" content. Combined eligibility notice informs an individual or household of their eligibility for multiple insurance affordability programs (IAPs). Coordinated content relates to the transfer of an individual's electronic account to another IAP (§435.1200).
- When the Exchange or other agency administering an IAP makes a Medicaid eligibility determination, they are required to provide a combined eligibility notice including information about an individual's Medicaid eligibility. The same requirement is applied to the state Medicaid agency when eligibility for other IAPs is discovered. The proposed regulations also require that such notice be provided, if applicable, to individuals denied eligibility for one IAP but found potentially eligible for another (§435.1200).
- The proposed rules add coordinated content requirements that address unique household situations. For example, a single, combined eligibility notice may not be feasible in a household with different members being determined eligible for different programs § (435.1200).
- The requirement to disseminate a combined eligibility notice is not effective until January 1, 2015. (§435.1200).

CHIP Eligibility Notices and Information Requirements (42 CFR §§457.10, 457.110, 457.340, 457.348, 457.350)

- Administrative corrections reflect the combined notice and coordinated definition and rules in the proposed Medicaid regulations (§457.110, 435.340).
- States are responsible for providing information to CHIP applicants with on Medicaid and other IAPs. Moreover, the discretion of the state to find an individual ineligible, provisionally eligible, or suspend the individual's application or CHIP until there is a Medicaid denial only applies at application (not at redetermination) (§457.350).

Items for Comment

- Comment is requested on the level of detail that should be required for all eligibility notices based on the applicable MAGI standard.

- In requiring states to provide the option for individuals to receive notices through a secure electronic format, HHS solicits comments on this process and other consumer safeguards for electronic notification.
- Whether to make other communications that occur between the applicant/beneficiary and Medicaid or CHIP agency available electronically by posting to the electronic account.
- Whether there are other situations when a combined eligibility notice is not feasible. HHS discusses two situations where multiple members of a single household are eligible for multiple IAPs. In these instances, notices would have to include appropriate coordinated content relating to all members eligible for some form of coverage.
- Whether the proposed effective date for states to begin providing combined eligibility notices should be January 1, 2015, or October 15, 2015.

Medicaid Eligibility Changes under the ACA

Former Foster Care Children (42 CFR §§435.150)

This section creates a new Medicaid eligibility coverage group for children through age 26 years who were in foster care and receiving Medicaid when they reached 18 or aged out of foster care.

Family Planning (42 CFR §§435.214)

This section allows states to provide family planning-only services to adults at the highest income level established for pregnant women under the state's Medicaid/CHIP plan. States may consider only the income of the individual applying for family planning when determining eligibility.

Items for Comment

- On the interpretation of the new foster care eligibility group.

Medicaid Enrollment Changes under the ACA to Achieve Coordination with the Exchange

- Certified Application Counselors help individuals understand, apply for, and provide necessary documentation (but do not sign forms or otherwise act on behalf of the individual). Their role will be similar to navigators but will not be funded through the Exchange. The proposed rule will require standards for authorizing application counselors (§435.908 and 457.330.
- Authorized representatives are individuals or organizations, such as attorneys and legal guardians, who may act on behalf of an applicant or recipient. The single streamlined

applications will provide applicants the opportunity to designate an authorized representative and will collect the necessary information (§435.923 and 457.340).

- The proposed rule requires states to inform individuals of the availability of accessibility services and how to access them. Renewal forms, websites, and electronic systems must meet accessibility standards (§435.905).

Medicaid Eligibility Requirements and Coverage Options Established by Other Federal Statutes

Coverage for Families

This section streamlines and simplifies eligibility rules for coverage of families and children, including removing duplicative and obsolete language and converts income calculations to MAGI-based. Many of the changes simply clarify language and have no meaningful impact on state programs. This section notes that the eligibility rules for the following coverage groups will be changed to convert to MAGI-standards:

- Extended eligibility for low income families (§435.112 and 115).
- Optional coverage for reasonable classifications of individuals under age 21 (§435.222).
- Optional eligibility for independent foster care adolescents (§435.226).
- Optional eligibility for individuals under age 21 who are under state adoption assistance agreements (§435.227).
- Optional targeted low income children (§435.229).
- Optional tuberculosis eligibility groups (§435.215).

This section also clarifies that optional eligibility for parents and caretaker relatives (§435.220) up to MAGI-based 133 percent of the federal poverty level (FPL) will be subsumed under the adult group. Coverage for adults above that level will remain in an optional category.

Presumptive Eligibility

This section proposes to revise Medicaid regulations for children's presumptive eligibility and to add regulations for presumptive eligibility for pregnant women and individuals needing treatment for breast and cervical cancer and the six new options for Medicaid presumptive eligibility provided by the ACA.

- This section clarifies that federal financial participation (FFP) is available for all services and necessary administrative costs for all types of presumptive eligibility, not just for children (§435.1001-1002).

- Presumptive eligibility for children: This section changes language to align with the adoption of MAGI-based methodologies and proposes that a state may require, as a condition of presumptive eligibility, that the individual or another person who attests to having reasonable basis to know the status, that the individual is a citizen or national of the U.S. or is in satisfactory immigration status. State may also require similar attestation of state residence (§435.1102).
- Presumptive eligibility for other individuals (§435.1103):
    - States may elect to provide presumptive eligibility for pregnant women in the same manner as for children, except that pregnant women are only covered for ambulatory prenatal care during a presumptive eligibility period.
    - Presumptive eligibility for pregnant women is limited to one presumptive eligibility period per pregnancy.
    - If the state has elected to provide presumptive eligibility for children or pregnant women, they may also elect to provide it for additional populations provided for in the ACA, as well as individuals needing treatment for breast and cervical cancer.
    - States may also provide family planning services on a presumptive eligibility basis.
- Presumptive eligibility determined by hospitals: Hospitals participating in Medicaid may determine presumptive eligibility, whether or not the state has elected to permit qualified entities to make presumptive eligibility determinations. Hospitals must meet the following basic criteria to be qualified to authorize presumptive eligibility (§435.1110):
    - Be a participating as a Medicaid provider.
    - Notify the Medicaid agency of its decision to make presumptive eligibility determinations.
    - Agree to make determinations consistent with state policies and procedures.
    - At state option, assist individuals in completing and submitting the full application and in understanding any documentation requirements.
    - Not be disqualified by the agency.
- States may limit presumptive eligibility determinations by qualified hospitals to the types of presumptive eligibility the state elects to cover, and may establish standards related to the proportion of individuals determined presumptively eligible by the hospital that submit a regular application before the end of the presumptive period and/or are determined eligible on the basis of application.

Medically Needy (42 CFR §§435.301, 435.310, 435.831)

Eligibility determination for medically needy is exempt from MAGI-based eligibility determination. The proposed rules provide states with the flexibility to apply, at state option, either AFDC-based methods or MAGI-based methods for determining income eligibility for medically needy children, pregnant women, parents, and other caretaker relatives. In order to meet maintenance of effort requirements, states would have to ensure that the adoption of MAGI-based methodologies is no more restrictive than the method currently used by the state.

Optional Eligibility of Lawfully-Residing Non-Citizen Children and Pregnant Women (42 CFR §§435.4, 435.406, 457.320)

This proposes to amend §435.406 to implement the Children's Health Insurance Program Reauthorization Act (CHIPRA) option of permitting states to provide Medicaid coverage to children, pregnant women, or both who are lawfully residing in the U.S., and are otherwise eligible for Medicaid/CHIP. This section also updates the definitions of "lawfully present," "non-citizen," and "qualified non-citizen." Updates to the definition of "lawfully present" include adding victims of human trafficking and individuals who have been granted an administrative stay of removal by DHS.

Deemed Newborn Eligibility (42 CFR §§435.117 and 457.360)

This proposed rule clarifies that babies born to mothers covered by Medicaid or a separate CHIP program shall be deemed eligible for the child's first year of life. It also gives states the option of recognizing the deemed newborn from another state for the purpose of enrolling babies born in another state without the need for a new application.

Items for Comment

- On the proposal to delete the alternative eligibility requirement in existing regulations at §435.227(a)(3)(ii) for optional eligibility for individuals under 21 in state adoptive assistance to delete the alternative eligibility requirement that the individual would have been eligible if the state's title IV-E foster care financial eligibility standards and methodologies were used.
- On the interpretation that the application of income standards applied to coverage of disabled individuals would continue to be applied to coverage under the TB eligibility group.
- Whether attestation of citizen status for presumptive eligibility determinations should be an option or a requirement.
- Whether standards for hospital presumptive eligibility determinations should be a federal requirement, a state option, or neither, and what such reasonable standards would be.

- Whether to include individuals who have been granted stays by the U.S. Department of Justice or by a court in the definition of "lawfully present."
- On the overall definition of "lawfully present" in the regulation.
- Whether states should have the option to extend automatic Medicaid enrollment to the extent that the state determines that, under normal circumstances, babies born to mothers in a separate CHIP program are likely to meet requirements for Medicaid eligibility: (1) to all babies born to mothers covered as a targeted low-income children under a separate CHIP program, (2) only to such babies if the state has elected the option to cover targeted low income women under its CHIP state plan, or (3) to no such babies born to mothers covered as a targeted low-income child under a separate CHIP .

Verification Exceptions for Special Circumstances

States may not require documentation from individuals for whom "documentation does not exists or is not reasonably available" during the application or renewal process. This includes individuals who are homeless and victims of domestic violence or natural disasters (§435.952).

