

Stakeholder considerations for ACA exchange and Medicaid interim final rules

Introduction

Through the Patient Protection and Affordable Care Act (ACA), individuals and qualified small businesses will be able to purchase private health insurance through Affordable Insurance Exchanges (exchanges) beginning on Jan. 1, 2014. Under the ACA, the Department of Health and Human Services (HHS) is charged with implementing exchanges and has begun to do so through rulemaking.

On March 27, 2012, HHS published an exchange establishment and eligibility final rule which codifies standards relating to operating an exchange, eligibility for enrollment in an exchange and insurance affordability programs, qualified health plan participation (QHP) in an exchange and the Small Business Health Options Program (SHOP). These regulations are effective May 29, 2012. On March 23, 2012, HHS published a Medicaid final rule which codifies policy and procedural changes to the Medicaid and CHIP programs relating to eligibility, enrollment and renewals and coordination across insurance affordability programs. These regulations are effective Jan. 1, 2014.

Both of these final rules contain provisions that are considered interim final and on which HHS is seeking public comment. Public comment on the exchange establishment and eligibility interim final rules is due by **May 11, 2012**. Public comment on the Medicaid interim final rules is due by **May 7, 2012**.

Following HHS's release of the rules, the Health Policy Institute of Ohio convened a diverse group of stakeholders comprised of representatives from provider, consumer, agent and broker, health plan, academic, small business and local government sectors to analyze the exchange rules and assess the implications of these rules on Ohio and Ohioans. Feedback from this group is reflected in this document, which summarizes the exchange establishment and eligibility and the Medicaid interim final rules and highlights key stakeholder considerations regarding the interim final rules. This document is intended to inform individuals and organizations and assist those who would like to provide comment on the interim final rules.

inside

Exchange Establishment and Eligibility Interim Final Rules	2
Agents and brokers	2
Medicaid and CHIP regulations	3
Exchange eligibility determinations, standards and verification	3
Administration of advance payments	4
Agreements between agencies administering insurance affordability programs	5
Medicaid — Interim Final Rules	6
Safeguarding information for non-applicants	6
Timely determination of eligibility	7
Coordination of eligibility and enrollment among insurance affordability programs —	
Medicaid Agency responsibilities	8
Application for, and enrollment in, the Childrens Health Insurance Program (CHIP)	8
Determination of CHIP eligibility by other insurance affordability programs	9
Eligibility screening and enrollment in other insurance affordability programs	9
Sources	9

Exchange Establishment and Eligibility Interim Final Rules

Comments deadline: May 11, 2012 5pm ET

Issue:

Agents and brokers

Interim Final Rule

§ 155.220(a)(3)

Summary of Rule

Establishes that a state may permit agents and brokers to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

To which exchange model does this Rule apply?

State exchange

Stakeholder Considerations

- Permitting states to allow agents and brokers to assist individuals in applying for insurance affordability programs allows states greater flexibility to structure their exchange to meet the needs of their particular market.
- The current financial arrangements between agents, brokers and insurers may raise the potential for financial conflicts of interest that may impact or influence the guidance agents and brokers provide to consumers. However, this risk may be mitigated by the ethical standards to which agents and brokers are held within their industry.
- In order to assist individuals applying for insurance affordability programs, the state should ensure that agents and brokers are able to acquire access to necessary applicant information from the exchange or other state agencies.
- This rule may create a more seamless customer service experience for the applicant, especially to the extent that agents and brokers assist in enrollment in QHPs and Medicaid.
- There is concern that the role of agents and brokers in the exchange may be too expansive and may have a negative impact on the function of the navigator program within the exchange.
- Requiring comprehensive state certification processes for agents and brokers can help ensure agents and brokers are educated and equipped to assist individuals in applying for insurance affordability programs.
- Because of the likelihood that agents and brokers, as well as navigators, will deal with sensitive financial and immigration status information, there is concern that the certification process should also include strong consumer protections and accountability measures in the event of breach of privacy.
- Currently, agents and brokers are required to provide safeguards to protect consumer information through the Health Insurance Portability and Accountability Act (HIPAA) and the Gramm-Leach-Bliley Act. Notably, some have advocated that consumer protection standards imposed on agents and brokers should be as robust for navigators within the navigator program.

Definitions

Qualified Health Plan — A health plan that has been certified by an exchange and meets minimum certification standards.

Navigator — A private or public entity or individual that is qualified, and licensed, if appropriate, to provide consumers with guidance and steer them through the exchange system.

