MEMORANDUM

TO: Board of Directors, Colorado Health Benefit Exchange

FROM: COHBE Staff

DATE: April 2, 2012

RE: **Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers**
http://www.ofr.gov/OFRUpload/OFRData/2012-06125_PI.pdf

A portion of the HHS rule issued on March 12th was issued on an interim final basis. HHS will consider comments from the public on the following provisions through May 11, 2012:

- §155.220(a)(3) – Related to the ability of a State to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.
- §155.300(b) – Related to Medicaid and CHIP regulations;
- §155.302 – Related to options for conducting eligibility determinations;
- §155.305(g) – Related to eligibility standards for cost-sharing reductions;
- §155.310(e) – Related to timeliness standards for Exchange eligibility determinations;
- §155.315(g) – Related to verification for applicants with special circumstances;
- §155.340(d) – Related to timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions; and
- §155.345(a) and §155.345(g) – Related to agreements between agencies administering insurance affordability programs.

A summary of the interim final rules are as follows:

1) §155.220(a)(3) – Related to the ability of a State to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs

The interim final rule clarifies that agents and brokers may assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent or broker is required to register with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange; receive training in the range of QHP options and insurance affordability programs; comply with the Exchange's privacy and security standards adopted consistent with §155.260; and comply with applicable State law related to agents and brokers, including applicable State law related to confidentiality and conflicts of interest.

2) §155.300(b) – Related to Medicaid and CHIP regulations

This section references Medicaid and CHIP regulations as those regulations that are implemented in accordance with policies and procedures as applied or approved by the State Medicaid or State CHIP agency. With that said, §155.302 was added to describe in greater detail the options available for configuring responsibilities related to eligibility determinations. It clarifies that there is an option under which the Exchange does not make Medicaid or CHIP eligibility determinations but is considered to be

compliant with this final rule; in such situations, the State Medicaid and CHIP agencies exercise final control over eligibility determinations for Medicaid and CHIP for applications submitted to the Exchange.

3) §155.302 – Related to options for conducting eligibility determinations

This section was added as an interim final rule to outline options for the Exchange to conduct *assessments of eligibility* for Medicaid and CHIP rather than an *eligibility determination* for Medicaid and CHIP. This interim final rule also gives the Exchange the option to implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions for the Exchange or rely on HHS to carry out this function. The section includes standards for such assessments and eligibility determinations.

4) §155.305(g) – Related to eligibility standards for cost-sharing reductions

A provision was added to include a special rule for non-citizens who are lawfully present in the US (but who are ineligible for Medicaid by reason of immigration status) who have a household income of less than 100 percent of the FPL and are eligible for advance payments of the premium tax credit can also be eligible for cost-sharing reductions. The interim rule also clarifies that individuals eligible for advance premium tax credits also will be eligible for cost sharing reductions if their household incomes are expected to be less than 250% FPL for the benefit year for which coverage is requested, and they are enrolled in silver level plans.

HHS also added language clarifying how cost-sharing reductions would be applied when multiple tax households are covered by a single policy. HHS specifies a hierarchy of available cost-sharing provisions, and explains that when multiple tax households are covered on a single policy, the Exchange will apply only the first category of cost-sharing reductions listed in this paragraph. The categories are listed such that the lowest level of cost-sharing reductions will be provided to the combined households. HHS notes that the tax households are always free to purchase separate policies, and in doing so, receive the benefit of all cost-sharing provisions for which they are eligible.

Lastly, HHS added language to clarify that household income for the purposes of eligibility for cost-sharing reductions is defined in accordance with section 36B(d)(2) of the Code, which is the same definition used for advance payments of the premium tax credit. HHS also clarified that the time period for measuring income for cost-sharing reductions is the same as for advance payments of the premium tax credit.

5) §155.310(e) – Related to timeliness standards for Exchange eligibility determinations

HHS adopted an interim timeliness standard of "promptly and without undue delay" for eligibility determinations made by the Exchange, but intends to further interpret this timeliness standard in future guidance in coordination with standards established for the Medicaid and CHIP programs. HHS notes that they think it is reasonable that the majority of eligibility determinations will be completed in a very short period of time and encourage the Exchange to continuously monitor and identify ways to shorten the time it takes to process an application and notify an applicant of his or her eligibility determination.

HHS plans to work closely with states to establish a more detailed understanding of the timing needed for an eligibility determination as well as how the length of time needed can be reduced.

6) §155.315(g) – Related to verification for applicants with special circumstances

An interim provision in §155.315(g) provides a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available. HHS proposed this language to account for situations in which documentation cannot be obtained, and to achieve consistency with the Medicaid program; examples of individuals for whom this provision may apply include homeless individuals, victims of domestic violence or natural disasters, and sporadic earners. HHS notes also that if at the conclusion of the 90 day period, the Exchange is unable to verify the applicant's attestation and the data from the data sources specified in §155.315 are unavailable, the Exchange must notify that applicant that the Exchange finds the applicant ineligible for the eligibility standard in question.

7) §155.340(d) – Related to timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions

In paragraph (d), HHS adopts, on an interim final basis, a timeliness standard that the Exchange must send eligibility information to both QHP issuers and to HHS to enable advance payment of premium tax credits and cost-sharing reductions "promptly and without undue delay." HHS expects Exchanges will send each QHP issuer an automated file of applicable eligibility and enrollment transactions, and simply include HHS on the transmission. HHS will issue future guidance outlining standards and timing for these transmissions.

8) §155.345(a) and §155.345(g) – Related to agreements between agencies administering insurance affordability programs

This section clarified that the Exchange must provide HHS with copies of any agreements made with other agencies administering insurance affordability programs upon request. These agreements must include a clear delineation of the responsibilities of each program to minimize burden on individuals, ensure prompt determinations of eligibility and enrollment, including redeterminations, and ensure compliance with paragraphs (c), (d), (e), and (g) of this section. These standards for coordination align with those outlined in the Medicaid final rule.

In addition, HHS clarified its intention to maintain a streamlined eligibility determination process for consumers. Consistent with the Medicaid final rule, HHS adds standards for how agencies administering Medicaid, CHIP, and BHP will transmit an application to the Exchange and how the Exchange will take the necessary steps to process such applications. These standards include:

- not duplicating eligibility and verification findings already made by the transmitting agency;
- not requesting information of documentation from an individual when it has already been provided to another insurance affordability program; and
- determining eligibility for enrollment in a QHP and advance payments of premium tax credits and cost sharing reductions promptly and without delay