Verification Procedures for Individuals Attesting to Citizenship or Satisfactory Immigration Status

Electronic Verification of Citizenship and Immigration Status (42 CFR §§435.940, 435.956)

- States will be required to verify citizenship and immigration status through the federal data services hub, if available. HHS is looking into appropriate procedures for verifying citizenship for qualified non-citizens who are veterans (or their spouses) with an honorable discharge and have fulfilled the minimum active-duty service requirements (§435.940).
- Proposed regulations make verification of citizenship (whether through documentation or electronic data match) a one-time activity that can be recorded in the individual's file (§435.956).

Reasonable Opportunity to Verify Citizenship or Immigration Status (42 CFR §§432.956, 435.949, 435.1008)

- Individuals who declare U.S. citizenship or satisfactory immigration status are afforded a reasonable opportunity period should one of the following situations occur: (1) the individual is unable to provide a social security number, needed for electronic verification with the Social Security Administration (SSA); (2) the federal data services hub, SSA, or HHS databases are temporarily down for maintenance or otherwise unavailable; (3) there is an inconsistency between the data available from an electronic source and the individual's declaration of citizenship or immigration status which the

agency must attempt to resolve, including identifying typographical or clerical errors; or (4) electronic verification is unsuccessful, even after agency efforts to resolve any inconsistencies, and additional information, including documentation, is needed (§432.956).

- Reasonable opportunity period is also triggered should the verification process not be completed promptly. The reasonable opportunity period encompasses all aspects of the process to verify citizenship immigration status, including time for the agency to resolve inconsistencies. HHS is considering a policy in which the reasonable opportunity period would be triggered if an agency cannot resolve inconsistencies with the electronic data match with SSA or HHS within a certain number of business days (§432.956).
- States are permitted to extend the reasonable opportunity period if the agency needs more time to verify citizenship. HHS proposes to apply the same reasonable opportunity period of 90 days to all citizenship verification processes and begin furnishing benefits during such period as of the date of application or declaration of citizenship status (§435.949). States are entitled to receive FF) for benefits provided during the reasonable opportunity period, regardless of whether the final eligibility determination is approved (§435.1008).

Changes to and Clarification of Current Policy (42 CFR §§435.3, 435.406, 435.407)

- For separate CHIP programs, information about a newborn deemed eligible for Medicaid or CHIP in one state is exempt from the citizenship requirement in the state in which the family is applying for Medicaid or CHIP. This also applies to children born to non-citizen mothers covered only for labor and delivery and other emergency services (§435.406).
- The following are permitted to make the declaration of citizenship or immigration status: the individual, an adult member of the individual's family or household, an authorized representative, and if the applicant is a minor or incapacitated, someone acting responsible for the applicant.
- Proposed regulations modified rules on citizenship that cannot be verified through the federal data services hub or an electronic data match directly by SSA. Non-statutory requirements that increase administrative burden and create unnecessary barriers to successful documentation are eliminated. The provisions eliminated do not compromise program integrity (§435.407). These include:
    - Changing to a two-tiered approach to documents: (1) individuals providing evidence of citizenship and (2) individuals providing evidence of citizenship but additional documentation to verify identity is needed.
    - Requirement for individuals to provide original copies of documents is removed. States are required to accept photocopies, facsimiles, scanned, or other copies of documents.

- States are permitted to maintain a record (including an electronic copy) of a successful verification instead of paper copies.
- Documents relating to federally-recognized Indian tribes are considered primary evidence of citizenship and identity. Indian tribes residing in states with an international border do not have further citizenship requirements.
- An individual no longer needs two affidavits signed by two individuals for the purposes of documenting citizenship.

- States are permitted to rely on findings by an express lane agency, regardless of whether the state exercised the option to rely on findings by such agency for Medicaid eligibility (§435.407).
- The age limit for the citizenship requirement is changed so that individuals less than 19 years (CHIP eligible) are not required.
- States cannot exclude eligible individuals from coverage if they are U.S. citizens or nationals, or qualified non-citizens that satisfy verification requirements. Furthermore, states can no longer accept self-attestation of citizenship to establish eligibility for CHIP. This is proposed in the same manner for Medicaid eligibility. States are required to follow all rules for verifying citizenship and immigration status (§457.320).

Items for Comment

- What are appropriate verification procedures to determine veteran status? (e.g., for qualified non-citizen veterans with an honorable discharge who fulfilled the minimum active-duty service requirements and who are exempt from the five-year waiting period to enroll in medical assistance or subsidized Exchange).
- Whether, consistent with existing regulations, Medicaid agencies should be expected to retain records relating to citizenship verification indefinitely or a more limited period of time (5 to 10 years).
- States have the option of some reasonable time to resolve inconsistencies and verify immigration status prior to providing the reasonable opportunity period. HHS is considering another option, either instead of or addition to, that the reasonable opportunity period (including the provision of benefits) would be triggered if the Medicaid or CHIP agency cannot resolve any inconsistencies with the electronic match with SSA or HHS within a specified number of business days.
- Whether to permit individuals who declare that they are citizens and also members of an Indian tribe to rely on the same tribal documents for identity verification, regardless of whether the tribe is located in a state with an international border.

Elimination or Changes to Unnecessary and Obsolete Regulations

Sections rendered obsolete due to the expansion of Medicaid coverage under the Affordable Care Act to most individuals at or below 133 percent of the FPL are deleted (§435.113, 435.114, 435.201, 435.210, 435.211, 435.220, 435.223, 435.401, 435.510, 435.522, 435.909, 435.1004).

Items for Comment

N/A

Coordinated Medicaid/CHIP Open Enrollment Process

- Medicaid and CHIP agencies are to begin accepting the single, streamlined application during the initial open enrollment period. Certain provisions relating to the final Medicaid eligibility rule are effective October 1, 2013, to align with the open enrollment period of the Exchange (§435.1205). These include:
    - Beginning October 1, 2103, states are required to either begin (1) accepting eligibility determinations based on MAGI that are made by the Exchange or (2) receiving electronic accounts of applicants determined to be potentially eligible for Medicaid by the Exchange—with such records being transferred to the state Medicaid agency for final determination.
    - A state Medicaid agency has the option of scheduling the first regular renewal for individuals applying during the open enrollment period to occur anytime between 12 months from the date of application and January 1, 2015. States must conduct post-eligibility data matching to ensure continued eligibility through the first regularly-scheduled renewal.
    - A state Medicaid agency may notify individuals that submit the single, streamlined application to submit a separate application to determine eligibility in 2013.
    - During the initial open enrollment period and at least through 2014, some individuals may submit the application used by the state to determine eligibility using 2013 rules.
- These provisions equally apply to states administering a separate CHIP program (§435.370).

Items for Comment

- HHS notes that it is open to discussion with states on transition options regarding (1) accepting determinations based on the MAGI made by the Exchange or (2) receiving

electronic accounts of applicants assessed as potentially Medicaid eligible by, and transferred from, the Exchange.

- Whether states should only notify a subset of applicants about the process to apply for coverage with an effective date in 2013.
- Whether the appropriate effective date for some or all of the regulations promulgated or revised in the Medicaid eligibility final rule should be October 1, 2013, or January 1, 2014, to ensure a smooth initial open enrollment period.
- HHS seeks comments on the best ways for states to ensure that individuals submitting applications during the open enrollment period are evaluated for coverage effective January 1, 2014, and to ensure that state Medicaid agencies receive additional information to determine if they are eligible for Medicaid.

Children's Health Insurance Program Changes

CHIP Waiting Periods (42 CFR §§457.805)

- CHIP state plans must include a description of "reasonable procedures" to prevent substitution that must account for coordinating between the Exchange and CHIP for families choosing to enroll through the Exchange during a waiting period for CHIP coverage (§457.805).
- States retain the ability to impose a waiting period of no more than 90 days. In addition, states retain the ability to grant state-defined exemptions from the waiting period. These exemptions include: (1) the cost of the discontinued coverage for the child exceeded 5 percent of household income; (2) the cost of family coverage that includes the child exceeds 9.5 percent of the household income; (3) the employer stopped offering dependent coverage; (4) changes in employment, including involuntary separation, resulting in loss of access to employer-sponsored insurance (ESI)—other than through payment of the full premium by the parent under the Consolidated Omnibus Budget Reconciliation Act (COBRA) insurance; (5) the child has special health care needs; and (6) child lost coverage due to the death or divorce of a parent.
- The proposed regulations consider limiting the application of waiting periods to children with family incomes above 200 or 250 percent of the FPL.
- Any waiting period imposed on children eligible for CHIP must also be applied in the same manner to a state's premium assistance program.

Limiting CHIP Premium Lock-Periods (42 CFR §§457.570)

States are permitted to continue to impose premium lock periods only cases where families have not paid outstanding premiums or enrollment fees. Lock-periods can only last up to 90 days.

Past-due premiums or enrollment fees for children subjected to a lock-period must be forgiven (§457.570).

Items for Comment

- HHS invites comments on (1) the proposal to allow CHIP waiting periods of up to 90, as well as other options and (2) the viability of alternative strategies to reduce substitution of coverage to best balance the goal of preventing coverage gaps for children while ensuring that CHIP coverage does not substitute for coverage available under group health plans.
- HHS invites comments on any alternative late payment policies to encourage families to make their CHIP premium payments in a timely manner in order to avoid gaps in coverage.

Premium Assistance (42 CFR §§435.1015)

- Premium assistance programs are authorized to support enrollment of individuals eligible for Medicaid, CHIP, and QHPs through the Exchange.
- States will be expected to demonstrate cost-effectiveness; the cost of the program may not exceed the costs of providing these services under the state plan. The test for cost-effectiveness includes administrative expenditures, costs of providing wraparound benefits, and services otherwise covered under the Medicaid state plan.
- States may claim FFP for premium payments for non-Medicaid eligible family members if enrollment in such a group plan is necessary for the enrollment of the Medicaid-eligible individual. This is allowed as long as the cost-effectiveness test is satisfied.

