Eligibility & Enrollment

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California Health Benefit Exchange Board Meeting
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Eligibility and Enrollment Guiding Principles

- Through a “No Wrong Door” approach, promote maximum enrollment into coverage.
- Facilitate a smooth enrollment process beginning with the use of a single streamline application and seamless renewal process.
- Present information in a manner that is accurate, accessible, understandable and transparent to consumers to inform and educate them.
- Continue to learn and adjust strategies and tactics based on input from our national partners, California stakeholders, ongoing research, evaluation and measurement of the programs’ impact on awareness and enrollment.

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Eligibility & Enrollment

Draft Proposed State Regulations

(Covered California Individual Subsidized and Non-Subsidized Programs)

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Eligibility & Enrollment State Regulations Timelines

Activity:	Timeline:
1st package of final Eligibility & Enrollment State Regulations presented at Board Meeting and Approved ***(Board Action)*** 2nd package of draft Eligibility & Enrollment State Regulations presented at Board Meeting ***(Discussion Item Only)***	June 20, 2013
Final Federal Regulations - Final Rule Regarding Eligibility and Enrollment Released by the Center for Medicare and Medicaid Services	July 15, 2013
Withdrew 1st package of final Eligibility & Enrollment State Regulations from the Office of Administrative Law, as a result of the need to conform State Regulations to the final Federal Regulations (release in July 2013)	August 12, 2013
Final Eligibility and Enrollment Regulations presented at Board Meeting ***(for Board Action)*** • Re-adopt 1st State Regulation package • Adopt 2nd State Regulation package Proposed Draft State Regulations – Single Family Plan ***(Discussion Item Only)***	August 22, 2013
Submission of Board Adopted State Regulations to the Office of Administrative Law	August 26, 2013
Final State Regulations – Single Family Plan presented at Board Meeting (for Board action)	September 19, 2013

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Final Proposed State Regulations - *For Board Action*

ARTICLE	SECTION	SECTION TITLE
4	§ 6454.	General Standards for Exchange Notices.
4	§ 6460.	Exemption from Individual Responsibility.
5	§ 6470.	Application.
5	§ 6490.	Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for Advanced Premium Tax Credits and Cost Sharing Reductions.
5	§ 6500.	Enrollment of Qualified Individuals into QHPs.
5	§ 6508.	Authorized Representative.

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Final Proposed State Regulations - *For Board Action*

ARTICLE	SECTION	SECTION TITLE
7	§ 6602.	General Eligibility Appeals Requirements.
7	§ 6604.	Notice of Appeal Procedures.
7	§ 6606.	Appeal Requests.
7	§ 6608.	Eligibility Pending Appeal.
7	§ 6610.	Dismissals.
7	§ 6612.	Informal Resolution.
7	§ 6614.	Hearing Requirements.
7	§ 6616.	Expedited Appeals.
7	§ 6618.	Appeals Decisions.
7	§ 6620.	Appeal Record.

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ARTICLE 4:
GENERAL PROVISIONS

For Board Action

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ARTICLE 4: Individual Responsibility Exemption – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6454. General Standards for Exchange Notices. (New Section based on recent Federal Regulations.)	➢ Any notice required to be sent by the Covered California to individuals or employers shall be written and include: • An explanation of the action reflected in the notice and effective date of the action; • Factual findings regarding the action taken; • Relevant regulations supporting the action; • Contact information for customer service resources; and • An explanation of appeal rights, if applicable. ➢ The Exchange shall reevaluate the appropriateness and usability of all notices. ➢ The individual market Exchange shall provide required notices either through standard mail, or if an individual elects, electronically.

ARTICLE 4: INDIVIDUAL RESPONSIBILITY EXEMPTION – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6460. Exemption from Individual Responsibility.	➢ Federal Regulations permit state Exchanges to rely on federal services to process requests for exemption from the individual responsibility. Covered California will rely on federal services to process these requests for exemptions.* ➢ Individuals may request a certificate of exemption if individuals are: • Unable to afford coverage (based on projected annual household income); • Below the tax filing threshold; • A member of a recognized religious sect or health sharing ministry; • Not United State citizens or nationals; • Incarcerated; • A member of an Indian tribe; and/or • Suffering a hardship under certain circumstances. ➢ Except in some cases, exemptions shall be granted only for the calendar year. ➢ Upon receipt of an application for exemption, Covered California shall transmit all information obtained with the request to the U.S. Department of Health and Human Services (HHS) promptly and without delay for verification and eligibility determination for one or more categories of exemptions. ➢ Individuals requesting exemptions shall provide applicable information. ➢ Individuals have the right to appeal an eligibility determination or redetermination for an exemption and shall request such an appeal directly to HHS. ➢ Covered California shall include the notice of the right to appeal and instructions regarding how to file an appeal with HHS in any notification issued. ➢ Covered California shall provide assistance and instructions to file an application ➢ Covered California shall provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption and has elected to receive electronic notifications, unless he or she has declined to receive such notifications. ➢ Covered California shall notify the individual to retain the records that demonstrates receipt of the certificate of exemption and qualification for the underlying exemption. ➢ An applicant's eligibility for exemptions shall be re-determined during a calendar year.

