Eligibility & Enrollment Regulations

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California Health Benefit Exchange Board Meeting
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Eligibility & Enrollment

Proposed State Regulations

(Covered California Individual Subsidized and Non-Subsidized Programs)

Final Staff Recommendations

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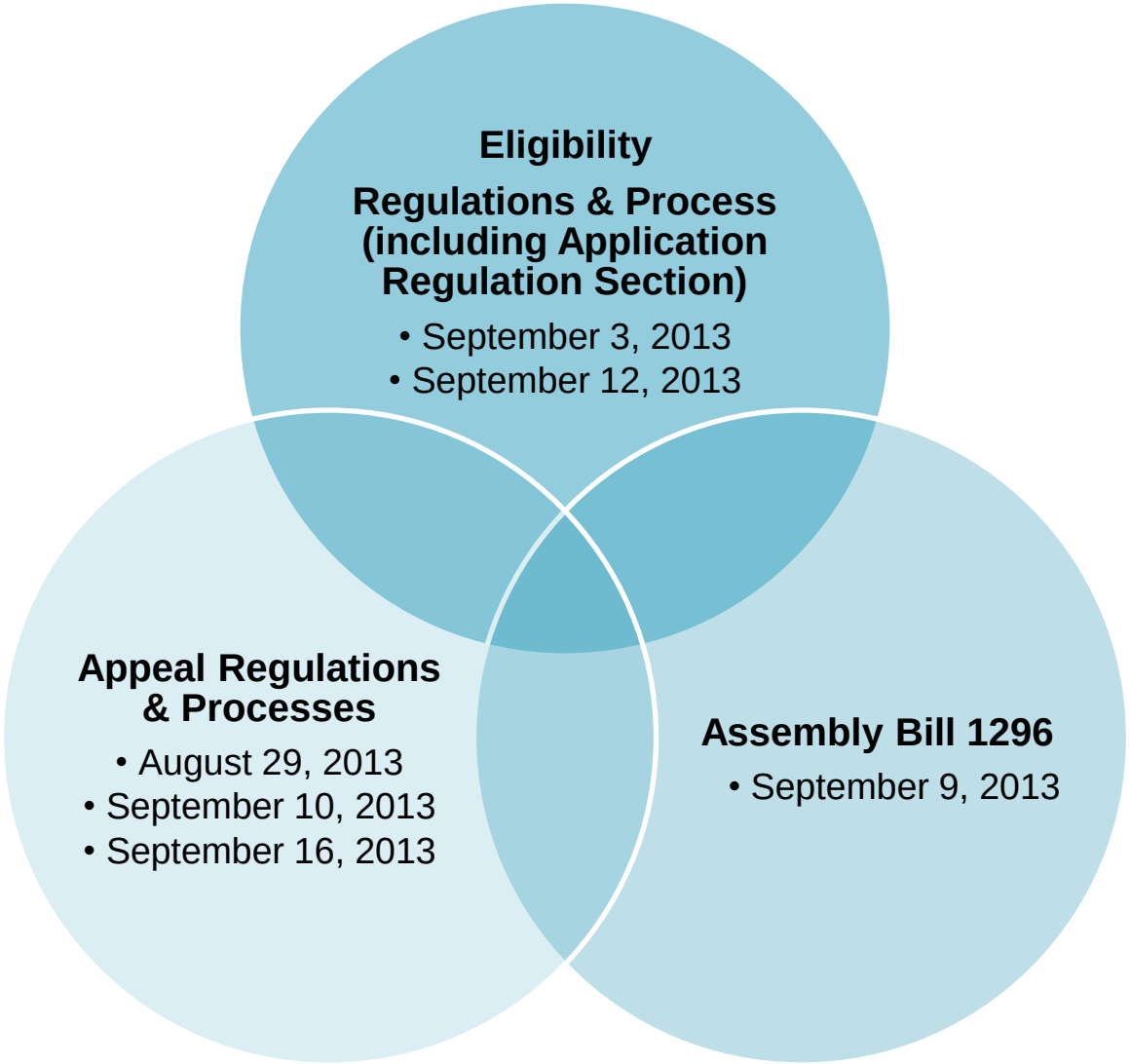
Meetings with Consumer Advocate Groups After August 22, 2013 Board Meeting



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Eligibility and Enrollment Regulations

(Subsidized and Non-Subsidized Programs)

Articles and sections of the Eligibility and Enrollment Regulations related to subsidized and non-subsidized programs are as follows:

Articles	Sections (High Level Summary)
Article 2: Abbreviations and Definition	• Abbreviations and definition of terms throughout the regulation
Article 4: General Provisions	• Accessibility and Readability Standards • ~~Exemption from Individual Responsibility~~ (Section removed from State Regulations)
Article 5: Application, Eligibility and Enrollment Process for the Individual Exchange:	• Application • Eligibility Determination Processes • Verification Processes • Special Eligibility Standards for Indians • Annual Eligibility and Redetermination • Initial and Annual Open Enrollment • Special Enrollment Period • Termination of Coverage
Article 7: Appeals Process	• Appeals Requests • Dismissals • Informal Resolution • Hearing Requirements • Appeal Decisions

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Eligibility & Enrollment – Key Policy Issues

State Regulation Section	Stakeholder Feedback	Final Staff Recommendations
§6410: Definitions.	• Definition of Domestic Partners needs to be included in the State Regulations, consistent with state law.	• New definition of Domestic Partners are now included in the State Regulations , in accordance to state law, Section 297 of California Family Code. • Domestic partners are also identified as dependents.
§6470(a): Application.	• 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	• The language has been modified to state that the single streamline application can be used for MAGI and non-MAGI Medi-Cal programs. • Revised and now reads: "~~The Exchange shall use a~~ A single, streamlined application shall be used to determine eligibility and to collect information necessary for enrollment in an Insurance Affordability Program, including: ~~• MAGI~~ Medi-Cal, • CHIP, • APTC, and • CSR." **NOTE:** Covered California will only determine eligibility for MAGI Medi-Cal programs through CalHEERS when no follow-up is required. For MAGI Medi-Cal applications that require follow-up or for non-MAGI Medi-Cal applications, referrals will ne made to the local county social services office.
§ 6470(c)(3): Application.	• A request for a home address cannot be mandatory, especially for homeless applicants. The regulation should only require a mailing address.	Language has been added to state that Covered California will allow a consumer to provide a mailing address, if they do not have a home address. The language now reads: "…For an applicant who does not have a home address, only a mailing address shall be provided."