Items for Comment

- HHS invites comments on how state Medicaid and CHIP agencies can coordinate with the Exchange to establish and simplify premium assistance arrangements and how these arrangements will be operationalized.
- HHS seeks comments on whether a provision should be included that addresses an arrangement where states may claim FFP for payment of premiums for non-Medicaid-eligible family members if enrollment in a group health plan of such members is necessary for the enrollment of the Medicaid-eligible individual, so long as the cost-effectiveness test is met.

Electronic Submission of the Medicaid and CHIP State Plan (42 CFR §§430.12, 457.50, 457.60)

The proposed regulations reflect the implementation of an automated transmission for the Medicaid and CHIP business processes. In consultation with states, HHS is developing the

MACPro (Medicaid and CHIP program) system to electronically receive and manage state plan amendments. MACPro will also house other Medicaid and CHIP business documents.

Items for Comment

N/A

Changes to Modified Adjusted Gross Income and MAGI Screen

Changes for Modified Adjusted Gross Income (MAGI)

- Stepparents are included in the definition of "parents" (§435.603).
- The across the board application of the 5 percent income disregard is eliminated. Instead, the income disregard should only be applied when its application affects eligibility on the basis of MAGI. The rules clarify that the 5 percent disregard only applies to the highest income threshold under a MAGI-based eligibility group (§435.603).
- Exception from MAGI-based financial methods for individuals seeking long term care services and supports only occurs if such individuals (1) are requesting coverage for an eligibility group for which a level-of-care need is a condition of eligibility or (2) such needed services are only available for individuals determined eligible using non-MAGI-based financial methods (§435.603).

MAGI Screen (42 CFR §§435.911)

- Two minor revisions are made to the "applicable MAGI standard" (§435.911):
    - Parents and caretaker relatives are included if the state adopted and phased in coverage for such groups.
    - There is no applicable standard for individuals aged 65 years and older or those aged 19 through 64 years who are entitled or enrolled in Medicare. The only exception is for pregnant women, parents, or caretaker relatives.

Items for Comment

- HHS seeks comments on the following situations and any other possible situation when an individual is counted as part of two households for the purposes of determining Medicaid eligibility: when one or both spouses filing as "married, not filing jointly" claims one or more tax dependents; when one or both members of an unmarried couple with a child in common have tax dependents of their own; and in some three-generation households, depending on the tax filing status of the household members.

Single State Agency – Delegation of Eligibility Determination to Exchanges (42 CFR §§155.110, 431.10, 431.11)

- Proposed regulations revert to previous proposed policy that limits the authority for state Medicaid agencies to delegate eligibility determinations to an Exchange. Such authority can only be delegated to Exchanges that are governmental agencies that maintain personnel standards on a merit basis.
- This section adds explicit language to (1) require the Medicaid agency to remain responsible for determining eligibility for all individuals applying for or receiving benefits and for conducting fair hearings, and (2) consolidate language relating to other state or federal agencies to which the single state agency currently is permitted to delegate authority to determine Medicaid eligibility.
- The requirement for a state plan to provide for a medical assistance unit within a Medicaid agency is deleted.

Items for Comment

- HHS seeks comment on the proposed change with regard to the permissible delegations of final Medicaid eligibility determinations. HHS proposed to revert to the policy that state Medicaid agencies would be limited to delegating eligibility determinations to Exchanges that are government agencies maintaining personnel standards on a merit basis.
- HHS seeks further comment on ways states can ensure a coordinated system by engaging non-profits and private contractors in the process of supporting Medicaid and CHIP eligibility determinations while ensuring that the eligibility determination is made by a government agency.
- HHS seeks comment on whether the requirement for the state plan to provide for a medical assistance unit within the Medicaid agency and a description of the organization and functions of such unit should be retained.

Medical Support and Payments (42 CFR §§443.138, 433.145, 433.147, 433.148, 433.152, 435.610)

- The proposed rule revises current Medicaid regulations to conform to the following statutory changes (§1912):
    - As a condition for Medicaid eligibility, adults must cooperate in establishing paternity and obtaining medical support at application. The rules clarify that enforcement of these provisions occurs after application, and that individuals must attest to cooperation during application.

- Technical corrections update references to pregnant women's eligibility (1902(a)(10)(A)(i).

Items for Comment

N/A

Conversion of Federal Minimum Income Standards

Section 1902(e)(14)(A) and (E) of the Act, as added by section 2002 of the ACA, provides for the conversion of the income standards in effect in the state prior to the ACA to thresholds that are not less than the levels that applied on the date of current rules. Since the publication of the Medicaid eligibility final rule, the Supreme Court decided that the Secretary does not have the authority to penalize a state for not adopting the new adult eligibility group. In states that do not expand coverage to the new adult group, and who reduce coverage for parents to statutory federal minimum thresholds, eligibility for coverage for these parents could be restricted if minimum eligibility thresholds are not converted. If the federal minimum thresholds are less than 100 percent of the FPL, parents in a state that does not expand may not even have the opportunity to receive an APTC to purchase coverage on the Exchange.

- The proposed rule retains the minimum income standards specified in federal statute for each eligibility group, while giving states the flexibility to set new standards using MAGI at a level that would take into account a state's current rules on calculating income to ensure that, in the aggregate, individuals that would have been eligible under Medicaid rules in effect prior to the ACA remain eligible once the new MAGI-based methodologies go into effect (1902(e)(14)(A) and (E)).
- The proposed rule changes the income standard by applicable family size for pregnancy benefits but does not require the conversion of federal minimum income standards and limits for all other eligibility groups and covered services §435.116(d)(4)(i).

Items for Comment

N/A

Section II. Essential Health Benefits in Alternative Benefit Plans (42 CFR §§ 440.305; 440.315; 440.335; 440.345; 440.347)

Background

Beginning in 2014, all non-grandfathered health insurance coverage in the individual and small group markets, Medicaid benchmark and benchmark-equivalent plans (Alternative Benefit

Plans), and BHPs will cover essential health benefits (EHBs), which include items and services in 10 statutory benefit categories.

Provision of the Proposed Rule - Medicaid Program; State Flexibility for Medicaid Benefit Packages

Benchmark Benefit and Benchmark-Equivalent Coverage -Conforming Changes to Medicaid to Align with Essential Health Benefits (§1937):

- States have the flexibility to amend Medicaid state plans to use "Alternative Benefit Plans"—benefit packages other than the standard Medicaid state plan benefit package—for certain populations as defined by the state, based on one of four benchmark or benchmark-equivalent packages:
    - Federal Employees Health Insurance Benefit plan (FEHB) Standard Blue Cross/Blue Shield Preferred Provider Option.
    - State employee health coverage.
    - Health insurance plan offered through the health maintenance organization with the largest insured commercial non-Medicaid enrollment in the state.
    - Secretary-approved coverage, which is a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population.
- Under The Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171), benchmark-equivalent coverage is provided when the aggregate actuarial value of the proposed benefit package is at least actuarially equivalent to the coverage provided by one of the benefit packages described above.
- The proposed rule revises current Medicaid regulations to conform to the following statutory changes and provides further interpretation of how EHBs apply to Medicaid:
    - Adds mental health benefits and prescription drug coverage to the list of benefits that must be included in benchmark-equivalent coverage (ACA 2001c) §440.335 (b)(7) and (b)(8).
    - Requires inclusion of EHBs beginning in 2014 (ACA 2001c) §440.347
    - Requires compliance with the Mental Health Parity and Addiction Equity Act of 2008 (ACA 2001c) §440.345(c) – 1937.
    - Establishes new adult eligibility group for low-income adults aged 19 to 64 through an Alternative Benefit Plan (ACA 2001c) §440.305 (d) revised to §440.386 (a) and (b).
    - Codifies that the new optional eligibility group for "former foster care children" under age 26 will not be included in the new adult eligibility group, and exempts

these individuals from mandatory enrollment in an Alternative Benefit Plan (ACA 2004) §440.315(h).

- Provides that medical assistance to individuals of child bearing age include family planning services and supplies (ACA 2303c) §440.345(b).
- Allows Alternative Benefit Plans that are determined to include EHBs as of January 1, 2014, to remain effective through December 31, 2015, without the need for updating and provides that states and stakeholders will be consulted to evaluate the process to determine how often states would need to update these types of Alternative Benefit Plans after that date §440.345(e).

- States have the option of selecting a different base-benchmark plan to establish EHBs for each Alternative Benefit Plan. States may choose to target populations for receipt of specialized benefit packages, allowing for different Alternative Benefit Plans to apply to different populations. Two standards for minimum coverage provision include §440.347(c):
  1. States select a coverage option from the choices found in section 1937 of the Act.
  2. States will determine whether that coverage option is also one of the base-benchmark plan options.
- Benefit design cannot discriminate "on the basis of an individual's age, expected length of life, or of an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions" (ACA 1302(b)(4)).
- Additional clarifications:
  - For Medicaid, medically necessary services, including pediatric oral and vision services, must be provided to eligible individuals under the age of 21 under the Medicaid Early Periodic Screening, Diagnostic and Testing (EPSDT) benefit.
  - Any limitation relating to pediatric services that may apply in a base benchmark plan in the context of the individual or small group market does not apply to Medicaid.
  - Any state that provides payment for drugs must cover all covered outpatient drugs, whereby drug manufacturers must pay statutorily defined rebates to the states through the Medicaid drug rebate program.
  - All other provisions under title XIX of the Act apply, unless a state can satisfactorily demonstrate that implementing such other provisions would be directly contrary to their ability to implement Alternative Benefit Plans.
  - The definition of "medically frail" is modified to specifically include individuals with disabling mental disorders; individuals with serious and complex medical conditions; individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or individuals with a disability determination.