***However, in the event the federal services is unable to process requests for exemptions based on final Federal Regulations, Covered California will amend State Regulations accordingly to give authority for Covered California to process exemption requests.**

ARTICLE 5:

APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

For Board Action

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ARTICLE 5: APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6470 Application.	➢ Covered California shall use a single, streamlined application to determine eligibility and to collect information necessary for: • Enrollment in a Covered California Health Plan; • Advanced Premium Tax Credits (APTC); • Cost Sharing Reductions (CSR) ; • Modified Adjusted Gross Income (MAGI) Medi-Cal or Children's Health Insurance Program (CHIP). ➢ An application filer may file an application through one of the following channels: • Covered California's Website; • Telephone; • Fax; • Mail; and • In person. ➢ The Application request the applicant to provide the following information: • Contact Information (e.g. Name, address, phone number); • Demographic Data; • Personal Tax Information (e.g. SSN, Taxpayer Identification number, etc.); • Household Composition and Income Information (Relationship to applicant, current income information, etc.); • Other Healthcare Information; • Optional Information (e.g. Race); • Declarations (e.g. Penalty of perjury statement, true and correct statement); • Signature (e.g. Applicant, Authorized Representative, and other certified individuals) ➢ Covered California shall accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any time during the year.

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ARTICLE 5: APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6490. Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-sponsored Plan Related to Eligibility Determination for Advanced Premium Tax Credits (APTC) and Cost Sharing Reductions (CSR).	➢ For eligibility determinations for APTC and CSR effective prior to January 1, 2015, Covered California shall: • Verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage for the benefit year for which coverage is requested. • If enrollment and eligibility data is unavailable, accept an applicant's attestation regarding enrollment without further verification. ➢ Covered California shall obtain: • Data about enrollment in and eligibility for an eligible employer-sponsored plan from any U.S. Department of Health and Human Services (HHS) - approved electronic data sources available to Covered California. ➢ For eligibility determinations for APTC and CSR effective on or after January 1, 2015, Covered California shall: • Rely on HHS for verification of enrollment, and eligibility for qualifying coverage, in an eligible employer-sponsored plan; • Send the notices as specified in the Eligibility Determination Process; and • Provide all relevant application information to HHS through a secure, electronic interface, promptly and without undue delay.

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ARTICLE 5: Enrollment of Qualified Individuals into QHPs – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6500. Enrollment of Qualified Individuals into QHPs**.**	➢ A qualified individual may enroll in a Qualified Health Plan (QHP) (and an enrollee may change QHPs) only during, the following periods: • The initial open enrollment period; • The annual open enrollment period; or • A special enrollment period for which the qualified individual has been determined eligible. ➢ Covered California shall accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP and shall: • Notify the applicant of her or his initial premium payment methodology options and of the requirement that the applicant's initial premium payment shall be received in full by the QHP issuer on or before the premium payment due date; • Notify the QHP issuer that the individual is a qualified individual and of the applicant's selected QHP and premium payment methodology option; • Transmit to the QHP issuer information necessary to enable the issuer to enroll the applicant within three business days from the date Covered California obtains the information; and • Transmit eligibility and enrollment information to Department of Health and Human Services (HHS) promptly and without undue delay, in a manner and timeframe as specified by HHS. ➢ Covered California shall maintain records of all enrollments in QHPs through the Covered California. ➢ Covered California shall reconcile enrollment information with QHP issuers and HHS no less than once a month.

ARTICLE 5: Enrollment of Qualified Individuals into QHPs – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6500. Enrollment of Qualified Individuals into QHPs**.** **(*Continued*)**	➢ A Qualified Health Plan (QHP) issuer shall accept enrollment information that is consistent with the privacy and security requirements established by Covered California and shall: • Acknowledge receipt of enrollment information transmitted from Covered California in accordance with the standards established by Covered California; • Enroll a qualified individual during the initial open enrollment, annual open enrollment, and special enrollment periods; • Notify a qualified individual of his or her premium payment due date; • Abide by the effective dates of coverage established by Covered California; • Notify Covered California of the issuer's timely receipt of a qualified individual's initial premium payment and his or her effective date of coverage; • Notify a qualified individual of his or her effective date of coverage upon the timely receipt of the individual's initial premium payment; and • Provide new enrollees an enrollment information package that is compliant with accessibility and readability standards within Covered California State Regulations.