Eligibility & Enrollment – Key Policy Issues

State Regulation Section	Stakeholder Feedback	Final Staff Recommendations
§ 6470(k): Application.	• Include subsections to specify or indicate that Covered California will: ➢ Accept incomplete applications and advise the applicant of the missing information rather than denying eligibility based on missing information.	• Language has been added to state Covered California will accept incomplete applications and will assist the consumer with providing missing information. • The language now reads: "If an applicant or application filer submits an incomplete application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for an Insurance Affordability Program, if applicable, the Exchange shall proceed as follows: (1) The Exchange shall provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information…"
§ 6506. Termination of Coverage in a QHP.	• Although the 3-month grace period as proposed in the previous draft State Regulations complies with federal regulations, the provision does not comply with state law.	• Requires additional discussion with the Board and stakeholders. Therefore, the 3-month grace period sub-section has been revised to make no reference to the procedures of the 2nd and 3rd months of the grace period. Once the Board approves the process that Covered California will implement during the 2nd and 3rd month grace period, a new section of the State Regulations will be promulgated at a later time. *[Note: This issue will be addressed later in the board meeting.]*
§ 6512. Special Rule for Family Coverage.	• Family members must be permitted to select different Covered California Health Plans.	• Requires additional discussion with the Board and stakeholders. Therefore, this Section has been **removed and deleted** from the State Regulations. Once the Board approves the policy, a new section of the State Regulations will be promulgated at a later time. *[Note: This issue will be addressed later in the board meeting.]*

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Eligibility & Enrollment – Key Policy Issues

State Regulation Section	Stakeholder Feedback	Final Staff Recommendations
§ 6606. Appeals request.	• Specify that the Administrative Law Judge (ALJ) will validate all incoming appeals. • All appellants have the right to a fair hearing, regardless of the appeal validity	• Revised State Regulations clearly indicate that the Administrative Law Judge will specifically validate all incoming appeals. • Staff recommends preserving the terminology "valid," since the Administrative Law Judge determines the validity of the case prior to the hearing date. Only valid appeals will have the right to a fair hearing request. The language is consistent with the Final Federal Regulations.
§ 6612. Informal Resolution.	• Indicate that an appellant's right to a hearing shall be preserved in any case, whether the appellant is satisfied with the informal resolution process or not. • Eliminate Covered California's process of sending written notice of the outcome of the informal resolution process.	• Appellant may proceed with a fair hearing even if the appellant is satisfied with the information resolution process. • Recommend preserving the Covered California process of sending written notification of the outcome of the information resolution process to consumers.

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Eligibility & Enrollment – Key Policy Issues

State Regulation Section	Stakeholder Feedback	Final Staff Recommendations
§ 6614. Hearing Requirements.	• Specifically indicate that the Administrative Law Judge will conduct the hearing. • Specifically indicate that the hearing will be conducted in person, unless the appellant requests the hearing be held telephonically or via video conference.	• Incorporated stakeholder feedback specifying that all hearings will be conducted by an Administrative Law Judge. In addition, the hearing will be conducted in person, unless the appellant requests for a telephonic of video conference hearing.
§ 6618. Appeal Decisions.	• Specifically indicate that the Exchange will implement the Administrative Law Judge's decision no later than 30 days from the date of the issuance of the hearing.	• Incorporated stakeholder feedback specifying that the Exchange will enroll the appellant on the first day of the following month or retroactively enroll the appellant to the date in which the incorrect eligibility determination was made.

Questions/Comments

Appendix

DRAFT REGULATION SECTION SUMMARY

Eligibility & Enrollment State Regulations Timelines

Activity:	Timeline:
1st package of final Eligibility & Enrollment State Regulations presented at Board Meeting and Approved ***(Approved by Board)*** 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 Exemptions and Miscellaneous Minimum Essential Coverage Provisions 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	August 12, 2013
Final Federal Regulations - Final Rule Regarding Eligibility Appeals Released by the Center for Medicare and Medicaid Services	August 30, 2013
Eligibility and Enrollment Regulations presented at Board Meeting ***(Discussion Item Only)*** Proposed Draft State Regulations – Single Family Plan ***(Discussion Item Only)***	August 22, 2013
Final Comprehensive Eligibility and Enrollment Regulations to the Board ***(for Board Action)***	September 19, 2013
Submission of Board Adopted State Regulations to the Office of Administrative Law	September 20, 2013

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Appendix

ARTICLE 2:

SUMMARY OF ABBREVIATIONS & DEFINITIONS

Appendix: ARTICLE 2 - Abbreviations & Definitions

REGULATION SECTION	SECTION SUMMARY
§ 6408. Abbreviations.	**Advance Payments of Premium Tax Credit (APTC):** Payment of the tax credits authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange.
§ 6410. Definitions.	**Annual Open Enrollment Period:** The period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange. **Applicable Children's Health Insurance Program (CHIP) MAGI–based Income Standard:** The applicable income standard , as applied under the State plan adopted, or waiver of such plan and as certified by the State CHIP Agency for determining eligibility for child health assistance and enrollment in a separate child health program. **Applicable Medi-Cal Modified Adjusted Gross Income (MAGI)-based Income Standard:** The same standard as "applicable modified adjusted gross income standard," as applied under the State plan adopted, or waiver of such plan, and as certified by the DHCS for determining eligibility for Medi-Cal. **Applicant:** An applicant means: (a) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the shared responsibility payment ~~for not maintaining minimum essential coverage pursuant to Section 6460 of Article 4 of this chapter~~, or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following: (i) Enrollment in a QHP through the Exchange; or (ii) Medi-Cal and CHIP. (b) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable. **Application Filer:** An applicant; an adult who is in the applicant's household, as defined in 42 CFR § 435.603(f), or family, as defined in 26 U.S.C. § 36B(d) and 26 CFR § 1.36B-1(d); an authorized representative; or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant; excluding those individuals seeking eligibility for an exemption ~~pursuant to Section 6460 of Article 4 of this chapter~~ from the shared responsibility payment. **Cost-sharing:** Any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services. **Cost-Sharing Reduction (CSR):** Reductions in cost-sharing for an eligible individual enrolled in a silver level plan in Covered California or for an individual who is an Indian enrolled in a Covered California Health Plan in Covered California. **Dependent:** A dependent as defined in Section 152 of IRC (26 U.S.C. § 152). <u>For purposes of eligibility determinations and enrollment in a QHP without requesting APTC or CSR, "dependent" also includes domestic partners. This definition applies only to the Individual Exchange.</u>