Other Changes to Simplify, Modernize, and Clarify Medicaid Benchmark Requirements and Make Technical Corrections to Coverage Requirements

- Defines regulatory definition of who can provide preventive services as "services…recommended by a physician or other licensed practitioner of healing arts within the scope of their practice under State law (ACA 1905(a)(13)) §440.130."
- Modifies public notice requirement for Alternative Benefit Plans to require that notice be given prior to implementing a state plan amendment (SPA) §440.386.

Items for Comment

- HHS seeks comments regarding whether the state-defined habilitative benefit definition for the Exchanges should apply to Medicaid or whether states should be allowed to separately define habilitative services for Medicaid.
    - Exchange Definition: If the EHB-benchmark plan does not include coverage for habilitative services and the state does not determine habilitative benefits, then a health insurance issuer must select from two options:
        - Provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services.
        - Decide which habilitative services to cover and report on that coverage to HHS.
- Whether individuals with a substance use disorder should be added to the definition of "medically frail" and therefore exempted from mandatory enrollment in an Alternative Benefit Plan.

Section III. Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges

Background

This section of the proposed rule makes additions to and amends the Exchange Final Rule, published on March 27, 2012.

Consumer Assistance Tools and Programs (45 CFR §§ 155.250; 155.225; 155.227)

The rule clarifies that individuals providing assistance through a formal consumer assistance program developed by the Exchange must be trained on QHP and IAP eligibility, options, and regulations.

Application Counselors (45 CFR § 155.225)

This section proposes a new category of individuals who may assist with applications and facilitate enrollment into QHPs. These "application counselors" will provide the same "core application assistance" as navigators and producers provide, but they will not be funded through the Exchange. Medicaid application counselors currently work with state Medicaid and CHIP agencies to provide Medicaid application assistance; this program is intended to provide the same assistance for QHP enrollment.

The proposed rule lays out certification standards and develops a certification process for application counselors. Specifically, individuals applying for application counselor certification:

- Must be trained regarding QHP and IAP options and eligibility rules.
- Disclose any conflicts of interest to the Exchange and potential applications (e.g., receiving payment from a carrier).
- Comply with the privacy and security standards under the ACA and any additional standards developed by the Exchange.
- Provide information in accordance with the ADA.
- Enter into an agreement with the Exchange.

The proposed rule further explains that the Exchange must establish a method of withdrawing certification where it finds noncompliance with the terms and conditions of the application counselor agreement. The Exchange must also propose procedures to ensure that applicants are aware of the responsibilities of the application counselors. Finally, application counselors may also be designated by the state Medicaid and CHIP agencies; in this case, the state has the option to develop one single certification process for both the Exchange and Medicaid/CHIP.

Authorized Representatives (45 CFR §155.227)

The proposed rule elaborates on requirements for authorized representatives who act on behalf of individuals or employees. First, the proposed rule explains that the Exchange must permit individuals and employees to designate an individual or an organization to act on its behalf. The designation must be in writing and requires a signature. Still, this designation may also be through representation due to a state law (e.g., legal guardianship), and legal documentation may be provided in lieu of an individual/employee's designation. The Exchange must ensure that the authorized representative be bound to maintain confidentiality and to comply with data security standards. Further, the Exchange must ensure that the authorized representative fulfill all its duties (e.g., signing the application, submit updates and respond to redeterminations, receive copies of notices and other Exchange communication), acting on behalf of and completing the duties to the same extent as the individual or employee.

The Exchange must allow individuals to designate authorized representatives at two times: (1) when the individual is completing the single, streamlined application and (2) when the individual is completing any alternative application developed by the state. Individuals and employees who do not use these methods of designation can do so through the website, call center, mail, or in person. The Exchange must also permit an individual/employee to withdraw the authorization at any time; an authorized representative may withdraw representation by notifying the Exchange and the individual/employee. Where authorized representatives are affiliated with organizations, both the authorized representative and the organization must sign an agreement with the Exchange that meets the certification standards for application counselors.

Items for Comment

- Whether the requirement to sign an agreement with the Exchange should be required of all authorized representatives rather than only those representatives who are affiliated with an organization.

Exchange Notices (45 CFR §155.230)

This section first explains that any notices required to be sent by the Exchange must be in writing and must include the action contained in the notice, its effective date, any factual findings related to the action, and identification of any relevant regulations. The Individual Exchange may provide notices through standard mail or, upon the individual/employer's election, via email. The rule proposes that these standards are not applicable to the Small Business Health Options Program (SHOP) Exchange. Still, CMS is considering applying the same standards to the SHOP Exchange and, in addition, allowing the SHOP Exchange to adopt an all-electronic approach.

Items for Comment

- On the proposed approach for providing notices and whether the alternative approach related to the SHOP Exchange should be adopted.

Eligibility

Conducting Eligibility Determinations (45 CFR §155.302)

The proposed rule clarifies that when the Exchange makes Medicaid/CHIP assessments, rather than determinations, the applicant's options for withdrawal of the application are limited. Specifically, where the applicant is assessed as ineligible for Medicaid/CHIP based on MAGI standards, the Exchange must provide the applicant with the option to withdraw the application. Where, however, the applicant is assessed as Medicaid eligible based on factors other than MAGI, the option to withdraw is not available as the application will be sent to the state Medicaid agency for a full determination. Further, the propose rule states that an individual's application should not be considered withdrawn where the individual appeals his or her

eligibility determination for APTCs or CSRs and the Exchange appeals entity finds that the individual may potentially be eligible for Medicaid/CHIP. This is to preserve the individual's right to Medicaid/CHIP determinations based on the initial date of application. Finally, the proposed rule explains that the Exchange must adhere to the Medicaid/CHIP appeals decisions made by the Medicaid agency, rather than only having to adhere to the initial eligibility determination.

Standards for Eligibility (45 CFR §155.305)

The proposed rule revises the residency standards, explaining that the Exchange may not terminate or deny and individuals' eligibility for enrollment into QHPs if the individual meets the residency standards set forth in the Final Rule but for a temporary absence from the Exchange's service area, provided that the individual intends to return and no other Exchange verifies that the individual meets its residency requirements.

The proposed rule also provides details on eligibility standards and APTC/CSR application to catastrophic plans. First, the rule reiterates that APTCs and CSRs do not apply to enrollment in QHP catastrophic plans. Second, the rule explains that the Exchange will determine an individual to be eligible for a QHP catastrophic plan where:

- The individual has not reached the age of 30 before the beginning of a plan year.
- The individual can certify that he or she is exempt from the shared responsibility requirement under §5000A of the Code.

Additional federal guidance on catastrophic plans and standards for exemptions is forthcoming.

Eligibility Process (45 CFR §155.310)

This section of the Exchange final rule is amended by the proposed rule to include a new "certification" process by which HHS will certify to the employer that one or more of its employees has enrolled for one or more months during a year into a QHP with respect to which APTC/CSR is allowed or paid, including employees who claim such on their tax return.

Verification Process for Eligibility for Enrollment into QHPs and IAPs (45 CFR §§ 155.315; 155.320)

The proposed rule clarifies the circumstances that trigger the "inconsistency process" (explained in 45 CFR §155.315(f)) related to verify an applicant's eligibility information. Specifically, the proposed rule describes two circumstances in which the Exchange should follow the inconsistency process:

- When electronic data is required but is not included in the available data sources.

- When electronic data is required but not reasonably expected to available within two days of the request.

The proposed rule explains that these circumstances have been presented to minimize use of the inconsistency process. Further, the rule explains that the Exchange should make a reasonable effort to identify the cause of, and address, the inconsistencies. The proposed rule explains that CMS expects most inconsistencies to be resolved in real-time (e.g., the system asking an applicant to re-enter information due to a typographical error).

With regard to verification of information for IAP eligibility, the rule amends the Exchange final rule by clarifying that there is no "tax identification number" needed for APTC/CSR calculations. Further, when an individual is applying through the Exchange, the Exchange must first verify that there is no APTC/CSR already being provided on behalf of the individual. Information to verify APTC/CSR will come from HHS.

The proposed rule then provides standards for verifying household income. Where an individual states that his or her household income has increased or is reasonably expected to increase from the income computed based on available data, the rule explains that the Exchange must accept the attestation without further verification. Where, however, the data shows that the income attested to is significantly higher than the income computed based on available data, the Exchange should proceed with the "inconsistency process" explained in 45 CFR §155.315(f).

The proposed rule also explains the process for verifying attested income that is significantly lower than the computed income. Where the income attested to is 10 percent lower than the income computed by available data, the Exchange should follow the "inconsistency process" explained in 45 CFR §155.315(f). Where the attested income is lower by less than 10 percent, the Exchange must accept the income attested to without seeking further verification.