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ARTICLE 5: Enrollment of Qualified Individuals into – For Board Discussion Only

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6500. Enrollment of Qualified Individuals into QHPs**. (*Continued)***	➢ If an applicant requests assistance from a Qualified Health Plan (QHP) issuer for enrollment through Covered California, the QHP issuer shall either: • Direct the individual to file an application with Covered California, or • Ensure the applicant received an eligibility determination for coverage through Covered California through the Covered California Internet Web Site by assisting the applicant to apply for and receive an eligibility determination for coverage through Covered California through the California Eligibility, Enrollment, and Retention System, provided that the QHP issuer: o Complies with the federal and state privacy and security standards; o Complies with the consumer assistance standards; and o Informs the applicant of the availability of other QHP products offered through Covered California and displays the Web link to or describes how to access the Covered California Web site. ➢ A QHP issuer shall follow the premium payment process established by Covered California, as follows: • Shall effectuate coverage upon receipt of a full initial premium payment from the applicant on or before the premium payment due date. • Shall acknowledge receipt of qualified individuals' premium payments by transmitting to the Exchange information regarding all received payments. • Shall initiate cancellation of enrollment by electronic transmission if the issuer does not receive the full initial premium payment by the due date. • Shall, no earlier than the first day of the month when coverage is effectuated, transmit to the Exchange the notice of cancellation of enrollment. • Shall, within five business days from the date of cancellation of enrollment due to nonpayment of premiums, send a written notice of the cancellation. ➢ A QHP issuer shall reconcile enrollment and premium payment files with Covered California no less than once a month.

ARTICLE 5: APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6508. Authorized Representative.	➢ Covered California shall permit an applicant or enrollee in the individual or small group market, subject to applicable privacy and security requirements to: • Designate an individual or organization to act on his or her behalf when applying for an eligibility determination or redetermination; or when carrying out other ongoing communication with Covered California. • Authorize their representative to: o Sign an application, submit an update, or respond to a redetermination on the applicant's or enrollee's behalf; o Receive copies of the applicant's or enrollee's notices and other communications from Covered California; and o Act on behalf of the applicant or enrollee in all other matters with Covered California. ➢ An authorized representative designation shall be in a written document signed by the applicant or enrollee, or through another legally binding format subject to applicable authentication and data security standards. • If submitted, the legal documentation of authority to act on behalf of an applicant or enrollee such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of the applicant's or enrollee's signature. ➢ The authorized representative shall: • Agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by Covered California. • Be responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the applicant or enrollee he or she represents.

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ARTICLE 7:
APPEALS

For Board Action

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ARTICLE 7: APPEAL PROCESS – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6602. General Eligibility Appeals Requirements.	➢ An applicant or enrollee may appeal: • Eligibility determinations/redeterminations; • Covered California's failure to provide a timely eligibility determination; • Eligibility determinations and re-determinations of an exemption request (Note: Appeal of an Exemption request will be reviewed by the U.S. Department of Health and Human Services); and/or • An eligibility determination and re-determination for the bridge program. ➢ An appellant may designate an authorized representative to act on his or her behalf, including making an appeal request.
§ 6604. Notice of Appeal Procedures.	➢ Covered California shall provide notice of appeal procedures at the time that: • The applicant submits an application; and • Covered California sends notice of eligibility determination and redetermination. ➢ Notice of appeal procedures shall 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.

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ARTICLE 7: APPEAL PROCESS – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6606. Appeal Requests.	➢ Covered California and the appeals entity shall: • Accept appeal requests submitted by all avenues in which an application may be submitted; • Assist the applicant or enrollee in making an appeal request; and • Not limit interfere with the right to make an appeal. ➢ Covered California and the appeals entity shall consider an appeal valid if: • The appeal is submitted within 90 days of the date of the notice of eligibility determination; and • If the appellant disagrees with the appeal decision of Covered California appeals entity, he or she can make an appeal request within 30 days of the decision notice. ➢ Upon receipt of a valid appeal request, the appeals entity shall: • Send timely acknowledgment to the appellant of the receipt of his or her valid appeal request; • Send a notice within 3 business days from the receipt of the appeal request via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal to the Covered California and to the Department of Health Care Services, where applicable; and • Confirm receipt of the records transferred by Covered California within 2 business days. ➢ Upon receipt of an appeal request that is not valid, the appeals entity shall: • Send written notice to the applicant or enrollee that the appeal request has not been accepted within 5 business days; and • Treat as valid an amended appeal request that meets the requirements. ➢ Upon receipt of a valid appeal request or upon receipt amended appeal Covered California shall transmit via secure electronic interface to the appeals entity: • The appeal request, if the appeal request was initially made to Covered California; and • The appellant's eligibility record. ➢ Upon receipt of the notice of an appeals request made to the HHS, Covered California appeals entity shall transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from Covered California, to the HHS within 3 business days from the date on which the appeal request is received..

