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Proposed Rule Issued on Health Insurance Exchanges

Beginning in 2014, individuals and small businesses will be able to purchase private health insurance through state-based competitive marketplaces known as Affordable Health Insurance Exchanges (Exchanges). On Jan. 14, 2013, the U.S. Department of Health and Human Services (HHS) released a **proposed rule** that would implement provisions of the Affordable Care Act (ACA) relating to the Exchanges.

Key provisions of this proposed rule include:

- Standards for appealing determinations of individual eligibility for federal premium subsidies to purchase health insurance through the Exchanges;
- Standards for adjudicating appeals of employer and employee eligibility to participate in the Small Business Health Options Program (SHOP);
- Criteria related to the verification of enrollment in and eligibility for minimum essential coverage through an eligible employer-sponsored plan; and
- Clarifications or amendments to standards related to other eligibility and enrollment provisions.

This Clarke & Company Benefits, LLC Legislative Brief describes several of these key provisions.

APPEALS OF ELIGIBILITY DETERMINATIONS

The proposed rules establish procedures for Exchanges to determine whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, and cost-sharing reductions and exemptions from the employer shared responsibility payment. Similarly, the proposed rule establishes a process by which individuals and employers can appeal these determinations.

Appeals Process for Individuals

The proposed rule gives individuals the right to appeal determinations of their eligibility for premium subsidies to purchase health insurance through an Exchange. Individuals can appeal initial eligibility determinations and any redeterminations of eligibility, as well as the amount of federal premium subsidies that they are eligible for.

Under the proposed rule, enrollees will first have the opportunity for a preliminary case review by appeals staff, referred to as "informal resolution." If the enrollee is satisfied by the outcome of the informal resolution, the decision stands as an official appeal decision. If the enrollee is dissatisfied with the outcome of the informal resolution process, he or she would have rights to a full appeal. As required by the ACA, a federally managed appeals process would be available to all enrollees in the individual market.

State-based Exchanges would have the flexibility to implement their own appeals processes in accordance with the proposed rule's standards. However, individuals would continue to have the right to a federal appeal at HHS after exhausting the state-based appeals process.

Appeals Process for Employers

Beginning in 2014, large employers may be subject to penalties if they do not offer coverage to full-time employees, or if the health coverage does not meet certain standards. These penalties are triggered when a full-time employee receives a premium tax credit or cost-sharing reduction for purchasing health insurance through an Exchange. When an employee receives a federal premium subsidy, the employer will be notified of the determination and their potential liability for a shared responsibility penalty.

The proposed rules allow employers to appeal a determination that:

- The employer does not provide minimum essential coverage through an employer-sponsored plan; or
- The employer does provide minimum essential coverage, but the coverage is not affordable with respect to the employee receiving the premium tax credit or cost-sharing reduction.

Through this appeals process, the employer can correct any information the Exchange received from an employee's application regarding the employer's offer of coverage. This appeal is separate from the IRS' process for determining whether an employer is liable for a shared responsibility penalty.

Exchanges would have the flexibility to implement their own appeals processes in accordance with the proposed rule's standards. For Exchanges that do not establish their own process, HHS will provide an employer appeals process.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

The ACA calls for the establishment of insurance options for small businesses through a SHOP. The SHOP will allow employers to choose the level of coverage they will offer and then offer employees choices of all Qualified Health Plans (QHPs) within that level of coverage. SHOP Exchanges can also allow employers to select a single plan to offer its employees, like is typically done today.

The proposed rule contemplates that the SHOP Exchange will coordinate with the functions of the individual market Exchanges for determining eligibility for insurance affordability programs. Additionally, the proposed rules establish a process by which employers and employees can appeal determinations of eligibility to participate in the SHOP.

VERIFICATION OF EMPLOYER-SPONSORED COVERAGE

Under the ACA, premium subsidies are not available to individuals who are enrolled in or eligible for coverage through their employer, as long as that coverage meets affordability and minimum value standards. Coverage is not considered affordable if the premium paid by employees for single coverage exceeds 9.5 percent of his or her wages. Additionally, premium subsidies are not available to employees earning more than 400 percent of the federal poverty level (FPL).

The proposed rule requires administrators of state and federal Exchanges to verify whether applicants seeking tax credits to buy health care coverage through an Exchange are enrolled or eligible for qualifying coverage in an employer-sponsored health care plan. Until a centralized database is available, exchange administrators will be permitted to use any available data electronic source approved by HHS (as well as paper records, when necessary) to confirm applicants' eligibility for the subsidies.

Alternatively, Exchange administrators can elect to have HHS regulators conduct the verification process.

OTHER KEY PROVISIONS

The proposed rule also addresses several other changes made by the ACA, such as notice and eligibility requirements for all insurance affordability programs, changes to Medicaid and the establishment of application counselors.

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Notice Requirements

The rule proposes that notices to applicants and beneficiaries would include combined, clear and accurate information about eligibility for all insurance affordability programs, including Medicaid, Children's Health Insurance Program (CHIP), advance payments of the premium tax credit and cost-sharing reductions and eligibility to enroll in a QHP through the Exchange.

The final combined, comprehensive notice would be generated by the agency that completed the last step in making the eligibility determination (which could be the Exchange or the Medicaid or CHIP agency). This coordinated process would not be required to be in place until **Jan. 1, 2015**, or, optionally, at an earlier date if all relevant agencies have the necessary systems in place.

Eligibility Requirements

The proposed rule completes the process of streamlining the eligibility categories that will be in effect in 2014. These provisions build on the Medicaid and CHIP eligibility final rule issued in March 2012. Specifically, the rule proposes to:

- Define the range of eligibility groups for Medicaid and eliminate obsolete categories to reflect the existing federal statute and the shift to use of the Modified Adjusted Gross Income (MAGI) methodology for determining eligibility with most populations;
- Codify eligibility categories authorized in the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the ACA, such as the new coverage for former foster care children up to age 26; and
- Simplify and align the citizenship documentation process across Medicaid, CHIP and the Exchange.

Changes to Medicaid

The proposed rule modifies existing "benchmark" regulations applicable to Medicaid programs, as previously described in a State Health Officials Letter, to implement the benefit options available to low-income adults beginning Jan. 1, 2014. The rule provides guidance on:

- The use of section 1937 benchmark and benchmark-equivalent plans (now known as Alternative Benefit Plans) for the new eligibility group for low-income adults;
- The relationship between Alternative Benefit Plans and Essential Health Benefits; and
- The relationship between section 1937 and other Title XIX provisions.

The rule also proposes to update and simplify policies around Medicaid premiums and cost-sharing requirements to promote the most effective use of services and to assist states in identifying cost sharing flexibilities. Specifically, the rule proposes to update the maximum allowable cost-sharing levels and consolidate redundant provisions in order to create one streamlined set of rules for all Medicaid premiums and cost sharing. Additionally, the rule proposes to allow states to establish higher cost sharing for non-preferred drugs and to impose higher cost sharing for non-emergency use of the emergency department.

Application Counselors

Application counselors play a key role in assisting individual in applying for and maintaining coverage in a qualified health plan through the Exchange and insurance affordability programs. The rule proposes standards for the certification of individuals seeking to become application counselors.

Source: Department of Health and Human Services

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