On January 14, 2013 the Centers for Medicare and Medicaid Services (CMS) released proposed regulations related to implementation of key provisions in the Affordable Care Act (ACA). The proposed regulations cover eligibility and enrollment issues by providing new policies as well as amending policies finalized in the March 2012 Medicaid and Exchange regulations. This brief provides an overview of the key Exchange provisions of the new federal guidance. Public comments are due February 21.

Notices

Combined Eligibility Notice

Defined as an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the insurance affordability programs (IAPs) (i.e. Medicaid, CHP+ and advance premium tax credits and cost sharing assistance) and enrolment in a qualified health plan (QHP) through the Exchange, for which a determination or denial was made.

A combined eligibility notice shall be issued by the last agency to make a determination of eligibility, regardless of which entity received the application. A combined notice must be timely, written in plain language, and accessible to persons who are limited English proficiency and individuals with disability; and contain the content described below, except that information described in §457.340(e)(1)(i)(C) must be included in a combined notice issued by another insurance affordability program only if known to that program.

Content of Combined Eligibility Notice for MAGI determinations (§457.340(e)(1), §435.917, and §155.230)must include:

- Approved Eligibility:
    - Basis and effective date of eligibility;
    - Reporting requirements and procedures for reporting any changes that may affect individual's eligibility ;
    - Citation to, or identification of, the relevant regulations supporting the action;
    - Contact information for available customer service resources;
    - Information on benefits and services and if applicable, information to any premiums, enrollment fees, and cost sharing required, and information on the enrollee's right and responsibilities, including opportunity for review of matters; and
    - An explanation of the right to review the determination (standard and expected time frames for review, manner in which a review can be requested, and circumstances under which enrollment may continue pending review).
- Denial, Termination, or Suspension of Eligibility
    - Basis supporting the action and the effective date;
    - Citation to, or identification of, the relevant regulations supporting the action;
    - Contact information for available customer service resources;
    - Information on the individual's right to review process (standard and expected time frames for review, manner in which a review can be requested, and circumstances under which enrollment may continue pending review); and

- In the case of suspension or termination of eligibility, the State must provide sufficient notice to enable the individual to take appropriate action to allow coverage to continue without interruption.

Coordinated Content
Defined as information included in an eligibility notice regarding the transfer of the individual or households' electronic account to another insurance affordability program for a determination of eligibility.

Agreements with the COHBE and HCPF must delineate responsibilities of each agency to (§155.345):
- Minimize burden on individuals,
- Ensure prompt determinations of eligibility and enrollment in the appropriate IAP with undue delay at any point in the year,
- Prior to January 1, 2015 include coordinated content (see definition above) in the notice of eligibility, and
- Beginning January 1, 2015 and to the extent feasible, provide for a combine eligibility notice to an applicant and the members of his or her household who apply together for enrollment in a QHP through the Exchange and for all IAPs. The notice will be issued by the last agency to determine the individual's eligibility (and must specify the agency that made the determination) except for eligibility based on nonMAGI Medicaid.

Delivery Methods (§155.1230 and §435.918)
Notices may either be sent by mail or, if an individual or employer elects, electronically. If an individual selects electronic mail as their preference, the individual will receive confirmation by regular mail of their selection of this option. The rule proposes to enable the SHOP to adopt an "all electronic" noticing approach.

Appeals

State Options
Exchanges have the option to oversee their appeals process or have HHS conduct it on their behalf. All Exchange appellants may have their appeal reviewed by HHS, even if an Exchange decides to review initial appeals (§155.505). The proposed rule also gives Medicaid agencies the ability to delegate its appeals authority to an Exchange. However, this provision does not apply to Colorado because COHBE is a non-governmental entity.

States are required to ensure coordination between appeals entities, including triggering automatic appeals and sharing individual account information related to eligibility. HHS proposes delaying this requirement until January 1, 2015, to provide states with sufficient time to prepare.

Appeal Request
Individuals must be able to request a hearing by telephone, by mail, in person, through other electronic means, or, at the state option until a later date, via an internet website (§155.520 and §431.221). An individual has 90 days to submit an appeal request, with an additional 30 days to appeal to HHS if he or she is unsatisfied with the original decision (§155.520).