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ARTICLE 7: APPEAL PROCESS – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6608. Eligibility Pending Appeal.	➢ Upon receipt of a valid appeal request an appellant previously determined eligible shall continue to be considered eligible while the appeal is pending. ➢ Covered California shall continue the appellant's eligibility for enrollment in a Covered California health insurance plan, Advanced Premium Tax Credits, and Cost Sharing Reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.
§ 6610. Dismissals.	➢ The appeals entity shall dismiss an appeal if the appellant: • Withdraws the appeal request; • Fails to appear at a scheduled hearing; • Fails to submit a valid appeal request without good cause; or • Dies while the appeal is pending, unless the appeal affects the remaining member(s) of the deceased appellant's household. ➢ If an appeal is dismissed, the appeals entity shall provide written notice to the appellant within 5 business days from date of the dismissal, that includes the reason for the dismissal, 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. ➢ If an appeal is dismissed, the appeals entity shall provide notice to Covered California, and to the California Department of Health Care Services, as applicable, including instruction regarding the eligibility determination to implement; and discontinuing eligibility pending appeal within 3 business days from the date of dismissal. ➢ The appeals entity may vacate a dismissal if the appellant makes a written request within 30 calendar days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.
§ 6612. Informal Resolution.	➢ An appellant shall have an opportunity for informal resolution prior to a hearing in accordance with the requirements of this section. ➢ Covered California shall contact the appellant to informally resolve the appellant to request additional information or documentation within 60 days from the date on which a valid appeal request is received. ➢ An appellant's right to a hearing shall 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 shall not be asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process. ➢ If the appeal does not advance to hearing, the informal resolution decision shall be final and binding.

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ARTICLE 7: APPEAL PROCESS – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6614. Hearing Requirements.	➢ An appellant shall have an opportunity for a hearing in accordance with the requirements of this section. ➢ When a hearing is scheduled, the appeals entity shall send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 calendar days prior to the hearing date. ➢ The hearing shall be conducted: • No earlier than 60 days after the appeal receipt date; • 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. ➢ The appeals entity shall provide the appellant with the opportunity to: • Review their appeal record at least 2 business days before the hearing as well as during the hearing; • 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 shall 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. ➢ The appeals entity shall review the appeal de novo and shall consider all relevant facts and evidence adduced during the appeal.
§ 6616. Expedited Appeals.	➢ The appeals entity shall establish and maintain an expedited appeals process for an appellant to request an expedited 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 the appeals entity denies a request for an expedited appeal, it shall: • Handle the appeal request under 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 within 2 business days of the denial.

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ARTICLE 7: APPEAL PROCESS – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6618. Appeals Decisions.	➢ Appeal decisions shall: • Be based exclusively on the evidence 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 and the eligibility requirements; • State the decision, including a plain language description of the effect of the decision on the appellant's eligibility; • Include a summary of 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 • Provide an explanation of the appellant's right to pursue the appeal at the Health and Human Services Agency if the appellant remains dissatisfied with the eligibility determination. ➢ The appeals entity shall: • Issue written notice of the appeal decision to the appellant within 90 days of the date an appeal request is received; • In the case of an expedited appeal request that the appeals entity determines meets the criteria for an expedited appeal, issue the notice as expeditiously as the appellant's health condition requires, but no later than 3 business days after the appeals entity receives the request for an expedited appeal; and • Provide notice of the appeal decision and instructions to cease the appellant's pended eligibility, if applicable, via secure electronic interface, to Covered California or the DHCS, as applicable. ➢ Upon receiving the notice from the Appeals Entity, Covered California shall promptly: • Implement the appeal decision: ○ Retroactive to the date the incorrect eligibility determination was made; ○ At a time determined, as applicable; or in accordance with Medi-Cal or CHIP standards. • Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision.

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ARTICLE 7: APPEAL PROCESS – For Board Action

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6620. Appeal Record.	➢ Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeals entity shall make the appeal record accessible to the appellant for at least 5 years after the date of the written notice of the appeal decision. ➢ The appeals entity shall provide public access to all appeal records, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

Regulation Section 6460: Exemption from Individual Responsibility

Federal Regulation/Guidance:

- **§ 155.610(g)(2)(C) "**Lack of affordable coverage based on projected income. The Exchange must determine an applicant eligible for an exemption for a month or months during which he or she, or another individual the applicant attests will be included in the applicant's family, as defined in 26 CFR 1.36B-1(d), is unable to afford coverage in accordance with the standards specified in section 5000A(e)(1) of the Code, provided that —

  For an individual who is eligible to purchase coverage under an eligible employer-sponsored plan, the Exchange determines the required contribution for coverage such that —

  In the case of an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage."