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Appendix: ARTICLE 2 - Abbreviations & Definitions

REGULATION SECTION	SECTION SUMMARY
§ 6410. Definitions. ***Continued***	**Domestic Partners:** Individuals as defined in Section 297 of California Family Code. **Federal Poverty Level (FPL):** The most recently published Federal poverty level (FPL), updated periodically in the Federal Register by the Secretary of Health and Human Services, as of the first day of the annual open enrollment of Article 5 of this chapter. **Reasonably Compatible:** The difference or discrepancy between the information that Covered California obtained through electronic data sources, provided by the applicant, or other information in the records of Covered California and an applicant's attestation does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions. **Minimum Essential Coverage (MEC):** Coverage as defined in Section 5000A(f) of IRC (26 U.S.C. § 5000A(f)) and in 26 CFR § 1.36B-2(c). **Premium Payment Due Date:** A date no earlier than the fourth remaining business day of the month prior to the month in which coverage becomes effective. **Qualifying coverage in an eligible employer-sponsored plan:** Coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in Section 36B(c)(2)(C) of IRC (26 U.S.C. § 36B(c)(2)(C)) and in 26 CFR § 1.36B-2(c)(3). **+**The difference or discrepancy between the information that the Exchange obtained through electronic data sources, provided by the applicant, or other information in the records of the Exchange and an applicant's attestation does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions. **Tax filer:** An individual, or a married couple, who indicates that he, she, or the couple expects: (a) To file an income tax return for the benefit year, in accordance with 26 U.S.C. §§ 6011, 6012, and implementing regulations; (b) If married (within the meaning of 26 CFR § 1.7703–1), to file a joint tax return for the benefit year; (c) That no other taxpayer will be able to claim him, her, or the couple as a tax dependent for the benefit year; and (d) That he, she, or the couple expects to claim a personal exemption deduction under Section 151 of IRC on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Appendix

ARTICLE 4:
SUMMARY OF GENERAL PROVISIONS

Appendix: ARTICLE 4 – General Provisions

REGULATION SECTION	SECTION SUMMARY
§ 6450. Meaning of Words.	Words shall have their usual meaning unless the context or a definition clearly indicates a different meaning. "Shall" means mandatory. "May" means permissive. "Should" means suggested or recommended.
§ 6452. Accessibility and Readability Standards.	All applications, forms, notices, and correspondence provided to the applicants and enrollees by Covered California and Covered California Plan issuers shall: • Be provided to applicants and enrollees in plain language, • To the extent administratively feasible, be formatted to be understood at the 9th grade level; • To the extent administratively feasible, not contain technical language beyond an 9th grade level or print smaller than 12 point; and • Not contain language that minimizes or contradicts the information being provided. Information shall be provided to applicants and enrollees at no cost to the individual and in a manner that is accessible and timely to: • Individuals living with disabilities through the provision of auxiliary aids and services, including accessible Web sites. • Limited English proficient individuals through the provision of language services, including: Oral interpretation or written translations; and Taglines in non-English languages that indicate language services are available. Covered California must inform individuals of the availability of and how to access these services.
§ 6454. General Standards for Exchange Notices.	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 <u>including local legal aid and welfare rights offices</u>; and • An explanation of appeal rights, if applicable. Covered California shall reevaluate the appropriateness and usability of all notices on an annual basis. The individual market Exchange shall provide required notices either through standard mail, or if an individual elects, electronically.

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Appendix: ARTICLE 4 – General Provisions

REGULATION SECTION	SECTION SUMMARY
§ 6460. Exemption from Individual Responsibility. ***NOTE: Exemption from Individual Responsibility Regulations have been removed and will be presented to the Board for approval at a later date.***	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.**

Appendix

ARTICLE 5:

SUMMARY OF

APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE – ADDITIONAL KEY POLICY ISSUES

State Regulation Section	Stakeholder Feedback	Final Staff Recommendations
§ 6470(c)(8): Application.	• The request for information about the employer's name should not be a mandatory criterion because it is not necessary for an eligibility determination.	• Language has been modified to remove the requirement to request the employer's name. • The language now reads: "The applicant's employment status~~, and if employed, the name of the employer~~…"
§ 6488: Verification Process for Modified Adjusted Gross Income (MAGI)-based Medi-Cal and Children's Health Insurance Program.	• 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 it's verification process.	• 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.

Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6470 Application.	A single, streamlined application shall be used to determine eligibility and to collect information necessary for: • Enrollment in a Covered California subsidized Health Plan; • Advanced Premium Tax Credits (APTC); • Cost Sharing Reductions (CSR) ; and • ~~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 requests the applicant to provide the following information: • Contact Information (e.g. Name, address, phone number); • Demographic Data; • Former foster Care status; • Personal Tax Information (e.g. SSN, Taxpayer Identification number, etc.); • Household Composition; • Income Information (Relationship to applicant, current income information, etc.); • Other Healthcare Information; • Declarations (e.g. Penalty of perjury statement, true and correct statement and efforts made to confirm answers not known personally with someone who did know personally); and • Signature (e.g. Applicant, Authorized Representative, and other certified individuals). Covered California shall accept an application from an applicant or applicant filer and make an eligibility determination for an applicant seeking an eligibility determination at any time during the year. If an applicant submits an incomplete application, Covered California shall: • Provide notice to the applicant indicating the information necessary to complete the application, • Provide a period of no less than 10 calendar days and no more than 90 calendar days from the date of the notice to provide needed information.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6472. Eligibility Requirements for Enrollment in a QHP through the Exchange.	For purposes of this section, an applicant includes all individuals listed on the application who are seeking enrollment in a Covered California Health Plan through Covered California and shall: • Provide his or her SSN to Covered California (if he or she has an SSN); • Be a U.S. citizen or U.S. national, or a non-citizen who is lawfully present in the U.S. and is reasonably expected to be a U.S citizen, U.S national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought; • Not be incarcerated, other than incarceration pending the disposition (judgment) of charges; • Meet applicable residency standards. Covered California shall not deny or terminate an individual's eligibility for enrollment in a Covered California Health or a QHP in another State Exchange if the individual: • Meets the residency standards except for a temporary absence from the service area of the Exchange; and • Intends to return when the purpose of the absence has been accomplished, unless another Exchange verifies that the individual meets the residency standard of such Exchange. Covered California shall determine an applicant eligible for enrollment in a minimum coverage plan through Covered California if the applicant: • Has not attained the age of 30 before the beginning of the plan year; or • Has a certification for any plan year that the applicant is exempt from the requirement to maintain minimum essential coverage, by reason of relating to individuals without affordable coverage; or ii. relating to individuals with hardships. APTC shall not be available to support enrollment in a minimum coverage plan through Covered California.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6474. Eligibility Requirements for APTC and CSR.	A tax filer shall be eligible for APTC if: • Expected to have a household income ≥ 100% but not more than 400% of the FPL for the benefit year for which coverage is requested; and • One or more applicants for whom the tax filer expects to claim a personal exemption deduction: ▪ Meets the requirements for eligibility for enrollment in a Covered California Health Plan; ▪ Is not eligible for Minimum Essential Coverage; and ▪ Is enrolled in a Covered California Health Plan . A non-citizen tax filer shall be eligible for APTC if: • Lawfully present and ineligible for Medi-Cal by reason of immigration status; • Tax filer is expected to have a household income of less than 100% of the FPL for the benefit year for which coverage is requested; and • One or more applicants for whom the tax filer expects to claim a personal exemption deduction is a non-citizen who is lawfully present and ineligible for Medi-Cal by reason of immigration status.
§ 6476. Eligibility Determination Process.	• Applicants may request an eligibility determination *only* for enrollment in a Covered California Health Plan *or* for an Insurance Affordability Program. • Enrollees may opt to accept less than the full amount of APTC. • If an applicant is determined eligible for MAGI-Medi-Cal, Covered California shall notify and transmit all information from Covered California records necessary to provide the applicant with coverage to DHCS promptly without undue delay. • Covered California shall provide timely written notice of any eligibility determination.

Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6478. Verification Process Related to Eligibility Requirements for Enrollment in QHP through the Exchange.	Covered California shall verify or obtain information as provided in this section to determine whether an applicant meets the eligibility requirements for enrollment in a Covered California Health Plan: • Covered California shall transmit the SSN and other identifying information to the U.S. Department of Health and Human Services (HHS) which will submit it to the Social Security Administration (SSA). **Verification of Social Security Number** • For an applicant who has a social security number or documentation that can be verified through the U.S. Department of Homeland Security (DHS) and who attests to lawful presence, or who attests to citizenship and for whom Covered California cannot substantiate a claim of citizenship through the SSA, Covered California shall transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the DHS. **Verification Citizenship, Status as a National, or Lawful Presence** For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom Covered California cannot verify such attestation through the SSA or the DHS, Covered California must follow the inconsistencies procedures specified in regulations, except that Covered California must provide the applicant with a period of 90 days from the date on which the notice described in regulations is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA or the DHS, as applicable. **Verification of Residency** Covered California shall verify the applicant's attestation that he or she meets the residency standards by accepting his or her attestation without further verification; or examining available HHS-approved electronic data sources If information provided by an applicant is not reasonably compatible with other information provided by the individual or in records of Covered California, Covered California shall examine information in available HHS-approved data sources. If the information in such data sources is not reasonably compatible with the information provided by the applicant, Covered California shall follow the inconsistency procedures specified in regulations. Evidence of immigration status may not be used to determine that an applicant is a State resident. **Verification of Incarceration Status** Covered California shall verify an applicant's attestation that he or she meets the requirements by relying on available HHS-approved electronic data sources; or if HHS-approved data source is unavailable, accepting the applicant's attestation without further verification. If an applicant's attestation is not reasonably compatible with information from HHS-approved data sources or other information provided by the applicant or in Covered California records, Covered California shall follow the specified the inconsistencies procedures.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6480. Verification of Eligibility for Minimum Essential Coverage (MEC) other than through an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR.	Covered California shall verify whether an applicant: • Is eligible for MEC other than through an eligible employer-sponsored plan, Medi-Cal, or Children's Health Insurance Program (CHIP), using information obtained from the HHS. • Has already been determined eligible for coverage through Medi-Cal or CHIP, using information obtained from the DHCS.
§ 6482. Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR.	**Family Size** • Covered California shall request tax return data regarding MAGI and family size from HHS for all individuals whose income is counted in calculating a tax filer's household income, in accordance with federal law, and for whom Covered California has a SSN or Taxpayer Identification Number. • If the identifying information for one or more individuals does not match a tax record on file with the IRS, Covered California shall follow specified inconsistencies procedures. **Annual Household Income** • An applicant's annual household income shall be verified as follows: ▪ The annual household family income shall be computed based on the tax return data. ▪ An applicant shall attest to a tax filer's projected annual household income. ▪ If an applicant's attestation indicates that the information represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for Advanced Payments of Premium Tax Credits and Cost-Sharing Reductions shall be determined based on the applicant's reported income. ▪ If the data is unavailable, or an applicant attests that a change in household income has occurred, or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year, the applicant shall attest to the tax filer's projected household income for the benefit year for which coverage is requested.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6484. Verification Process for Increases in Household Income Related to Eligibility Determination for APTC and CSR.	• Covered California shall accept the applicant's attestation for the tax filer's family without further verification if: ▪ An applicant attests that a tax filer's annual household income has increased, or is reasonably expected to increase, from the data for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage; and ▪ Covered California has verified the applicant's MAGI-based income through the process specified in federal regulations not to be within the applicable Medi-Cal or CHIP MAGI–based income standard. • If Covered California finds that an applicant's attestation of a tax filer's projected annual household income is not reasonably compatible with other information provided by the application filer or available to Covered California, the applicant's attestation shall be verified using data obtained through electronic data sources. • If the data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by Covered California to support attestation.
§ 6486. Alternate Verification Process for APTC and CSR Eligibility Determination for Decreases in Annual Household Income or If Tax Return Data Is Unavailable.	• Covered California shall accept the applicant's attestation for the tax filer's family without further verification if: ▪ An applicant attests that a tax filer's annual household income has increased, or is reasonably expected to increase, from the data for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage; and . ▪ Covered California has not verified the applicant's MAGI-based income through the process specified in federal regulations to be within the applicable Medi-Cal or CHIP MAGI–based income standard. • If Covered California finds that an applicant's attestation of a tax filer's projected annual household income is not reasonably compatible with other information provided by the application filer or available to Covered California, the applicant's attestation shall be verified using data obtained through electronic data sources. • If the data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by Covered California to support attestation.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