If an individual has been denied eligibility for Medicaid/CHIP by the State or other entity authorized to make such determination, the State must treat an appeal to the Exchange appeals entity of a determination of eligibility for APTC/CSR, as a request for a review of denial of Medicaid/CHIP eligibility.

When a state Medicaid agency is managing a request for a fair hearing, then a decision must be issued within 45 days from the date the Exchange appeals entity issues its decision. States have the option to perform these processes simultaneously, such as for individuals close to the Medicaid eligibility threshold (§431.244). If a decision made by the Medicaid agency regarding Medicaid eligibility conflicts with the decision of the Exchange appeals entity, the Medicaid agency's determination will take precedence. Similar processes apply for the Children's Health Insurance Program (CHIP).

State based exchanges have the option to implement an informal resolution process that will serve as a first level of review prior to the formal Exchange appeals.

Agreements between COHBE and HCPF (§155.510)
The Exchange or appeals entity must enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes. Each entity will have specific responsibilities in the appeals process and must ensure that appellants are not asked to provide duplicative information related to the appeal, and that timely appeals decisions are made.

Appellants will have the option of pursing an appeal of an adverse Medicaid or CHIP determination made by the Exchange directly with the Medicaid/CHIP agency. In this situation, the appeals entity would electronically transmit the eligibility determination and all related information to the Medicaid/CHIP agency as soon as possible.

Certified Application Counselors

The Exchange must certify staff and volunteers of Exchange-designated organizations and organizations designated by state Medicaid and CHIP agencies in accordance with the Medicaid rule as application counselors to (*§*155.225):

- Provide information about IAPs and coverage options,
- Assist individuals and employees to apply for coverage in a QHP through the Exchange and for Medicaid and CHIP, and
- Help to facilitate enrollment of eligible individuals in all IAPs.

Certification Standards
The Exchange must certify an individual to become an application counselor if he/she:

1) Registers with the Exchange;
2) Is trained regarding QHP options, IAPs, eligibility, and benefit rules and regulations governing all IAPs prior to functioning as an application counselor;
3) Discloses to the Exchange and potential applicants any relationships the application assister or sponsoring agency has with QHPs or IAPs, or other potential conflicts of interest;
4) Complies with the Exchange's privacy and security standards and data security standards;

5) Agrees to act in the best interest of the applicants assisted;
6) Complies with applicable state law related to application counselors, including but not limited to state law related to conflicts of interest;
7) Provides information with reasonable accommodations for those with disabilities, as defined by the ADA, if providing in person assistance; and
8) Enters into an agreement with the Exchange regarding compliance.

The Exchange must ensure that applicants:

- Are informed of the functions and responsibilities of certified application counselors and
- Provide authorization for the disclosure of applicant information to an application counselor prior to a counselor helping the applicant submit an application.

The Exchange must also establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization when it finds noncompliance.

Verification Procedures

Employer Sponsored Coverage (§155.320)

The proposed rule requires Exchanges to verify applicants access to employer coverage through a combination of applicant attestation, data sources, and a sampling process where Exchanges will solicit information from employers. Key provisions of the verification of employer-sponsored coverage include:

- Exchanges may rely on HHS to conduct the verification of this verification process.
- As part of its determination of whether an employer is liable for the shared responsibility payment, the IRS will adopt methods to certify to an employer that one or more employees has enrolled for one or more months during a year in a QHP with APTC or CSR.
- Exchanges must obtain data from the SHOP on employer sponsored plans.
- The preamble contemplates the use of a pre-enrollment template to assist applicants in gathering information about access to coverage through an eligible employer sponsored plan. CMS envisions that an applicant would download a one-page template from the Exchange website and present the document to his or her employer. An employer could also voluntarily download and populate the template with information regarding its coverage offerings and distribute to employees at hiring, upon request, on the employer intranet or benefit site, or in conjunction with other information about employer-sponsored coverage. CMS intends to release the template for comment soon.

Catastrophic Plan

The proposed rule clarifies that individuals enrolled in catastrophic plans are not eligible for APTC (*§155.305)*. The rule also states that Exchanges must verify a catastrophic plan applicant's attestation that he or she meets the requirements by verifying the applicant's age and/or that the applicant received a certificate of exemption. The preamble states that an applicant will not be determined eligible through the Exchange in a QHP that is a catastrophic plan until verification of necessary information can be completed.