Draft State Regulation:

- **§ 6454(f)(1)(A) "**An individual cannot afford coverage in a month if the individual's required contribution, determined on an annual basis of this section, for Minimum Essential Coverage for the month exceeds eight percent of such individual's household income for the taxable year. An individual's household income is increased by any amount of the required contribution made through a salary reduction arrangement that is excluded from gross income."

Stakeholder Feedback:

Stakeholders recommend that Covered California:

- Although the language is from the federal regulations, Subdivision (f)(1)(A) should be stated more clearly.
- Include language which specifies that Covered California will provide information to consumers to assist them in applying for an exemption from the individual mandate.

Final Staff Recommendation:

- The language has been modified to clearly state which subsections are referenced. Language now reads:
  - An individual cannot afford coverage in a month if the individual's required contribution, ~~determined on an annual basis~~ as described in subdivisions (f)(1)(C) through (F) of this section…" (**Note**: Subsection 6454 (f)(1)(A) is now Section 6460 (f)(1)(B).
- State Regulations, furthermore, now reads: "Provide the ~~tools~~ assistance and instruction to file an application."

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Regulation Section 6470: Application

Federal Regulation/Guidance:

- **§ 155.405(a)(c):** "The Exchange must use a single streamlined application to determine eligibility and to collect information necessary for: (1) Enrollment in a QHP; (2) Advance payments of the premium tax credit; (3) Cost-sharing reductions; and (4) Medicaid, CHIP, or the BHP, where applicable."

  The Exchange must: (1) Accept the single streamlined application from an application filer; (2) Provide the tools to file an application: (i) Via an Internet Web site; (ii) By telephone through a call center; (iii) By mail; and (iv) In person, with reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act."

Draft State Regulation:

- **§ 6470(a)(e):** "The Exchange shall use a single, streamlined application to determine eligibility and to collect information necessary for: Enrollment in a QHP; APTC; CSR; and MAGI Medi-Cal or CHIP. An application filer may file an application through one of the following channels: The Exchange's Internet Website; Telephone; Facsimile; Mail; or In-person."

Stakeholder Feedback:

Stakeholders recommend that Covered California:

- Include subsections to specify or indicate that Covered California will:
  - Use the application to determine potential eligibility for non-Modified Adjusted Gross Income (MAGI) Medi-Cal; and
- Change the use of "facsimile" to "other commonly available electronic means" as a channel the application filer can use to submit his or her application. This change provides consistency with CA Welfare and Institutions Code Section 1596(b).

Final Staff Recommendation:

- Preserve language as specified in the State Regulations for the following reasons:
  - Covered California will refer applications to the counties for non-MAGI Medi-Cal eligibility determinations, in the event the consumer requests for such a referral or appears to be eligible for non-MAGI based on the information provided on the application.
  - Consulted with the Office of Administrative Law (OAL) regarding the ability to use the terminology, "other commonly available electronic means." OAL indicated that the language being proposed by stakeholders is too vague and OAL further clarified that State Regulations must be more explicit and provide examples of what is considered to be other electronic means. Since the State Regulations identify internet website and facsimile as channels in which consumers may apply for coverage, preserve the existing language in the State Regulations.

Regulation Section 6488: Verification Process for Modified Adjusted Gross Income (MAGI)-based Medi-Cal and Children's Health Insurance Program

Federal Regulation/Guidance:

- **§ 155.320: "**If the Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange, with the exception of the data described in paragraph (c)(1)(i) of this section, the Exchange must utilize data obtained through other electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation to support the attestation."

Draft State Regulation:

- **§ 6488: "**If an applicant's attestation to the individuals that comprise his or her household for Medi-Cal and Children's Health Insurance Program (CHIP) is not reasonably compatible with other information provided by the application filer for the applicant or in the records of the Exchange, the applicant's attestation shall be verified using data obtained through electronic data sources."

Stakeholder Feedback:

- Remove this section as it governs Medi-Cal eligibility procedures. While MAGI Medi-Cal rules are being built into the CalHEERS rules engine, these rules are still governed by Department of Health Care Services (DHCS) as the Medi-Cal agency. Covered California should not promulgate regulations related to Medi-Cal.
- The special session Medi-Cal legislation specifies Medi-Cal's rules and standards regarding its verification process.

Final Staff Recommendation:

- Remove language in State Regulation (Section § 6488) since this section governs Medi-Cal eligibility procedures. Covered California will not promulgate regulations related to Medi-Cal. In addition, state law sets forth and describes the Medi-Cal Eligibility verification process.

Regulation Section 6490: Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for Advanced Premium Tax Credits and Cost Sharing Reductions

Federal Regulation/Guidance:

- **§ 155.320(d)(2): "**The Exchange must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. Except as specified in paragraphs (d)(3)(ii) or (iii) of this section, the Exchange must accept an applicant's attestation regarding the verification specified in paragraph (d) of this section without further verification."