This section of the proposed rule next explains the process for verifying enrollment in an ESI plan. First, HHS can complete the verification. Should a state choose to verify on its own, however, all data sources used by the state must be HHS-approved. The rule explains that for federal employees, HHS data sources should be used; for SHOP Exchange eligible employees, SHOP data sources should be used. Where information related to employee enrollment in an ESI plan is unavailable, the Exchange must select a statistically significant random sample, and handle inconsistencies related employment or household income through the sampling process. In the sampling process, the Exchange would first notify the applicant who is selected as part of the random sampling that the Exchange will contact any employer identified on the application of the applicant to verify eligibility for an ESI plan. The Exchange should then also proceed with all other elements of eligibility determination for enrollment, and ensure that ATPC and CSR are provided to individuals who are otherwise eligible. The Exchange, in the meantime, must make reasonable attempts to contact any employer identified on the application via phone or mail. An alternative is also proposed, whereby the onus would be on the consumer to obtain information from his or her employer. In either case, if the Exchange receives information from the employer

related to the individual's eligibility for an ESI plan, it should proceed with eligibility using that information. If, however, the Exchange is unable to obtain the necessary information within 90 days, it should proceed using the applicant's attested information.

Items for Comment

- Whether available data sources should be used as points of information in verifying enrollment in an ESI plan or should be comparison tools.
- Whether it is feasible for an Exchange to connect to the necessary data sources.
- How the Exchange should communicate selection for the sampling process to an applicant.
- Whether the alternate approach—putting the onus on the consumer to obtain the employer information—should be implemented.
- Whether the sampling approach is feasible.
- Whether there are ways to further simplify this process for ensuring that an individual's attestation of income is not understated.
- Ways the Exchange can most efficiently interact with employers, including other entities that employers may rely upon to support this process, such as third-party administrators.
- On limiting notifications to situations in which the information provided by an employer changes an applicant's eligibility determination.
- The proposed rule states that after a period of 90 days from the date the notice is sent to an applicant, and the Exchange is unable to obtain the necessary information from an employer, the Exchange will determine the applicant's eligibility based on his or her attestation regarding that employer. HHS seeks comment on this proposal and whether it is preferable to include an additional notice to the applicant and employer at the end of the 90-day period.
- The use of the pre-enrollment template and ways it can be used to assist consumers with providing the necessary information to complete the verification described in this paragraph while minimizing burden on employers. HHS intends to release the template for comments "in the near future."

Redeterminations

During a Benefit Year (45 CFR §155.330)

The proposed rule clarifies that the Exchange must conduct periodic examinations of data sources to identify eligibility for determinations of Medicare, Medicaid, CHIP, and the BHP as applicable, only for enrollees who are being provided APTC/CSRs, and not all QHP enrollees. Further, the Exchange must notify enrollees of their redeterminations *and* CSR changes as a

result of the change they report in their circumstances or of the periodic examination of the data sources.

The proposed rule also explains how the exchange should proceed with data matching when an individual is deceased (45 CFR §155.330(e)(2)).

Finally, this section of the proposed rule adds coverage effective dates for eligibility changes as a result of appeals decisions, events related to eligibility redeterminations, and changes affecting only enrollment and premiums. Specifically:

- For appeals decisions that change eligibility, the change in coverage is effective on the first day of the month following the date of the notice of the appeal decision; where an appeal is retroactive, coverage is effective on the date stated in the decision.
- For eligibility redeterminations, the change in coverage is effective on the first day of the month following the individual's redetermination notice.
- For changes affecting only enrollment and premiums, the change in coverage is effective on first day of the month following the date on which the Exchange is notified of the change.

Where changes occur after the fifteenth day of the month, the Exchange may establish a date beyond which the change is effectuated not on the following month, but the month after (i.e., on the first day of the second calendar month after the change occurs). Still, the Exchange must effectuate changes on the first day of the month following the change when it results in a decrease in APTC or a decrease or increase in CSR.

Items for Comment

- HHS seeks comments on adding a provision such that if an enrollee experiences a change in his or her level of CSRs as a result of the redetermination, the notice issued by the Exchange will describe how the enrollee's amount of deductibles, co-pays, coinsurance, and other forms of cost sharing would change as a result of the change in level of cost-sharing reductions if the enrollee stays in the same qualified health plan (QHP) and only changes plan variations).
- HHS believes that including in the notice a description of how the enrollee's amount of deductibles, co-pays, coinsurance, and other forms of cost sharing would change as a result of the change in level of cost-sharing reductions (if the enrollee stays in the same QHP with only changes in plan variation) will be particularly important in the event an individual does not decide to change QHPs during the special enrollment period. HHS seeks comment on whether such an approach should be adopted.

- HHS notes that the special enrollment period does not currently address children placed in foster care and solicits comments on whether HHS should expand it to cover this population.
- HHS seeks comments on the following change: HHS reiterates that APTCs and CSRs may only be provided for a "coverage month" that requires coverage to be in place on the first of the month. The Exchange may not authorize these benefits for periods other than when an individual is in a coverage month.

Annual Redeterminations (45 CFR §155.335)

The proposed rule explains that the Exchange will conduct eligibility redeterminations on an annual basis for all qualified individuals, rather than those just enrolled in QHPs. This is to cover an individual in the situation where the individual submitted an application prior to the open enrollment period and was determined eligible for enrollment in a QHP, but did not meet the criteria for a special enrollment period. Conversely, the Exchange does not have to perform an eligibility redetermination where a qualified individual does not select QHP before a redetermination and is not enrolled in a QHP at any time during the benefit year before the redetermination.

Items for Comment

- On adding a provision related to benefit year redeterminations to explain that if an enrollee experiences a change in his or her level of CSRs as a result of the redetermination, the notice issued by the Exchange will describe the enrollee's amount of deductibles, co-pays, coinsurance, and other forms of cost sharing that would change as a result of the change in CSRs.

Coordination with Medicaid, CHIP, the BHP, and PCIP (45 CFR §155.345)

As explained above, the proposed rule elaborates on requirements for collaboration between the Exchange and other state agencies. This section imposes the same requirements for combined notices on the Exchange as is required for the state Medicaid agency earlier in the proposed rule. Specifically, this section explains that the Exchange must provide *coordinated* notices prior to January 1, 2015, and *combined* notices beginning on January 1, 2015. The following briefly explains both:

- Coordinated notices: When an individual submits an application to the state Medicaid agency, is found ineligible for Medicaid, and is then transferred to the Exchange, the Medicaid agency will first send a notice to the individual explaining that the individual is denied eligibility and that the individual's information is being transferred to the Exchange for determination of enrollment in a QHP, and for APTC/CSR eligibility. The

Exchange would then send a second notice explaining the individual's eligibility for QHP enrollment and APTC/CSRs.

- Combined notices: This eligibility notice will inform an individual of his or her eligibility for QHP enrollment, APTC/CSR, Medicaid/CHIP eligibility, and all other IAPs. A combined notice will be issued by the last agency to perform an eligibility determination, except where the determination is for Medicaid on a non-MAGI basis. In the scenario above, January 1, 2015, the Exchange would provide a combined eligibility notice that includes information about the individual's denial of eligibility for Medicaid and the individual's eligibility for enrollment into QHPS and APTC/CSRs.

This section also notes that any agreements the Exchange enters into with agencies administering Medicaid/CHIP, and, where applicable, the BHP must delineate responsibilities of each agency and must provide for combined eligibility notices beginning on January 1, 2015. Further, it explains that the Exchange will notify an agency transmitting an account to the Exchange of receipt of the account, and will also notify the transmitting agency of the individual's eligibility determination for QHP enrollment and APTC/CSR.

Items for Comment

- On situations in which combined eligibility notices may or may not be appropriate.
- On how to assess where combined notices are feasible.
- On the phased-in approach and the use of coordinated content for eligibility notices by the Exchange and agencies administering IAPs .

Enrollment

Enrollment of Qualified Individuals into QHPs (45 CFR §155.400)

This section proposes that in addition to sending eligibility and enrollment information to QHP issuers and HHS without undue delay, the Exchange must also send updated eligibility and enrollment information to HHS. "Updated eligibility and enrollment information" means all enrollment-related transactions, including, but not limited to:

- Enrollments sent to issuers for which the qualified individual has not yet remitted premiums.
- Enrollment for which payment has been made on any applicable enrollee premium.
- Cancellations of enrollment prior to coverage becoming effective.
- Terminations of enrollment.
- Enrollment changes (including termination and cancellations initiated by the issuer).

Special Enrollment Periods (45 CFR §155.420)

The proposed rule clarifies the scope of the special enrollment periods described in the ACA and Exchange final rule. The rule first explains that dependent includes an individual who becomes eligible for coverage under a QHP because of a relationship with the qualified individual or enrollee. The proposed rule extends special enrollment period eligibility to dependents when the specific triggering events occur:

- Loss of minimum essential coverage.
- Enrollment in a QHP is unintentional, erroneous, or inadvertent is and is the result of the error, misrepresentation, or inaction of an Exchange or HHS employee, agent, or officer.
- The QHP in which the dependent is enrolled substantially violated a material term of the contract in relation the enrollee.
- Access to a new QHP as a result of a permanent move.
- Newly eligible/ineligible for APTC/CSR while enrolled in QHP or in an ESI plan (if expected to lose the employer-sponsored coverage within 60 days are allowed to terminate the coverage).
- Individual meets other exceptional circumstances.

Finally, this section provides standards around coverage effective dates related to specific events triggering a special enrollment period.

Items for Comment

- Whether the dependent should be eligible for special enrollment periods in circumstances beyond those described in the proposed rule.
- Whether the special enrollment periods should cover children placed in foster care.
- Standards for appropriate coverage effective dates related to special enrollment periods.

Termination of Coverage (45 CFR §155.430)

The proposed rule clarifies that the Exchange must allow individuals to terminate their coverage through a QHP when the individual is determined eligible for, and enrolls into, other minimum coverage.