Eligibility Redeterminations

The proposed rule provides that Exchanges will periodically review Medicare, Medicaid, and CHIP eligibility for enrollees who receive APTC/CSR (*§155.330)*. The Exchange must also redetermine eligibility of qualified individuals on an annual basis and provide qualified individuals with an annual redetermination notice. Individuals will have 30 days from the date of the notice to report any changes with respect to the information in the notice by phone, email, or mail; and must sign and return the notice to the Exchange. After the 30-day period has elapsed the Exchange must run eligibility based on the information provided in the notice and supplemented with any information from the individual.

Effective Dates

Regular Effective Date Policy

For a QHP selection received by the Exchange from the qualified individual between the 1-15th day of any month, coverage must be ensured the first day of the following month; and between the 16th and last day of the month, coverage must be ensured the first day of the second following month.

Mid-Year Determination Effective Dates

The proposed rule adds coverage effective dates for eligibility changes that result from redeterminations, appeals decisions, and other changes that impact enrollment or premiums, but do not affect eligibility (§155.330).

Trigger	Effective Date Policy
Eligibility redetermination*	First day of the month following the date of the individual's redetermination notice
Appeal decision changing eligibility*	1. First day of the month following the date of the notice, or 2. On the date specified in the appeal decision
Change in enrollment (e.g. name changes or phone number changes) **or premium ONLY** (e.g. changes to the amount of tax credit a household elects to apply to its premium)*	First day of the month following the date on which the Exchange is notified of the change
Erroneous enrollment	Exchanges will provide effective date based on specific circumstance of each situation

*Indicates Exchanges' flexibility to specify a reasonable point in a month (i.e. no earlier than the 15th) after which a change will not be effective until the first day of the month after the month for the (*) triggers.

The proposed rule also provides more prescriptive effective dates for eligibility changes that result from a redetermination that do affect eligibility.

Trigger	Effective Date Policy
Decrease in amount of APTC or level of CSR	First day of the month following the date of the notice
Increase level of CSR, including newly eligible for CSR	First day of the month following the date of the notice
Ineligible for QHP	Exchanges must maintain eligibility for enrollment in a QHP without APTC and CSR effective the last day of the month following the month in which the notice is sent unless individual requests earlier termination

Special Enrollment Periods

The proposed rule provides conditions and parameters for special enrollment periods, including eligibility for dependents and effective dates (*§*155.420).

The Exchange must allow a qualified individual or enrollee (and when specified his or her dependents) to enroll in a QHP or change from one QHP to another if one of the following triggering events occur:

- The individual or his or her dependent loses minimum essential coverage (MEC)
    - In the case of a QHP decertification, the triggering event is the date of the notice of decertification
    - In all other cases, the triggering event is the date the individual/dependent loses eligibility for MEC
- Individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption
- Individual gains citizenship, national status, or lawfully present status
- Individual/dependent, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS
- An enrollee/dependent shows the QHP has substantially violated a material provision of its contract
- Newly eligible or ineligible for APTC or change in eligibility for CSR (individual or dependent)
    - Includes individuals whose ESI is no longer affordable
- New access to QHPs as a result of a permanent move
- Indians may enroll in a QHP or change from one QHP to another one time per month
- Exceptional circumstances
- Individual/Dependent is enrolled in an ESI plan that does not provide minimum value

and/or is not affordable. The Exchange must allow this special enrollment period 60 days prior to the end of his or her coverage through such eligible employer-sponsored plan.

Effective Dates for Special Enrollment Periods

Trigger	Effective Date Policy
Birth, adoption, or placement for adoption	Coverage must be effective on the date of birth, adoption, or placement for adoption
Marriage or loss of minimum essential coverage	Effective on the first day of the following month
Unintentional, inadvertent, or erroneous enrollment	1. The date of the event that triggered the special enrollment or 2. In line with the regular effective date policy
An enrollee shows the QHP has substantially violated a material provision of its contract	1. The date of the event that triggered the special enrollment or 2. In line with the regular effective date policy
Other exceptional circumstances	1. The date of the event that triggered the special enrollment or 2. In line with the regular effective date policy