Draft State Regulations:

- **§ 6490: "**For eligibility determinations for Advanced Premium Tax Credits (APTC) and Cost Sharing Reductions (CSR) that are effective before January 1, 2015, if the Exchange does not have any of the information specified in paragraphs (b)(1) through (3) of this section for an applicant, the Exchange shall accept an applicant's attestation regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested without further verification."

Stakeholder Feedback:

- Since the large employer mandate is postponed until 2015, stakeholders are concerned about the availability of using federal services database to conduct employer-sponsored coverage verifications. State regulations needs to address any contingency plans that must be used until then, consistent with the most recent Federal Regulations which allow Covered California to rely on self-attestation by the applicant as to whether they have access to employer-sponsored coverage, without having to verify that coverage is not available or affordable.

Final Staff Recommendation:

- Preserve the language as specified in the State Regulations for the following reason:
  - Covered California will rely on the consumer's attested information, in the event the federal services database is unavailable or cannot verify an individual's eligibility for qualifying coverage and enrollment in an employer-sponsored plan.
  - Since the federal services database in not available until January 1, 2015, State Regulations allow Covered California to accept a consumer's attestation through December 31, 2014.

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Regulation Section 6508: Authorized Representative

Federal Regulation/Guidance:

- **§ 155.227:** "The Exchange must permit an applicant or enrollee in the individual or small group market, subject to applicable privacy and security requirements, to designate an individual person or organization to act on his or her behalf in applying for an eligibility determination or redetermination, under subpart D, G, or H of this part, and in carrying out other ongoing communications with the Exchange."

Draft State Regulation:

- **§ 6508(a)(h): "**The Exchange shall permit an applicant or enrollee in the individual or small group market, subject to applicable privacy and security requirements, to designate an individual or organization to act on his or her behalf in applying for an eligibility determination or redetermination and in carrying out other ongoing communications with the Exchange. When an organization is designated as an authorized representative, staff or volunteers of that organization that exercise that capacity for an applicant before the Exchange and the organization itself shall enter into an agreement with the Exchange to comply with the certification requirements set forth by the Exchange."

Stakeholder Feedback:

- Stakeholders expressed concerns about allowing an organization to be an authorized representative and recommend changes to allow a designated individual to be an authorized representative. Stakeholders understand that while many authorized representatives work for organizations, it is important to designate a particular individual which is consistent with the recent Medi-Cal state law enacted under special session, that require an individual authorized representative be named.

Final Staff Recommendation:

- Preserve the language in State Regulations regarding the designation of an organization as an authorized representative, since this is a requirement set forth in Federal Regulations.

Regulation Section 6602: General Eligibility Appeals Requirements

Federal Regulation/Guidance:

- **§ 155.505(b)(1)-(3):** "An applicant or enrollee must have the right to appeal—
  (1) An eligibility determination made in accordance with subpart D, including initial determination and redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions.
  (2) An eligibility determination for an exemption
  (3) A failure by the Exchange to provide timely notice of an eligibility determination."

Draft State Regulation:

- **§ 6602:** "An applicant or enrollee may appeal:
  - Eligibility Determinations/Redeterminations.
  - Eligibility Determination of an exemption request*
  - Covered California's failure to provide a timely eligibility determination."

Stakeholder Feedback:

Stakeholders recommend that Covered California:

Add "or enrollment" after "eligibility" in (a)(1) and elsewhere to make it clear that consumers can appeal enrollment decisions, such as those related to open enrollment and special enrollment periods.

Final Staff Recommendation:

Preserve the language as specified in the State Regulations for the following reasons:

- Consumers may appeal decisions related to eligibility determinations, in order to enroll into a Covered California Plan. However, consumers cannot appeal enrollment decisions regarding plan selections. Concerns regarding enrollment into a health insurance plan will be handled through a consumer review process.
- Consumers may appeal decisions related to their eligibility to participate in the Medi-Cal Bridge Plan Products. Since this law is not effective, according to the Office of Administrative Law, Covered California cannot reference the Medi-Cal Bridge Plan Products in these Regulations. Therefore, future State Regulations will include eligibility for the Medi-Cal Bridge Plan Products as an appealable circumstance.

*(Note: Appeal of an Exemption request will be reviewed by the U.S. Department of Health and Human Services).

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Regulation Section 6604: Notice of Appeal Procedures

Federal Regulation/Guidance:

- **§ 155.515 "**Notice of appeal procedures**.** Notices must contain:
  1) An explanation of the appeal rights; 2) description of the procedures by which the applicant or enrollee may request an appeal; 3) 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, 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."

Draft State Regulation:

- **§ 6604: "**Covered California shall provide notice of appeal procedures at the time that the Applicant submits an application; and Covered California sends notice of eligibility. Notice of appeal procedures shall 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."