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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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6492. Inconsistencies.	• For an applicant whose attestations are inconsistent with the data obtained by Covered California from available data sources, or for whom Covered California cannot verify information required to determine eligibility for enrollment in a Covered California Health Plan, or for APTC and CSR, including when electronic data is required in accordance with this section but not available, Covered California: ▪ Shall make a reasonable effort to identify and address the causes of such inconsistence by contacting the application filer to confirm the accuracy of the information. ▪ If unable to resolve the inconsistency, provide notice to the applicant regarding the inconsistency and provide the applicant with a period of 90 days from the date on which the notice is sent to the applicant to either present satisfactory documentary evidence through the channels available for the submission of the application, except by telephone, or otherwise resolve the inconsistency. ▪ May extend the period for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period. • Covered California shall provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified and the applicant's explanation of circumstances as to why the applicant does not have documentation if: ▪ An applicant does not have documentation with which to resolve the inconsistency through the process because such documentation does not exist or is not reasonably available; ▪ Covered California is unable to otherwise resolve the inconsistency for the applicant; and ▪ The inconsistency is not related to citizenship or immigration status. **NOTE:** An applicant shall not be required to provide information beyond the minimum necessary to support the eligibility and enrollment processes of Covered California, Medi-Cal, and CHIP.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6494. Special Eligibility Standards and Verification Process for Indians.	An Indian applicant's eligibility for Cost Sharing Reductions (CSR) shall be determined based on the following procedures: • An Indian applicant shall be eligible for CSR if he or she: ▪ Meets the eligibility requirements ▪ Is expected to have a household income that does not exceed 300 percent of the Federal Poverty Level for the benefit year for which coverage is requested; and ▪ Is enrolled in a Covered California Health Plan. • If an Indian applicant meets the eligibility requirements: ▪ Such applicant shall be treated as an eligible insured; and ▪ The Covered California Health Plan shall eliminate any cost-sharing under the plan. • Regardless of an Indian applicant's income and the requirement to request an eligibility determination for all Insurance Affordability Programs, such applicant shall be eligible for CSR if the individual is: ▪ Enrolled in a QHP through the Exchange; and ▪ Furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services. If an Indian applicant meets the eligibility requirement the issuer: • Shall eliminate any cost-sharing under the plan for the item or service; and • Shall not reduce the payment to any such entity for the item or service by the amount of any cost-sharing that would be due from the Indian. An Indian applicant's attestation that he or she is an Indian shall be verified by: • Using any relevant documentation verified; • Relying on any approved electronic data sources that are available; or • If approved data sources are unavailable or data sources are not reasonably compatible with an applicant's attestation: ▪ Verifying documentation provided by the applicant that meets the following requirements for satisfactory documentary evidence of citizenship or nationality: ✓ A document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood). ✓ With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation that the Health and Human Services Agency has determined to be satisfactory documentary evidence of citizenship or nationality.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6496. Eligibility Redetermination during the Benefit Year	Covered California shall: • Redetermine eligibility if Covered California receives and verifies new information reported by an enrollee of a Covered California Health Plan or identified through the data matching process. ▪ Except for enrollees who have not requested an eligibility determination for Insurance Affordability Programs; • Provide electronic notification to enrollees who have opted to receive electronic notifications, regarding the requirements for reporting changes and enrollee's opportunity to report any changes. • Examine available data sources on a semiannual basis to identify changes in circumstances (e.g. death and eligibility determinations for Medicare, Medi-Cal or CHIP).
§ 6498. Annual Eligibility Redetermination.	Covered California shall: • Annually redetermine the eligibility of an enrollee in a Covered California Health Plan and for Insurance Affordability Programs. • Have on file an active authorization from the enrollee to obtain updated tax information. • Provide an annual redetermination notice with a pre-populated form that includes: 1. Data requested from HHS and data regarding Modified Adjusted Gross Income (MAGI)-based income; 2. Data used in the enrollee's most recent eligibility determination; 3. The enrollees projected eligibility determination for the following year. • Redetermine eligibility if Covered California verifies any enrollee reported changes that affect eligibility.
§ 6500. Enrollment of Qualified Individuals into Qualified Health Plans (or Covered California Health Plan).	A qualified individual may enroll in a Covered California Health Plan 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 Covered California Health Plan selection from an applicant who is determined eligible for enrollment in a Covered California Health Plan and shall: • Notify the applicant of her or his initial premium payment options and of the requirement that the applicant's initial premium payment shall be received in full by the Covered California Health Plan on or before the premium payment due date in order for the applicant's coverage to be effectuated. • Notify the Covered California Health Plan that the individual is a qualified individual; Covered California shall maintain records of all enrollments. Covered California shall reconcile enrollment information with QHP issuers and HHS no less than once a month.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY
§ 6500. Enrollment of Qualified Individuals into Qualified Health Plans (or Covered California Health Plan). ***Continued***	A Covered California Health Plan 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 Covered California information regarding all received payments. • Shall initiate cancellation of enrollment 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 Covered California 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 to the enrollee. A Covered California Health Plan shall reconcile enrollment and premium payment files with Covered California no less than once a month.
§ 6504. Special Enrollment Periods.	Covered California Special Enrollment Periods are triggered by: 1. A qualified individual or a dependent's loss of minimum essential coverage; 2. A qualified individual gains a dependent or becomes a dependent; 3. An individual not previously a U.S. citizen, U.S. national or lawfully present gains such status; 4. A qualified individual's enrollment or disenrollment in a Covered California Health Plan is unintentional, inadvertent, or erroneous as a result of an error, misrepresentation, or inaction of the staff or instrumentalities of Covered California or Health and Human Services. In such cases, Covered California takes necessary actions to correct or eliminate the effects of an identified determination error, misrepresentation or inaction. 5. An enrollee adequately demonstrates that a Covered California Health Plan substantially violated a material provision of its contract in relation to the enrollee. 6. An enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR; 7. An individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value. 8. A qualified individual or enrollee gains access to new Covered California Health Plan as a result of a permanent move; also applies to individuals recently released from incarceration. 9. A qualified individual who is an Indian may enroll in a Covered California Health Plan or change to another from one time per month.

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Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

REGULATION SECTION	SECTION SUMMARY

§ 6506. Termination of Coverage in a Qualified Health Plan (or Covered California Health Plan).	• An enrollee may terminate his or her coverage in a Covered California Health Plan, including as a result of the enrollee obtaining other minimum essential coverage (MEC), with at least a 14 day notice to Covered California.
	