Items for Comment

- HHS seeks comments on the proposed rule adding language to account for circumstances in which an Exchange finds an enrollee eligible for other minimum essential coverage, thus resulting in the enrollee's ineligibility for APTCs.

- HHS seeks comments on the proposed rule adding language requiring the Exchange to provide a qualified individual with the opportunity to choose to remain enrolled in a QHP if the Exchange identifies that the individual has become eligible for other minimum essential coverage through data matching and the enrollee does not request a termination.

Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

This section of the rule provides standards around appeals of APTC/CSR determination, including coordination with the state Medicaid agency, notice of appeal, appeal requests, and the manner by which the Exchange should conduct appeals.

Definitions (45 CFR §155.500)

The proposed regulation begins by setting forth additional definitions, including "appeal record," "appeal request," "appeals entity," "appellant," "de novo review," "evidentiary hearing," and "vacate."

Items for Comment

- HHS seeks comments on the proposed definitions of "appeals entity," "appellant," "de novo review," "evidentiary hearing," and "vacate."

General Eligibility Appeals Requirements (45 CFR §155.505)

The NPRM applies to state-based Exchanges and FFEs alike. 45 CFR 155.505(a). The appeals process set forth in the NPRM applies to eligibility for enrollment in a QHP, Medicaid, CHIP, and the BHP, if applicable, and for APTC and CSR eligibility for QHP enrollment periods and eligibility for enrollment in a catastrophic plan as well as redeterminations. 45 CFR §155.505(b). The appeals process also applies to eligibility determination for an exemption made in accordance with §1311(d)(4)(H) of the ACA (individual responsibility section); or failure to provide timely notice of an eligibility determination.

The NPRM provides that an Exchange eligibility appeals may be conducted by the Exchange or HHS, upon exhaustion of the SBE appeals process or if the Exchange has not established an appeals process. 45 CFR §155.505(c). 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.[2] The NPRM proposes that appeals entities must comply with the

[2] CMS anticipates that states will have an interest in adjudicating appeals of eligibility determinations made by their state-based Exchanges; therefore, the NPRM proposes to provide flexibility for states to provide an appeals process while respecting the requirement in section 1411(f)(1) of the ACA that a federal appeals process be available to appellants in the individual market. Comment is requested.

standards set forth for providing fair hearings established by Medicaid at 42 CFR 431.10(c)(2).[3] 45 CFR §155.505(d). An appellant may designate an authorized representative to act on his or her behalf.[4] 45 CFR §155.505(e). Further, the appeals processes must comply with the accessibility requirements. 45 CFR §155.505(f). Finally, an appellant may seek judicial review to the extent it is available by law. 45 CFR §155.505(g).

Items for Comment

HHS seeks comments on the following:

- Whether the provisions relating to the eligibility appeals standards apply to all Exchange eligibility appeals process, regardless of whether the appeals process is provided by a state-based Exchange appeals entity or by HHS.
- The scope of determinations that an applicant or enrollee may appeal.
- The degree of flexibility for states to provide an appeals process while respecting the requirement of ACA §1411(f)(1) that a federal appeals process be available to appellants in the individual market.
- Whether an appellant may designate an authorized representative to act on his or her behalf, including making an appeal request.
- The degree that appeals processes must be accessible to appellants who have limited English proficiency or who are living with disabilities.
- Whether an appellant may seek judicial review to the extent allowable by law.

Appeals Coordination (45 CFR §155.510)

The NPRM proposes general coordination requirements for the appeals entities and the agencies administering IAPs. 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. 45 CFR §155.510(a). If an appellant elects to pursue his or her appeal regarding an adverse Medicaid or CHIP 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 or CHIP agency.[5] 45 CFR §155.510(b).

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[3] Medicaid due process requirements is part of the minimum standard an entity must meet to be eligible to process Medicaid appeals, which we propose may be delegated to Exchange appeals entities. Comment is requested

[4] Comments are requested.

[5] If the Exchange appeals entity conducts the hearing on the Medicaid or CHIP denial that hearing decision would be final under the proposed rule. Comments are requested.

Where the Medicaid or CHIP 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 and CHIP eligibility.[6] 45 CFR §155.510(b)(2). 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 information provided as part of the appeal via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency. 45 CFR §155.510(b)(3).

The Exchange must consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid or CHIP as ineligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards for purposes of determining eligibility for APTC and CSR. 45 CFR §155.510(b)(4).

CMS anticipates that appeals-related data will need to be passed between the Exchange, Medicaid, CHIP, and the state-based Exchange and HHS appeals entities in order to process appeal requests and implement appeal decisions. In addition, specific appeals-related information will be shared with the Internal Revenue Service via HHS in order to facilitate the tax reconciliation process under 26 CFR 1.36B-4.T. Thus, the NPRM requires an appeals entity to ensure that all data exchanges that are part of the appeals process comply with the data exchange requirements in §155.260, §155.270, and §155.345(h) and all data sharing requests made by HHS. 45 CFR §155.510(c).

Items for Comment

- On provisions requiring that the appeals entity for the Exchange must enter into agreements with the agencies administering insurance affordability programs as are necessary to fulfill federal requirements.
- On the proposed and alternative provisions relating to coordination standards for Medicaid and CHIP appeals.
- Whether the appeals entity may include in the appeals decision a determination of Medicaid and CHIP eligibility.
- Whether 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 or CHIP agency, as applicable.

[6]The appeals entity must apply MAGI-based income standards and standards for citizenship and immigration status using verification rules and procedures consistent with Medicaid and CHIP requirements under 42 CFR parts 435 and 457. Further, notices required in connection with an eligibility determination for Medicaid or CHIP must be performed by the appeals entity consistent with standards set forth by this subpart, subpart D, and by the state Medicaid or CHIP agency, consistent with applicable law. Comments are requested.

- Whether the Exchange must consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid or CHIP as ineligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards for the purposes of determining eligibility for APTCs and CSRs.
- On the provisions relating to appeals coordination between the Exchange, the appeals entities, and the Medicaid and CHIP agencies, where applicable.

Notice of Appeal Procedures (45 CFR §155.515)

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.[7] 45 CFR §155.515(a). A 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 to 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. 45 CFR §155.515(b).

Items for Comment

- HHS solicits comments on the proposed publication of appellate procedures

Appeals Requests (45 CFR §155.520)

The Exchange and the appeals entity must accept appeal requests submitted by telephone, by mail, in person (if capable of receiving in-person appeal requests) or via the Internet. 45 CFR §155.520(a). The Exchange must consider an appeal request to be valid if it is submitted in accordance with the requirements of the NPRM.[8] 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. 45 CFR §155.520(b). 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. 45 CFR §155.520(c).

[7] CMS assumer Exchanges can meet the notice requirement by including a reference to the appeals process in the single streamlined application required under §155.405 and in the eligibility determination notices required under §§155.310(g), 155.330(e)(1)(ii), and 155.335(h)(1)(ii) and future guidance on exemptions under section 1311(d)(4)(H) of the Affordable Care Act.

[8] The Exchange may assist the applicant or enrollee in making the appeal request and must not limit or interfere with the applicant or enrollee's right to make an appeal request.

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. 45 CFR §155.520(d)(1)(i). 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. 45 CFR §155.520(d)(1)(ii). 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. 45 CFR §155.520(d)(1)(iii). The appeals entity must promptly confirm receipt of the records transferred to the Exchange or the state-based Exchange appeals entity. 45 CFR §155.520(d)(1)(iv).[9] Upon receipt of an appeal request that is not valid because it fails to meet the requirements of the proposed 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 of the nature of the defect in the appeal request; and treat as valid an amended appeal request that meets the requirements of the NPRM. 45 CFR §155.520(d)(2). 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. 45 CFR §155.520(d)(3). Finally, upon receipt of a notice of an appeal of a decision to HHS, the Exchange appeals entity must transmit via secure electronic interface the appellants appeal record, including the appellant's eligibility record as received from the Exchange to HHS. 45 CFR §155.520(d)(3).

Upon receipt of the notice of an appeal to HHS, a state-based Exchange appeals entity must transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to HHS. 45 CFR §155.520(d)(4).

Items for Comment

- Whether the Exchange and the appeals entity must accept appeal requests submitted by telephone, via mail, in person, or through the Internet.
- Whether the Exchange or appeals entity must allow an applicant or enrollee to request an appeal within 90 days of the date of the eligibility determination notice.
- On the appeal acknowledgement and notification provisions.

Eligibility Pending Appeal (45 CFR §155.525)

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. 45 CFR

[9] The Exchange plans to seek clarification on this requirement.

§155.525(a). 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.[10] 45 CFR §155.525(b). As is standard, the NPRM proposes that a continuation of benefits should be available to individuals already enrolled in coverage while appealing a change in current eligibility. This approach ensures continuity of coverage and care during an appeal. 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 requests an appeal will receive eligibility per the original determination during the course of the appeal.

Dismissals (§155.530)

The appeals entity must dismiss an appeal if the appellant withdraws the appeal request in writing, fails to appear at a scheduled hearing, fails to submit a valid appeal request as specified in the NPRM, or dies while the appeal is pending.[11] 45 CFR §155.530(a). If an appeal is dismissed, the appeals entity must provide timely notice to the appellant, including the reason for the dismissal and an explanation of the dismissal's effect on the appellant's eligibility, and an explanation of how the appellant may show good cause why the dismissal should be vacated. 45 CFR §155.530(b). If an appeal is dismissed, the appeals entity must provide timely notice to the Exchange, and to the agency administering Medicaid or CHIP, as applicable, including instruction regarding the eligibility determination to implement; and discontinuing eligibility provided under §155.525. 45 CFR §155.530(c). The appeals entity may vacate a dismissal if the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated. 45 CFR §155.530(d).