Stakeholder Feedback:

Stakeholders recommend that Covered California include the following language in Subsection 6604:

- Information about each insurance affordability program for which an individual or multiple family members of a household have been determined to be eligible or ineligible and the effective date of eligibility and enrollment.
- Information regarding the specific bases of eligibility or ineligibility for non-Modified Adjusted Gross Income (MAGI) Medi-Cal and the benefits and services afforded to individuals eligible on those bases, sufficient to enable the individual to make an informed choice as to whether to appeal the eligibility determination or the date of enrollment. Any notice of ineligibility or other adverse determination must contain all of the information provided for in Medicaid notices of action, pursuant to 42 CFR §431.210.

Final Staff Recommendation:

Preserve the language as specified in the State Regulations for the following reasons:

- Each person or family will receive determination notices from Covered California and/or Medi-Cal depending on the outcome of their eligibility determination via the California Enrollment, Eligibility, and Retention System (CalHEERS).
- Covered California does not conduct eligibility determinations for non-MAGI Medi-Cal. Rather, applications that are non-MAGI Medi-Cal will be forwarded to the counties in order for the eligibility determination to occur. The counties are responsible for sending the consumers the non-MAGI Medi-Cal eligibility decisions.

Regulation Section 6606: Appeals Requests

Federal Regulation/Guidance:

- **§ 155.520(d)(1): "**Upon receipt of a valid appeal request pursuant to paragraph (b), (c), or (d)(3)(i) of this section, the appeals entity—
  (i) Must send timely acknowledgment to the appellant of the receipt of his or her valid appeal request, including—
  (A) Information regarding the appellant's eligibility pending appeal pursuant to § 155.525; and
  (B) An explanation that any advance payments of the premium tax credit paid on behalf of the tax filer pending appeal are subject to reconciliation under 26 CFR 1.36B-4."

Draft State Regulation:

- **§ 6606 Appeals Requests**
  (d) Upon receipt of a valid appeal request, the appeals entity:
  - Shall send timely acknowledgment to the appellant of the receipt of his or her valid appeal request.
  - Shall send timely notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal to the Covered California and to the Department of Health Care Services, where applicable.

  (e) Upon receipt of an appeal request that is **not** valid because it fails to meet the requirements of this section or Section 6602(a), the appeals entity shall:
  (1) 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
  (2) Treat as valid an amended appeal request that meets the requirements of this section and of Section 6602(a).

Stakeholder Feedback:

Stakeholders recommend that Covered California:

- Include the acknowledgement of the appeal request and an explanation of the informal resolution process.
- Include language informing the applicant/enrollee of the right to address the problems with the defect of an "invalid" appeal by explaining that the applicant or enrollee can cure the defect and resubmit the appeal so long as it meets the timeliness requirement.

Staff Preliminary Recommendation:

- Incorporate Stakeholder feedback in order to inform consumers about their request for an appeal and ability to conduct an informal resolution process. Revised State Regulations now read:

  § 6606(d)(1): Shall, <u>within five business days form the date on which the appeal request is received,</u> send ~~timely~~ <u>written</u> acknowledgement to the appellant of the receipt of his or her valid appeal request, including:
  (A) <u>Information regarding the appellant's opportunity for information resolution prior to the hearing pursuant to Section 6612."</u>

- Consider stakeholder feedback regarding the ability to inform applicants/enrollees of the right to address problems with the defect of an "invalid" appeal in future State Regulations.

*Note: Appeal of an Exemption request will be reviewed by the U.S. Department of Health and Human Services.

Regulation Section 6614: Hearing Requirements

Federal Regulation/Guidance:

§ 155.535 Informal resolution and hearing requirements.

"A state-based Exchange appeals entity may also provide an informal resolution process prior to a hearing."

Draft State Regulation:

§ 6614 "Conducting the hearing.
(d) The appeals entity shall provide the appellant with the opportunity to:
(1) 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."

Stakeholder Feedback:

Stakeholders recommend that Covered California:

- Amend subsection (c) to provide the appellant the choice of format of the hearing, including in person, telephone or videoconferencing and consulted when choosing a date for the hearing.
- In addition, Regulations must clarify the meaning of "reasonable time" in Section 6614(d)(1).

Final Staff Recommendation:

- Department of Social Services (DSS) shall be the Covered California designated appeals entity. When adjudicating appeals, DSS currently provides appellants the choice of format of the hearing (e.g., in person, telephone and videoconferencing). This is DSS' standard process when adjudicating appeals. Therefore, staff recommends to preserve the language as currently written within the State Regulations. However, staff will consider stakeholder feedback in future State Regulations.