	• Covered California may initiate the termination of an enrollee's Covered California Health Plan coverage, and shall permit a Covered California Health Plan to terminate such coverage, provided that the issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals in the following circumstances:
	  • The enrollee is no longer eligible for coverage in a Covered California Health Plan through Covered California;
	  • The enrollee fails to pay premiums for coverage, and the three-month grace period required for individuals receiving Advance Premium Tax Credits (APTC) has been exhausted;
	  • The enrollee's coverage is rescinded for cause by the Covered California Health Plan issuer;
	  • The Covered California Health Plan issuer terminates or is decertified; or
	  • The enrollee changes from one Covered California Health Plan to another during an annual open enrollment period or special enrollment period.
	
	• In the case of termination of an enrollee's coverage due to premium non-payment, a Covered California Health Plan shall:
	  • Provide the enrollee, who is delinquent on premium payment, with notice of such payment delinquency.
	  • Provide a grace period of three consecutive months if an enrollee receiving APTC has previously paid at least one full month's premium during the benefit year; and
	  • If an enrollee receiving APTC exhausts the three-month grace period without paying all outstanding premiums:
	  ▪ Terminate the enrollee's coverage on specified effective date, provided that the Covered California Health Plan meets the specified notice requirements; and
	  ▪ Return APTC paid on behalf of such enrollee for the second and third months of the grace period.

Appendix: ARTICLE 5 - APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

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:
	  • Sign an application, submit an update, or respond to a redetermination on the applicant's or enrollee's behalf;
	  • Receive copies of the applicant's or enrollee's notices and other communications from Covered California; and
	  • 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.

§ 6510. Right to Appeal.	Covered California shall include the notice of the right to appeal and instructions regarding how to file an appeal in any eligibility determination and redetermination notice issued to the applicant.

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Appendix

ARTICLE 7:
SUMMARY OF APPEAL PROCESS

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Regulation Section 6606: Appeal Requests – Key Policy Issues

Final Federal Regulation:

§ 155.520(a)(4): "The Exchange and the appeals entity must consider an appeal request to be valid for the purpose of this subpart, if it is submitted in accordance with the requirements of paragraphs (b) and (c) of this section and § 155.505(b)."

"(b) *Appeal Request.* The Exchange and the appeals entity must allow an applicant or enrollee to request an appeal within: (1) 90 days of the date of the notice of eligibility determination; or (2) A timeframe consistent with the state Medicaid agency's requirement for submitting fair hearing requests, provided that timeframe is no less than 30 days, measured from the date of the notice of eligibility determination."

Draft State Regulation:

§ 6606 Appeal Requests:

(b) The Exchange and the appeals entity shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination.

Stakeholder Feedback:

Stakeholders recommend that Covered California:

- Specify that the Administrative Law Judge (ALJ) will validate all incoming appeals.
- Specify what constitutes as a Holiday in accordance with Government Code Section 6700 et seq.
- Specify that the appeal will be validated only at the hearing.
- Eliminate the word "valid" from regulations, as every appellant has the right to a fair hearing request, regardless of the appeal validity.

Continued: Regulation Section 6606: Appeal Requests – Key Policy Issues

Final Staff Recommendation:

- Incorporate Stakeholder feedback in order to specifically state that the ALJ will specifically validate all incoming appeals. Revised State Regulations now read:
    - (b) The appeals entity shall consider an appeal request to be valid for purposes of this Article, as specified in Section 6602(c), if it is submitted in accordance with the requirements of subdivisions (c) and (d) of this section and Section 6602(a).
- Incorporate Stakeholder feedback in order to clarify what constitutes a holiday. Revised State Regulations now read:
    - (c) The Exchange and the appeals entity shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination, unless the appeals entity determines, in accordance with Section 6602(c), that there is good cause, as defined in Section 10951 of the Welfare and Institution Code, for filing the appeals request beyond the 90-day period. Any appeal requests filed after 180 days of the date of the notice of eligibility determination shall not be accepted. For purposes of this subdivision, if the last day of the filing period falls on a Saturday or holiday, as defined in Government Code Section 6700, the filing period shall be extended to the next business day, in accordance with Government Code Section 6707.
- Staff recommends preserving the word “valid” throughout this section, since the current process is for an ALJ to determine the validity of the case prior to the hearing date. Only valid appeals will have the right to a fair hearing request. Preserving the language that is specified in Final Federal Regulations.

Regulation Section 6610: Dismissals - Key Policy Issues

Final Federal Regulation:

§ 155.530 Dismissals:

"Dismissal of appeal. The appeals entity must dismiss an appeal if the appellant (1) Withdraws the appeal request in writing; (2) Fails to appear at a scheduled hearing without good cause; (3) Fails to submit a valid appeal request as specified in §155.520(a)(4); or (4) Dies while the appeal is pending."

Draft State Regulation:

§ 6610 Dismissals:

"(d) The appeals entity shall dismiss an appeal if the appellant: (1) Withdraws the appeal request; (2) Fails to appear at a scheduled hearing; (3) Fails to submit a valid appeal request as specified in Section 6606(a)(4) without good cause, as determined by the appeal entity on a case-by-case basis; or (4) Dies while the appeal is pending, unless the appeal affects the remaining member(s) of the deceased appellant's household."

Stakeholder Feedback:

- Stakeholders recommend that Covered California:
  - Specifically indicate that an appellant may withdraw his/her case through a conditional withdraw in addition to a unconditional withdrawal and the withdrawal must be signed by both parties.
  - Specify that it will be the Administrative Law Judge who determines what is "good cause" on a case-by-case basis when an appellant fails to appear.

Continued: Regulation Section 6610: Dismissals - Key Policy Issues

Final Staff Recommendation:

Incorporate Stakeholder feedback to include verbiage indicating that Covered California will accept any type of withdrawal. Revised State Regulations have been amended to reflect the Stakeholder feedback:

- The appeals entity shall dismiss an appeal if the appellant:
  - Unconditionally or conditionally ~~W~~ withdraws the appeal request in writing prior to the hearing date;
  - Fails to appear at a scheduled hearing without good cause;
  - 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 or the appeal can be carried forward by a representative of the deceased appellant's estate.
- 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~~ shall vacate a dismissal and proceed with the appeal 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.
- The appeals entity shall provide written notice of the denial of a request to vacate a dismissal to the appellant within 5 business days from the date of such denial, if the request is denied.

Regulation Section 6612: Informal Resolution - Key Policy Issues

Final Federal Regulation:

§ 155.535 Informal resolution and hearing requirements.

"(a)(2) The appellant's right to a hearing is preserved in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process."

Draft State Regulations:

§ 6612 "(d) 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."