Issue:

Medicaid and CHIP regulations

Interim Final Rule	§ 155.300(b)
Summary of Rule	Clarifies that references to Medicaid and CHIP regulations in subpart D refer to those regulations as implemented in accordance with rules and procedures that are the same as those applied by the State Medicaid or State CHIP agency or approved by such agency in the agreement described in § 155.345(a).
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none">• The language of § 155.300(b) helps ensure that exchange eligibility determinations for Medicaid and CHIP comply with state plans and interpretive policies and procedures of the state agency or agencies administering the Medicaid or CHIP programs.

Issue:

Exchange eligibility determinations, standards and verification

Interim Final Rule	§ 155.302
Summary of Rule	Outlines the various options that a state may implement to conduct eligibility determinations for Medicaid and CHIP and for advance payments of the premium tax credit and cost-sharing reductions. The exchange has the option to: <ol style="list-style-type: none">1. Execute eligibility determinations directly, through contracting arrangements or a combination of both.2. Conduct an assessment of eligibility for Medicaid and CHIP rather than eligibility determination, and where the applicant appears eligible or desires further review, transmit the information to the state Medicaid/CHIP agency for final eligibility determination for Medicaid/CHIP3. Implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions or rely on HHS to carry out this function
To which exchange model does this Rule apply?	State exchange <i>(Note: The options for eligibility determination enumerated in the interim final rules are separate and distinct from what would be implemented under the "partnership" exchange model.)</i>
Stakeholder Considerations	<ul style="list-style-type: none">• Providing options regarding eligibility determination for Medicaid and CHIP and for advance payments of the premium tax credit and cost-sharing reductions may provide states with greater flexibility to retain control of core functions and/or cede control of functions that another agency or HHS may be best equipped to conduct.• Increasing handoffs between the state exchange and the state Medicaid and CHIP programs for determination of Medicaid and CHIP eligibility could disrupt applicants' seamless consumer experience, create process duplication between agencies and the exchange and increase the likelihood for process errors.• The provision does not clearly denote that applicants found ineligible for Medicaid and CHIP will be notified that they may be eligible for advance payments of the premium tax credit and cost-sharing reductions. A lack of notification to applicants may delay or impede an applicant's enrollment process.• There is some concern that HHS should more clearly define the terms "promptly" and "undue delay." More guidance from HHS on the timeliness standard is expected.• The configuration of options outlined in the provision requires close coordination between a state exchange, HHS and the state Medicaid and CHIP agency. The data sharing elements for some options may require greater resources and/or time to implement. Federal funding for building the required IT infrastructure is available to states via exchange establishment grants and enhanced federal Medicaid match. Establishment grant applications will be accepted through 2014.

Exchange eligibility determinations, standards and verification (cont.)

Interim Final Rule	§ 155.305(g)
Summary of Rule	Outlines the eligibility criteria and categories an exchange must utilize to determine if an applicant is eligible for cost-sharing reductions. The provision also clarifies how to address cost-sharing reductions in situations in which multiple tax households are covered by a single policy.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none"> • The provision may increase the affordability of coverage for lawfully present immigrants by enabling those with incomes below 100 percent FPL who are eligible for advance payments of the premium tax credit (but ineligible for Medicaid) to also be considered within the 100 to 150 percent FPL eligibility category for purposes of determining eligibility for cost-sharing reductions. • Under the interim final rule, multiple tax households covered by a single policy may not be able to receive the benefit for all the cost-sharing provisions for which they are eligible.
Interim Final Rule	§ 155.310(e)
Summary of Rule	Establishes that an exchange must conduct and make eligibility determinations promptly and without undue delay.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none"> • Timeliness standards can help ensure that consumers' exchange experiences are smooth and seamless. • There is some concern that HHS should more clearly define timeliness standards. More guidance from HHS on the timeliness standard is expected.
Interim Final Rule	§ 155.315(g)
Summary of Rule	States that an exchange will implement a case-by-case approach and accept an applicant's attestation to information required to determine an applicant's eligibility for enrollment in a QHP, advance payments of premium tax credits or cost-sharing reductions, if documentation with which to resolve an inconsistency does not exist or is not reasonably available, with the exception of inconsistencies related to citizenship and immigration status.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none"> • Provision of a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available accounts for situations where such documentation cannot be obtained and also allows for consistency with standards set for the Medicaid program. • Allowing for a case-by-case exception can help ensure that at-risk populations (such as homeless individuals, victims of domestic violence or natural disasters and sporadic earners) are still able to enroll in the exchange and participate in insurance affordability programs. • Allowing for a case-by-case exception may increase the administrative burden on exchanges, as well as the need for greater administrative oversight to minimize incidences of fraud and abuse.