Items for Comment

- HHS seeks comment on the proposed approach for appeal dismissals and vacating an appeal dismissal.

Informal Resolution Process (45 CFR §155.535)

The NPRM permits state-based Exchanges to have an informal resolution process prior to undertaking a formal appeal. CMS anticipates that the process will provide appellants the opportunity to work with appeals staff to try to resolve the appeal pre-hearing through a review of case documents, verification of the accuracy of submitted documents, and the opportunity for the appellant to submit updated information or provide further explanation of previously

[10] Continued receipt of APTC during the appeal may impact the amount owed or due at the IRS reconciliation process, depending upon the appeal decision.
[11] This provision is not intended to exclude appeal requests that may have other minor deficiencies or are submitted without complete information.

submitted documents. The informal process must comply with the scope of review specified in the NPRM; 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. 45 CFR §155.535(a).

Items for Comment

- Whether the appeals entity must consider the information used to determine the appellant's eligibility and any relevant evidence presented during the course of the appeal, including at the hearing.
- On the informal resolution and hearing requirements and standards.

Hearing Requirements (§155.535)

The appeals entity must send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date.[12] 45 CFR §155.535(b). All hearings must be conducted at a reasonable date, time, and location or format; after notice of the hearing; as an evidentiary hearing; and by one or more impartial officials who have not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter.[13] 45 CFR §155.535(c).

The appeals entity must provide the appellant with the opportunity to review his or her appeal record, including all documents and records to be used by the appeals entity at the hearing, at a reasonable time before the date of the hearing as well as during the hearing. 45 CFR §155.535(d). The appeals entity must permit the appellant to bring witnesses to testify; establish all relevant facts and circumstances; present an argument without undue interference; and question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses. The appeals entity must consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeal, including at the hearing. 45 CFR §155.535(e). The appeals entity will review the appeal de novo and will consider all relevant facts and evidence adduced during the appeal. 45 CFR §155.535(f).

[12] If the appellant informs the appeals entity that the designated date and time are prohibitive of participation, we expect that the appeals entity will work with the appellant to set a reasonable and mutually convenient date and time. Also, CMS expects that the appeals entity will not schedule a hearing until the appellant has indicated that he or she is dissatisfied with the outcome of the informal resolution process, if so adopted.

[13] HHS permits the format of a hearing to encompass telephonic hearings and hearings held by video teleconference.

Expedited Appeals (§ 155.540)

The appeals entity must establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need of health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function. 45 CFR § 155.540(a). In the case of an appeal request that 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 3 working days after the appeals entity receives the request for an expedited appeal. 45 CFR §155.545(b)(2). If the appeals entity denies a request for an expedited appeal, it must handle the appeal request under the standard process and issue the appeal decision in accordance with §155.545(b)(1); and make 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 2 days of the denial. 45 CFR § 155.540(b).

Items for Comment

- Whether the appeals entity must establish and maintain an expedited appeals process where there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function.
- If an appeal entity denies a request for an expedited appeal, whether it must handle the appeal through the standard process and issue the appeal decision and make 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, either electronically or in hard copy, within two days of the denial.

Appeal Decisions (§155.545)

Appeal decisions must be based exclusively on the information and evidence specified in the NPRM and the eligibility requirements under subpart D of the NPRM. 45 CFR §155.545(a). 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, as administratively feasible.[14] 45 CFR §155.545(b)(1). The appeals entity must provide notice of the appeal decision and instructions to cease pended eligibility to the appellant, if applicable, via

[14] CMS acknowledges that during open enrollment or high-volume redetermination periods might require additional time.

secure electronic interface, to the Exchange or the Medicaid or CHIP agency, as applicable. 45 CFR §155.545(b)(3). Exchange or the Medicaid or CHIP agency, as applicable, must promptly implement appeal decisions upon receiving the notice. 45 CFR §155.545(c). Such decisions should be retroactive to the eligibility date that is the basis of the appeal.[15]

Items for Comment

- If the appeals entity is a state-based Exchange appeals entity, whether the appeal decision must include an explanation of the appellant's right to pursue an appeal at HHS if the appellant remains dissatisfied with the post-hearing eligibility determination.
- HHS seeks comments on the proposed appeal decision notice requirements.
- HHS seeks comments on the operational considerations associated with retroactive eligibility as a result of an appeal, and whether potential operational difficulties, if any, could be alleviated by limiting the policy on retroactive eligibility.
- HHS seeks comment on whether the ability to enroll in coverage retroactively should be optional or limited and, if so, in what way.
- HHS seeks comment on whether the Exchange or the Medicaid agency, as applicable, must promptly redetermine the eligibility of other members of the appellant's household who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision.

Appeal Record (45 CFR § 155.550)

Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeals entity must make the appeal record accessible to the appellant at a convenient place and time. 45 CFR § 155.550(a). The appeals entity must provide public access to all appeal records, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information. 45 CFR § 155.550(b).

Employer Appeals Process (45 CFR §155.555)

An Exchange may establish an employer appeals process through which an employer may appeal a response to a notice regarding an employer's potential tax liability, a determination that the employer does not provide minimum essential coverage through an ESI plan or that the employer does provide such coverage but it is not affordable coverage. 45 CFR §155.555. Where an Exchange has not established an employer appeals process, HHS will provide an employer appeals process.

[15] CMS would like comments about the operational feasibility of this provision.

The Exchange and appeals entity must allow an employer to request an appeal within 90 days from the date the notice described under §155.310(h) is sent; allow an employer to submit relevant evidence to support the appeal; and allow an employer to submit an appeal request to the Exchange or the Exchange appeals entity, if the Exchange establishes an employer appeals process; or HHS, if the Exchange has not established an employer appeals process.[16] 45 CFR §155.555.

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, including an explanation of the appeals process; send timely notice to the employee of the receipt of the appeal request, including an explanation of the appeals process; instructions for submitting additional evidence for consideration by the appeals entity; and an explanation of the potential effect of the employer's appeal on the employee's eligibility.[17] 45 CFR §155.555(d). 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; and treat as valid an amended appeal request that meets the requirements of this section, including standards for timeliness. Upon receipt of a valid appeal request from an employer, the Exchange must promptly transmit via secure electronic interface to the appeal entity the appeal request, if the appeal request was initially made to the Exchange; and the employee's eligibility record. 45 CFR §155.555(e). The appeals entity must promptly confirm receipt of records transmitted pursuant to this section to the entity that transmitted the records. The appeals entity must dismiss an appeal if the request fails to comply with the standards set forth in the NPRM. 45 CFR §155.555(f). Further, the appeals entity must provide timely notice of the dismissal to the employer, employee, and Exchange including the reason for dismissal; and 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 review the information described in §155.310(h)(1); the 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, as set forth by standards described in 26 CFR 1.36B; and other data used to make the determination described in §155.305(f) or (g). 45 CFR §155.555(g). Neither the Exchange nor the appeals entity may make available to an employer

[16] An employer appeal may be submitted by telephone, mail, in person where available, or by Internet, and the appeals entity may assist the employer with making the appeal request and must not limit or interfere with the employer's right to request an appeal. Comments are requested.

[17] CMS anticipates that the notice to the employee will be the primary means through which the employee will learn about the employer's appeal. Just as the employer will have the opportunity to submit information in support of the appeal to the appeals entity, the employee's notice will describe the employee's opportunity to participate in the employer appeal process.

any tax return information of an employee as prohibited by §6103 of the Code. 45 CFR §155.555(h).

An employer appeals must be reviewed by one or more impartial officials who have not been directly involved in the employee eligibility determination implicated in the appeal; consider the information used to determine the employee's eligibility as well as any additional relevant evidence provided by the employer or the employee during the course of the appeal; and be reviewed de novo. 45 CFR §155.555(i).

An employer appeal decisions must be based exclusively on the information and evidence and the eligibility standards; state the decision, including a plain language description of the effect of the decision on the employee's eligibility; and comply with the requirements set forth in §155.545(a)(3) through (5). 45 CFR §155.555(j).

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. 45 CFR §155.555(k). After receipt of the notice, if the appeal decision affects the employee's eligibility, the Exchange must promptly redetermine the employee's eligibility.[18] 45 CFR §155.555(l). The appeal record must be accessible to the employer and to the employee in a convenient format and at a convenient time. 45 CFR §155.555(m).

Items for Comment

- Whether an appeals process should be established through which an employer may appeal a determination that the employer does not provide the minimum essential coverage through an ESI plan or that the employer does provide such coverage. HHS is working closely with the IRS to educate and develop notices that help employers understand their potential tax liabilities and the consequences of a successful appeal.
- On the proposed process and standards for requesting an appeal.
- Whether the appeals entity may assist the employer with making the appeal request and must not limit or interfere with the employer's right to request an appeal.
- Whether an appeals entity must consider an appeal request valid if it is submitted within 90 days of the notice to the employer of a determination that the employer does not provide minimum essential coverage through an ESI plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee.

[18] CMS is considering and soliciting comments on, two alternative options regarding whether an employee may appeal the results of a redetermination which has resulted from an employer appeal. Under the first option, the employee would be permitted to appeal a change in eligibility reflected in the redetermination notice generated after an employer appeal. Under the second option, an employee would not be permitted to appeal a change in eligibility reflected in the redetermination notice generated after an employer appeal. Instead, an employee would be issued a redetermination notice under this section which would not be appealable under §155.505(b)(1)(ii).