Stakeholder Feedback:

- Stakeholders recommend that Covered California:
  - Indicate that an appellant's right to a hearing shall be preserved in any case, whether the appellant is satisfied with the informal resolution process or not.
  - Indicate that the appellant may withdraw unconditionally or conditionally, and must sign the agreement to withdraw.
  - Eliminate Covered California's process of sending written notice of the outcome of the informal resolution process.

Final Staff Recommendation:

- Incorporate stakeholder feedback to include verbiage indicating that Covered California will accept any type of withdrawal (conditional or unconditionally) and allow the appellant to receive a fair hearing, even if the appellant is satisfied with the informal resolution process. However, the appellant's conditional or unconditional withdrawal must be made by telephone or in writing. Revised State Regulations now reads:
  - "(d) An appellant's right to a hearing shall be preserved in any case ~~in which the appellant remains dissatisfied with~~ notwithstanding the outcome of the informal resolution process unless the appellant unconditionally or conditionally withdraws his or her appeal request prior to the hearing date, in accordance with the procedure set forth in Section 6610(a)(1)."

- Staff recommends preserving Covered California's process of sending written notification of the outcome of the informal resolution process to consumers.

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Regulation Section 6614: Hearing Requirements - Key Policy Issues

Final Federal Regulation:

§ 155.535 "(c) *Conducting the hearing*. All hearings under this subpart must be conducted–

(4) 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."

§ 155.535 "(d) *Procedural rights of an appellant*. The appeals entity must 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."

Draft State Regulations:

§ 6614 "(c)(4): "The hearing shall be conducted 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."

§ 6614 "(d)(1): "Review his or her appeal record, including all documents and records to be used by the appeals entity at the hearing, at least two business days before the date of the hearing as well as during the hearing."

Stakeholder Feedback:

Stakeholders recommend that Covered California:

- Indicate that it will be the ALJ who will conduct the hearing.
- Indicate the hearing will be conducted in person, unless the appellant requests the hearing be held telephonically or via video conference.
- Indicate that any appellant can review any information regarding his/her case file at any time.
- Indicate that the appellant may be represented by an attorney, a friend, or any other person designate by the appellant.
- Add language regarding postponements, as consumers should be given the option of postponing their hearing date at least once without the need to provide "good cause."

Continued: Regulation Section 6614: Hearing Requirements - Key Policy Issues

Final Staff Recommendation:

- Incorporate Stakeholder feedback to include verbiage that indicates that the administrative law judge will specifically hear the case. Revised State Regulations now states:

  "(4) By ~~one or more impartial officials~~ an administrative law judge who ~~have~~ has not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter."

- According to the California Department of Social Services' Manual of Policies and Procedures Title 22, the State Hearings Division shall be permitted to schedule hearings to be conducted by telephone or video conference in lieu of an in-person hearing. Such hearings shall be conducted by telephone or video conference only if the claimant agrees. Because this is CDSS's existing process, staff recommends to add the following into State Regulations:

  "(5) By telephone, video conference, or in person, in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-045."

- In regards to making the appeal record and all documents and records available to the appellant at any time, staff recommends to keep the verbiage that is consistent with Final Federal Regulations, but specifically indicate that the record will be made available at least two business days before the date of the hearing. Revised State Regulations state:

  "(a) 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 least two business days before the date of the hearing as well as during the hearing;"

- Staff recommends to incorporate Stakeholder feedback and add language that the appellant may be represented by a person of his/her choosing. Revised State Regulations now states:

  (6) Be represented by an authorized representative, a legal counsel, a relative, a friend, or another spokesperson designated by the appellant.

- Staff recommends to incorporate Stakeholder feedback and add information about postponements. Revised State Regulations state:

  (g) Postponements and continuances shall be conducted in accordance with the California Department of Social Services' Manual of Policies and Procedures Section 22-053.

Regulation Section 6618: Appeal Decisions - Key Policy Issues

Final Federal Regulation:

§ 155.545 Appeal Decisions:

"(c) Implementation of appeal decisions. The Exchange, upon receiving the notice described in paragraph (b), must promptly

(1) Implement the appeal decision effective:

(i) Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with § 155.330(f)(2) or (3), if applicable; or

(ii) Retroactively, to the date the incorrect eligibility determination was made, at the option of the appellant."

Draft State Regulation:

§ 6618. Appeal Decisions

"(c) Upon receiving the notice described in subdivision (b) of this section, the Exchange shall:

(1) Implement the appeal decision:

(A) Retroactive to the date the incorrect eligibility determination was made;

(B) At a time determined under Section 6496(k) through (m) of Article 5 of this chapter, as applicable; or

(C) In accordance with the applicable Medi-Cal or CHIP standards in 42 CFR parts 435 or 457; and

(2) Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in Section 6472 and 6474 of Article 5 of this chapter."

Stakeholder Feedback:

Stakeholders recommend that Covered California:

- Specifically indicate that the Exchange will implement the appeals entity's final decision no later than 30 days from the date of the issuance of the hearing decision.
- Request that a form be created for those individuals who wish to appeal directly to US Department of Health and Human Services upon the exhaustion of the initial appeals process.

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Continued: Regulation Section 6618: Appeal Decisions - Key Policy Issues

Final Staff Recommendation:

- Incorporate Stakeholder feedback to show that the Exchange will enroll the appellant on the first day of the following month or retroactively enroll the appellant to the date in which the incorrect eligibility determination was made. Revised State Regulations now reads:

  "(c) Upon receiving the notice described in subdivision (b) of this section, the Exchange shall promptly:

  (1) Implement the appeal decision effective:

  (A) Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with Section 6496(l), if applicable; or

  (B) Retroactively, to the date the incorrect eligibility determination was made, at the option of the appellant; and

  (2) Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in Section 6472 and 6474 of Article 5 of this chapter."

- At this time, staff currently recommends Covered California to collaborate and coordinate with the U.S. Department of Health and Human Services (HHS) to identify types of federal forms that will be available for appellants to complete and send to HHS upon the exhaustion of the appeals process.

Appendix: ARTICLE 7 – GENERAL ELIGIBILITY APPEALS REQUIREMENTS & NOTICE OF APPEAL PROCEDURES

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 • A denial of a request to vacate a dismissal made by the Exchange appeals entity in accordance with Section 6610(d)(2), made pursuant to subdivision (g) of this section. ➢ An appellant may ~~designate~~ represent him or herself, or be represented by an authorized representative, ~~to act on his or her behalf, including making an appeal request~~ or by legal counsel, a relative, a friend, or another spokesperson, during the appeal. ➢ The Exchange shall provide the appellant with the opportunity to review his or her eligibility file at any time during the course of the appeal.
§ 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, including expedited appeals; • Information on the applicant or enrollee's right to represent himself or herself, or to be represented by legal counsel or another ~~authorized~~ representative; • Information on how to get a legal aid referral or free legal help; • An explanation that all hearings shall be held in person, unless the appellant requests that the hearing be held telephonically or via video conference; • 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 that such a change shall ~~may~~ be handled as a redetermination of eligibility for all household members.