Issue:

Administration of advance payments

Interim Final Rule	§ 155.340(d)
Summary of Rule	Establishes that an exchange must transmit, promptly and without undue delay, necessary applicant information to enable advance payments of the premium tax credits and cost sharing reductions.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none">• Inclusion of a timeliness standard can help ensure that the exchange functions in a smooth and seamless manner.• There is some concern that HHS should more clearly define timeliness standards. More guidance from HHS on the timeliness standard is expected.

Issue:

Agreements between agencies administering insurance affordability programs

Interim Final Rule	§ 155.345(a)
Summary of Rule	Requires exchanges to establish agreements with insurance affordability programs to clearly delineate the responsibilities required of each program.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none">• Established agreements between the exchange and insurance affordability programs (i.e. Medicaid and CHIP) can help improve the cooperation and coordination of these programs with one another, prevent duplication of processes, minimize the burden on applicants and designate responsibility for critical functions among organizations.• The ability to increase cooperation and coordination among exchanges and related agencies is likely to necessitate a significant data sharing requirement between organizations. Federal funding for building the required IT infrastructure is available to states via exchange establishment grants and enhanced federal Medicaid match. Establishment grant applications will be accepted through 2014.

Issue:

Agreements between agencies administering insurance affordability programs (cont.)

Interim Final Rule	§ 155.345(g)
Summary of Rule	Requires an exchange to establish standards for applications submitted directly to an agency administering an insurance affordability program to ensure that an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit and cost-sharing reductions is performed. Provides standards for applications transmitted between agencies administering insurance affordability programs.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none">Established standards between the exchange and insurance affordability programs (i.e. Medicaid and CHIP) can help improve the cooperation and coordination of these programs with one another, prevent duplication of processes, minimize the burden on applicants and designate responsibility for critical functions among organizations.The ability to increase cooperation and coordination among exchanges and related agencies is likely to necessitate a significant data sharing requirement between the organizations. Federal funding for building the required IT infrastructure is available to states via exchange establishment grants and enhanced federal Medicaid match. Establishment grant applications will be accepted through 2014.

Medicaid — Interim Final Rules

Comments deadline: May 7, 2012 5 PM EDT

Issue:

Safeguarding information for non-applicants

Interim Final Rule	§ 431.300(c)(1) and (d)
Summary of Rule	Requires state agencies to have adequate safeguards for information shared across agencies, including ensuring that information exchanged by state agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information. Safeguards apply to information gathered about non-applicants as well as applicants and beneficiaries.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none">Ensuring safeguards are built into the business processes and operations of all entities that have a role in assessing and/or determining eligibility for Medicaid and insurance affordability programs may require substantial resources and data sharing capacity.Federal funding for building the required IT infrastructure is available to states via exchange establishment grants and enhanced federal Medicaid match. Establishment grant applications will be accepted through 2014.

Issue:

Safeguarding information for non-applicants (cont.)

Interim Final Rule	§431.305 (b)(6)
Summary of Rule	States that any information received for verifying income eligibility and amount of medical assistance payments must be safeguarded and follow the safeguarding protocols of the Social Security Administration or Internal Revenue Service as applicable.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none">• Ensuring safeguards are built into the business processes and operations of all entities that have a role in assessing and/or determining eligibility for Medicaid and insurance affordability programs may require substantial resources and data sharing capacity.• Federal funding for building the required IT infrastructure is available to states via exchange establishment grants and enhanced federal Medicaid match. Establishment grant applications will be accepted through 2014.

Issue:

Timely determination of eligibility

Interim Final Rule	§435.912
Summary of Rule	<ul style="list-style-type: none">• Each state plan must include timeliness and performance standards for processing applications promptly and without undue delay. These standards apply to eligibility or potential eligibility determinations conducted by a single state agency or transferred to or received from another insurance affordability program.• The timeliness and performance standards must cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program.• Requires that, except for noted exceptions, determination of eligibility may not exceed:<ol style="list-style-type: none">1. 90 days for applicants who apply for Medicaid on basis of disability2. 45 days for all other applicants
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none">• Note: Ohio currently has a 30-day standard for Medicaid eligibility for applicants not applying on basis of disability and 90 days for those applying on basis of disability.• Timeliness and performance standards can help ensure that the exchange functions in a smooth and seamless manner.• Ensuring agency compliance with the timeliness and performance standards may necessitate major technology and system redesign and restructuring. The resources needed to carry out these changes are likely to be substantial.• Federal funding for building the IT infrastructure required is available to states via exchange establishment grants and enhanced federal Medicaid match. Establishment grant applications will be accepted through 2014.• There is concern that the timeliness period should always start with the date of initial application, even in instances where a transfer occurs between the exchange and Medicaid, in order to ensure a timely decision for consumers.• State performance standards should reflect that systems and technological capacities will generally make it possible for real time determinations of eligibility in most cases.