- Upon receipt of a valid appeal request, whether the appeals entity must send timely acknowledgement of the receipt of the appeal request to the employer, including an explanation of the appeals process.
- On the provisions relating to dismissal.
- On the proposed procedural rights of the employer requesting an appeal.
- On the employer's right to review data and information used to make the employee's eligibility determination.
- On the proposed process and standards for adjudication of employer appeals.
- On the proposed standards for employer appeal decisions.
- On the proposed content of and timelines for issuing the notice of appeal decision.
- On the two approaches and alternatives with regard to limiting recurring appeals among the employee and employer.
- On the proposed rules that the appeal record be accessible to the employer and the employee in a convenient format and at a convenient time.

Functions of a SHOP (45 CFR §155.705)

A SHOP must provide data to the individual market Exchange that corresponds to the service area of the SHOP related to eligibility and enrollment of a qualified employee. 45 CFR §155.705(c).

Items for Comment

- HHS seeks comment on the feasibility of sharing SHOP data and the usefulness of such data in determining eligibility for APTCs and CSRs.

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

A state must provide an eligibility appeals process for the SHOP. 45 CFR § 155.740(b). An employer may appeal a notice of denial of eligibility under §155.715(e); or a failure of the SHOP to make an eligibility determination in a timely manner. 45 CFR § 155.740(c). An employee may appeal a notice of denial of eligibility under §155.715(f); or a failure of the SHOP to make an eligibility determination in a timely manner. 45 CFR § 155.740(d).

Notices of the right to appeal a denial of eligibility under §155.715(e) or (f) must be written and include the reason for the denial of eligibility, including a citation to the applicable regulations; and the procedure by which the employer or employee may request an appeal of the denial of eligibility. 45 CFR § 155.740(e).

The SHOP and appeals entity must allow an employer or employee to request an appeal within 90 days from the date of the notice of denial of eligibility to the SHOP or the appeals entity; or HHS, if no state-based Exchange has been established. 45 CFR § 155.740(f). The SHOP and appeals entity must accept appeal requests submitted by telephone, by mail, in person where available, or via the Internet; comply assist the employer or employee with the submission and processing of the appeal request and must not limit or interfere with an employer or employee's right to request an appeal and consider an appeal request valid if it is submitted within the 90-day timeframe.

Upon receipt of a valid appeal request, the appeals entity must send timely acknowledgement to the employer, or employer and employee if an employee is appealing, of the receipt of the appeal request, including an explanation of the appeals process; and instructions for submitting additional evidence for consideration by the appeals entity. 45 CFR § 155.740(g). The appeals entity must promptly notify the SHOP of the appeal, if the appeal request was not initially made to the SHOP. Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section, the appeals entity must promptly and without undue delay, send written notice to the employer or employee that is appealing that the appeal request has not been accepted and of the nature of the defect in the appeal request; and treat as valid an amended appeal request that meets the requirements of this section.

Upon receipt of a valid appeal request, the SHOP must promptly transmit, via secure electronic interface, to the appeals entity the appeal request, if the appeal request was initially made to the SHOP; and the eligibility record of the employer or employee that is appealing. 45 CFR § 155.740(h). The appeals entity must promptly confirm receipt of records transmitted to the SHOP that transmitted the records.

The appeals entity must dismiss an appeal if the employer or employee that is appealing withdraws the request in writing; or employee that is appealing, or the employer or employee's authorized representative, withdraws the request in writing, either electronically or in hard copy. 45 CFR § 155.740(i). The appeals entity must provide timely notice to the employer or employee that is appealing the dismissal of the appeal request, including the reason for dismissal, and must notify the SHOP of the dismissal. The appeals entity may vacate a dismissal if the employer or employee 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, or the employer and employee if an employee is appealing, the opportunity to submit relevant evidence for review of the eligibility determination. 45 CFR § 155.740(j).

SHOP appeals must be reviewed by an impartial official who has not been directly involved in the eligibility determination subject to the appeal, and appeals must be reviewed de novo. 45 CFR § 155.740(k). The information considered in the appeal include the information used to determine the employer or employee's eligibility as well as any additional relevant evidence

submitted during the course of the appeal by the employer or employee. 45 CFR § 155.740(k). Appeal decisions must be based solely on the evidence and eligibility requirements for the SHOP. 45 CFR § 155.740(l). Further, appeal decisions must comply with the standards set forth in the NPRM and be effective retroactive to the date the incorrect eligibility determination was made, if the decision finds the employer or employee eligible, or effective as of the date of the notice of the appeal decision, if eligibility is denied.

The appeals entity must issue written notice of the appeal decision to the employer—or to the employer and employee if an employee is appealing—and to the SHOP within 90 days of the date the appeal request is received. 45 CFR § 155.740(m). The SHOP must promptly implement the appeal decision upon receiving the notice. 45 CFR § 155.740(n).

Subject to the requirements of §155.550, the appeal record must be accessible to the employer, or employer and employee if an employee is appealing, in a convenient format and at a convenient time. 45 CFR § 155.740(o).

Items for Comment

- Whether a state establishing an Exchange must provide an eligibility appeals process for the SHOP.
- Whether a SHOP should provide a notice of the employer's or employee's right to appeal a determination of denial of eligibility in the written notice.
- On the proposed timeframe for which a SHOP and appeals entity allow an employer or employee to request an appeal.
- On the proposed rule that states that the SHOP and appeals entity must consider an appeal request valid if it is submitted within the 90-day timeframe.
- Whether an appeals entity is allowed to dismiss appeal requests that do not meet these baseline standards.
- On the proposed standards for the appeals entity to send timely acknowledgement of valid appeal request to the employer, or the employer and employee that includes an explanation of the appeals process as well as instructions for submitting additional evidence for consideration by the appeals entity.
- On the timeline standard for "promptly."
- On the procedural rights of a SHOP appellant, the proposed requirements for adjudicating a SHOP appeal, and the proposed requirements relating to the SHOP appeal decision standards.
- On the proposed requirements for issuing notice of the SHOP appeals decision.

- Whether the SHOP should promptly implement the appeal decision upon receiving notice. HHS notes that specific timeliness requirements are not included to allow flexibility for SHOPs.
- Whether the appeal record must be made accessible to the employer (or the employer and employee) in a convenient format and at a convenient time.

Section IV. Medicaid Premiums and Cost Sharing

Background

The proposed regulations would change the rules for Medicaid premiums and cost-sharing. Under the current §1916 of the Social Security Act (Act), cost sharing is limited to nominal amounts, and premiums may be imposed on certain beneficiaries with income above 150 percent of the FPL. States may impose higher cost sharing on certain higher income groups for certain services, but it may not exceed 5 percent of household income. The proposed rules would update these rules by deleting the entirety of current Medicaid premium and cost sharing rules at §447.5-447.82 and replace with a new §447.5-447.57.

Cost Sharing (42 CFR §447.52-54)

The proposed rules would:

- Update the maximum nominal cost sharing for individuals with income below 100 percent of the FPL by (§447.52):
    - Creating new maximum nominal levels of cost-sharing to $4 for outpatient services and $4, $50, or $100 for inpatient services.
    - Proposing that these nominal amounts continue to be updated and to freeze the CPI-U index until October 2015.
- Permit higher cost sharing for individuals above 100 percent of the FPL (§447.52) by allowing states to:
    - Impose cost sharing up to 10 percent of the cost of the service to the state for people between 100 and 150 percent of the FPL.
    - Target different cost sharing levels for different groups of individuals.
- Authorize states to establish differential cost sharing for preferred and non-preferred drugs up to (§447.53):
    - $8 for non-preferred drugs for individuals below 150 percent of the FPL.
    - 20 percent of the cost the agency pays for the non-preferred drug for individuals above 150 percent of the FPL.

- $4 for preferred drugs for all income groups.

- Propose a new provision allowing up to $8 in cost sharing for non-emergency use of the emergency department (ED) for individuals up to 150 percent of the FPL, and no limit on cost sharing for those above 150 percent of the FPL (§447.54).

Premiums (42 CFR §447.55)

- Premiums may be imposed on individuals above 150 percent of the FPL, including pregnant women and infants.
- The medically needy and children with disabilities may also be charged premiums on a sliding scale based on income.

Limitations on Premiums and Cost Sharing (42 CFR §447.56)

The following groups are exempt from premiums and cost sharing: children below 100 percent of the FPL, foster children, certain pregnant women, individuals in hospice, certain individuals in institutions, Native Americans, and individuals in breast and cervical cancer programs. Cost sharing may not be imposed for the following services: emergency services, family planning services, children's preventive services, and pregnancy-related services.

Items for Comment

- Any element of the proposed rule that aims to significantly streamline and expand flexibility regarding premiums and cost sharing.
- Whether to add definitions of "inpatient stay" and "outpatient services" for purposes of cost sharing to take into account situations in which an individual might return to an inpatient institution after a brief period when the return is for treatment of a condition that was present in the initial period.
- The new maximum allowable copayment for outpatient services ($4), including the impact on individuals with significant service needs.
- The best approach to cost sharing for an inpatient stay for individuals with very low income.
- Whether to create a separate nominal cost-sharing category for community-based long-term services and supports and the unit of services for which separate cost sharing should be charged.
- Whether regulations should specifically address the targeting of cost sharing that would be allowed, keeping in mind that such targeting must be based on reasonable categories of beneficiaries, such as a specific income group, and state methodologies to make such targeting easier to implement.

- Approaches to reduce non-emergency use of the ED and to distinguish between emergency and non-emergency services.
- Whether there are sufficient alternatives to using an automated system to track aggregate limits on premiums and cost sharing.

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