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Appendix: ARTICLE 7 – APPEAL REQUESTS

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6606. Appeal Requests.	➢ Covered California and the appeals entity, and the counties making eligibility determinations for the Exchange shall: • Accept appeal requests submitted ~~by all avenues in which an application may be submitted~~ through any of the following channels: The Exchange's internet web site; telephone; facsimile; mail; or in person. • Assist the applicant or enrollee in making an appeal request; and • Not limit or interfere with the applicant or enrollee's right to make an appeal. ➢ Covered California and the appeals entity shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination, unless the appeals entity determines, that there is good cause for filing the appeals request beyond the 90-day period. • Any appeal requests filed after 180 days of the date of the notice of eligibility determination shall not be accepted. • For purposes of this subdivision, if the last day of the filing period falls on a Saturday or holiday, the filing period shall be extended to the next business day. ➢ If the appellant disagrees with the appeal decision of Covered California appeals entity, he or she can make an appeal request to HHS within 30 days of the decision notice or notice of denial of a request to vacate a dismissal. ➢ 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; • Inform the appellant of the informal resolution process, • Provide information regarding the appellant's eligibility pending appeal, • Provide an explanation providing that any APTC paid on behalf of the tax filer pending appeal are subject to reconciliation, • 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~~ appellant that the appeal request has not been accepted within 5 business days; ~~and~~ • The nature of the defect of the appeal request, • Inform the appellant that the defect can be amended within 30 days, and • Treat as valid an amended appeal request that meets the requirements. ➢ Upon receipt of a valid appeal request or upon receipt of an 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. ➢ Covered California's appeals entity shall transmit, via secure electronic interface, the appellant's record to HHS within 3 business days from the date on which the appeal request is received.

Appendix: ARTICLE 7 – ELIGIBILITY PENDING APPEAL & DISMISSALS

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, or reinstate within 5 business days, 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: • Unconditionally or conditionally ~~W~~ withdraws the appeal request in writing prior to the hearing date; • Fails to appear at a scheduled hearing without good cause; • 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 or the appeal can be carried forward by a representative of the deceased appellant's estate. ➢ 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~~ shall vacate a dismissal and proceed with the appeal 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. ➢ The appeals entity shall provide written notice of the denial of a request to vacate a dismissal to the appellant within 5 business days from the date of such denial, if the request is denied.

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Appendix: ARTICLE 7 – INFORMAL RESOLUTION

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6612. Informal Resolution.	➢ An appellant shall have an opportunity for informal resolution prior to a hearing in accordance with the requirements of this section. ➢ Upon receipt of a valid appeal request, Covered California shall contact the appellant to informally resolve the appeal prior to the hearing date. ~~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~~ notwithstanding the outcome of the informal resolution process unless the appellant unconditionally or conditionally withdraws his or her appeal request prior to the hearing date. ➢ 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. ➢ Covered California shall issue a Statement of Position and all papers pertaining to the appeal record to the appeals entity to make available to the claimant at least 2 business days before the hearing. ➢ If the appellant is satisfied with the conditional withdrawal process and conditionally withdraws his/her appeal request, Covered California shall send a written notice within 5 business days which states the outcome and the effective date, if applicable. Covered California shall transmit this outcome to the appeal's entity within 3 business days via secure electronic interface. ➢ ~~If the appeal does not advance to hearing,~~ If the appeal request is dismissed in accordance with Section 6610, the informal resolution decision shall be final and binding.

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Appendix: ARTICLE 7 – HEARING REQUIREMENTS

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;~~ Within the timelines specified in 6606(c), except for the expedited appeals specified in 6616; • After notice of the hearing; • As an evidentiary hearing; • By ~~one or more impartial officials who~~ an administrative law judge who has ~~have~~ not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter; and • Over the telephone, through video conference, or in person. ➢ 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~~.~~; • Be represented by an authorized representative, a legal counsel, a relative, a friend, or another spokesperson designated by the appellant. ➢ 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 appeals process, 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 process. ➢ Postponements and continuances shall be conducted in accordance with the California Department of Social Services' Manual or Policies and Procedures Section 22-053.

Appendix: ARTICLE 7 – EXPEDITED APPEALS

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 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 appeals 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.~~ • Inform the appellant of the denial decision within 3 business days through electronic or oral notification, if possible. • Send a written notice of the denial decision to the appellant within 5 business days if the appellant could not be reached through oral notification. • Send the written notice that shall include the reason for the denial, an explanation that the appeal request will be transferred to the standard appeals process, and an explanation of the appellant's rights under the standard appeals process. ➢ If the request for an expedited appeal is approved, the appeals entity shall: • Ensure a hearing date is set on an expedited basis, provide the appellant with written notice within 10 calendar days from the date on which the expedited appeal is granted, unless a shorter timeframe is established by HHS. • Send a notification that shows the appellant's request is granted and it will show the date, time, and type of the hearing that will be convened. • Provide this notice via secure electronic interface to Covered California and to DHCS within 3 business days from the date on which the appellant's request for an expedited appeal is granted.

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Appendix: ARTICLE 7 – APPEAL DECISIONS

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6618. Appeal 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~~ before the HHS ~~Agency~~ appeals entity, including instructions to file, 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 on which a valid ~~an~~ appeal request is received, unless the 90-day timeline is extended due to good cause, in which case, the notice of the appeal decision shall be issued within the applicable extended timeline; • In the case of an expedited appeal request that the appeals entity determines meets the criteria for an expedited appeal, issue the notice of the appeal decision as expeditiously as reasonably possible ~~the appellant's health condition requires~~, but no later than ~~3 business~~ 10 calendar days after the appeals entity receives the request for an expedited appeal, unless a shorter timeframe is established by HHS; 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 effective: ~~o Retroactive to the date the incorrect eligibility determination was made;~~ Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with Section 6496(1), if applicable; or o Retroactively, to the date the incorrect eligibility determination was made, at the option of the appellant; and ~~o 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.

Appendix: ARTICLE 7 – APPEAL RECORD

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~~ decisions, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

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