Issue:

Coordination of eligibility and enrollment among insurance affordability programs—Medicaid agency responsibilities

Interim Final Rule	§435.1200
Summary of Rule	<ul style="list-style-type: none">Establishes the standards and guidelines for ensuring simple, coordinated and timely eligibility determinations between state Medicaid agencies and exchanges, regardless of which of the following options the state chooses for coordinating eligibility determinations:<ol style="list-style-type: none">State Medicaid agencies make final Medicaid eligibility based on exchange's initial reviewState Medicaid agency may accept final eligibility determination made by exchange that uses state eligibility rules and standardsWhen the Medicaid agency determines that an applicant is not eligible for Medicaid, it must promptly and without undue delay determine potential eligibility for another insurance affordability program and, as appropriate, transfer the individual's information to the other program.These provisions apply not only to eligibility determination at initial application, but also at renewal and when a change in eligibility criteria is reported or identified.Requires the state Medicaid agency to operate a web site for current and prospective Medicaid applicants and beneficiaries, which can be operated in conjunction with, or be linked to, the exchange website.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	<ul style="list-style-type: none">Requires that states adopt a coordinated business process and supporting systems to ensure an efficient and seamless evaluation of an individual's eligibility for insurance affordability programs.There is some concern that HHS should require the adoption of a shared eligibility service to eliminate the need for electronic transfer of information among agencies.Allowing states two options for determining applicant eligibility may provide states with greater flexibility.The lack of a requirement to operate a single web site for insurance affordability programs may create confusion and disruption in the application process for consumers.Allowing exchanges to determine Medicaid eligibility, instead of the state Medicaid agency, raises some concerns for Medicaid beneficiaries, including:<ul style="list-style-type: none">How to ensure an entity's accountability for timelinessIssues of transparency in regards to how applications are handledResponsiveness to beneficiary concerns, coordination with other public benefits, and participation in the fair hearings process

Issue:

Application for and enrollment in the Child Health Insurance Program (CHIP)

Interim Final Rule	§457.340(d)
Summary of Rule	<ul style="list-style-type: none">The Medicaid timeliness standards in §435.912 apply equally to CHIP, except transferring electronic accounts to other insurance affordability programs pursuant to §457.350 and standards for receiving applications from other insurance affordability programs pursuant to §457.348.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	Note: Ohio does not have a separate CHIP program.

Issue:

Determination of Children's Health Insurance Program eligibility by other insurance affordability programs

Interim Final Rule	§457.348
Summary of Rule	<ul style="list-style-type: none">• The state may accept final determinations of CHIP eligibility made by the exchange and set standards regarding agreements with other insurance affordability programs, consistent with Medicaid.• Aligns CHIP eligibility and enrollment rules with Medicaid standards.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	Note: Ohio does not have a separate CHIP program.

Issue:

Eligibility screening and enrollment in other insurance affordability programs

Interim Final Rule	§457.350 (a)-(c), (f), (i), (j) and (k)
Summary of Rule	Aligns CHIP eligibility and enrollment rules with Medicaid standards.
To which exchange model does this Rule apply?	State, Federal and Partnership exchange*
Stakeholder Considerations	Note: Ohio does not have a separate CHIP program.

* The current interpretation of these rules suggests that their intent would apply to all exchange models. However, once all final rules and guidance governing the federal and partnership exchanges have been released, there may be variation in the way these rules are operationalized and implemented across models.

Sources

1. The Patient Protection and Affordable Care Act, Pub. L. No.111-148, §1311(b) (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 11-152 (2010), is referred to herein as the "Affordable Care Act" or "ACA."
2. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers 77 Fed. Reg. 18310 et seq. (published March 27, 2012) is referred to herein as the "exchange establishment and eligibility" final rule available at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>.
3. Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 77 Fed. Reg. 17144 et seq. (published March 23, 2012) is referred to herein as the "Medicaid" final rule available at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf>.
4. State Exchange Implementation Questions and Answers (published Nov. 29, 2011) available at http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.