- State regulations have been revised specifically to indicate the appellant has at least 2 business days before the date of the hearing to review his or her appeal record. Regulations have been revised to read:

§ 6614(d): "The appeals entity shall provide the appellant with the opportunity to:
(1) 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~~ <u>at least two business days</u> before the date of the hearing as well as during the hearing."

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Regulation Section 6618: Appeal Decisions

Federal Regulation/Guidance:

- **§ 155.545 Appeal Decisions.**
  (b)(1): Propose the standards for the appeals entity to issue written notice of the appeal decision, either electronically or in hard copy, to the appellant. Such notice to the appellant be issued within 90 days of the date an appeal request under § 155.520(b) or (c) is received, as administratively feasible.

Draft State Regulation:

- **§ 6614:** (b)(1): "Issue written notice of the appeal decision to the appellant within 90 days (the Exchange has requested HHS an extended 120-day timeframe so that an appropriate and effective informal resolution process can be implemented) of the date an appeal request under Section 6606(b) is received, as administratively feasible."

Stakeholder Feedback:

- Stakeholders recommend that Covered California remove the language referencing "as administratively feasible" because it is inconsistent with the 90-day timeframe currently set forth in the proposed State Regulations.
- Stakeholders recommend the inclusion of additional language regarding implementing appeals decision, which relates to "adverse action that are taken."

Final Staff Recommendation:

- The timeframe to adjudicate an appeal will continue to be 90 days. Covered California removed the "as administratively feasible" from the State Regulations in order to prevent any confusion regarding the 90 day processing timeframe to adjudicate an appeal. Revised State Regulations now read:

  § 6614: (b)(1): "Issue written notice of the appeal decision to the appellant within 90 days ~~(the Exchange has requested HHS an extended 120-day timeframe so that an appropriate and effective informal resolution process can be implemented)~~ of the date an appeal request under Section 6606(b) is received~~, as administratively feasible~~."

- Staff recommends preserving the existing language currently specified in State Regulations, regarding implementing appeal decisions retroactively to the date the incorrect eligibility determination was made which does not include adverse actions. Adverse actions are not limited to eligibility determinations.

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ARTICLE 5:

APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

Board Action

(Previously approved State Regulations)

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Final Proposed State Regulations - *For Board Action*

- The 1st package of State Regulations were previously approved by the Board on June 20, 2013.
- Based on recently released final Federal Regulations, technical revisions were made to the previously adopted State Regulations (1st package) to conform to the Federal Regulations to add clarity to the language previously approved by the Board.

ARTICLE	SECTION	SECTION TITLE
5	§ 6478.	Verification Process Related to Eligibility Requirements for Enrollment in a QHP through the Exchange.
5	§ 6482.	Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR.
5	§ 6484.	Verification Process for Increases in Household Income Related to Eligibility For APTC and CSR.
5	§ 6492.	Inconsistencies.
5	§ 6496.	Eligibility Redetermination During a Benefit Year.
5	§ 6498.	Annual Eligibility Redetermination.
5	§ 6504.	Special Enrollment Periods.
5	§ 6506.	Termination of Coverage in a QHP.

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ARTICLE 5:

APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

For Discussion Only

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Section 6512: Special Rule For Family Coverage – For Board Discussion Only

SUMMARY OF PROPOSED DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6512. *Special Rule For Family Coverage.* ***(Board Discussion Only)*** ***Comments Due:*** ***September 6, 2013*** ***Board Action:*** ***September 19, 2013 Board Meeting***	➢ As part of the plan and rate negotiations, requiring all members of a tax household to enroll into a single family plan was factored into the negotiation process between Covered California and the health plans. Unfortunately, this policy was not brought forth to the Board and stakeholders for further review, input and discussion. ➢ Requiring a single family plan is a standard practice in the private individual market. ➢ Covered California consulted with the Center for Consumer Information and Insurance Oversight (CCIIO) to obtain additional federal guidance, regarding the single family plan requirement. CCIIO indicated that it is permissible for Covered California to require family members to enroll in a single family plan, so long as there are exceptions to allow members to enroll in different health plans under certain exceptions. ➢ All members of a tax household shall enroll in a single family plan through the subsidized Exchange program (e.g., tax credit and cost sharing reduction), unless at least one of the following exceptions applies to any member(s) of the household: • A tax-dependent, such as a college student, who resides in a different rating region than his or her primary tax filer. • A non-custodial parent who applies for health insurance for his or her tax-dependent child(ren) that live with the custodial parent in a different rating region than the non-custodial parent. • Federally-recognized American Indian or Alaska Native members of a mixed-Indian-status tax household who are entitled to special CSR in accordance with Section 6494. • Other exceptional circumstances which may be approved by the Exchange on a case-by-case basis.

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QUESTIONS and SUGGESTIONS?

Submit written comments/suggestions to:

Eligibility@covered.ca.gov

Due Date:

September 6, 2013

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